PREFACE

PHILOSOPHY

Therapeutic work with families is a recent scientific phenomenon but an ancient art. Throughout human history, designated persons in all cultures have helped couples and families cope, adjust, and grow. In the United States, the interest in assisting families within a healing context began in the 20th century and continues into the 21st. Family life has always been of interest, but because of economic, social, political, and spiritual values, outsiders made little direct intervention, except for social work, into ways of helping family functioning until the 1950s. Now, there are literally thousands of professionals who focus their attention and skills on improving family dynamics and relationships.

In examining how professionals work to assist families, the reader should keep in mind that there are as many ways of offering help as there are kinds of families. However, the most widely recognized methods are counseling, therapy, educational enrichment, and prevention. The general umbrella term for remediation work with families is *family therapy*. This concept includes the type of work done by family professionals who identify themselves by different titles, including marriage and family therapists, licensed professional counselors, psychologists, psychiatrists, social workers, psychiatric nurses, pastoral counselors, and clergy.

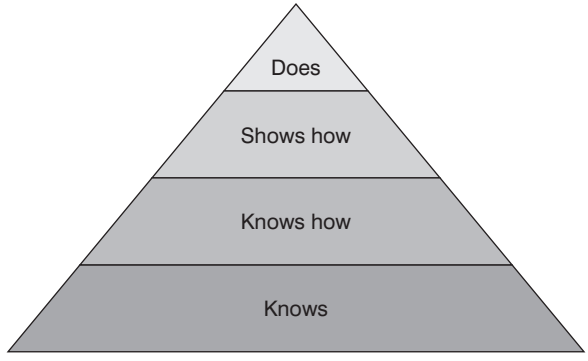
Family therapy is not a perfect term; it is bandied about by a number of professional associations, such as the American Association for Marriage and Family Therapy (AAMFT), the American Counseling Association (ACA), the American Psychological Association (APA), and the National Association of Social Workers (NASW). Physicians who treat families also debate this term. As doctors, are they "family therapists," or, because they are engaged in the practice of medicine, are they "family medical specialists"? For purposes of this book, the generic term *family therapy* is used because of its wide acceptance among the public and professionals who engage in the practice of helping families. Within this term, some aspects of educational enrichment and prevention are included.

ORGANIZATION

As a comprehensive text, this book focuses on multiple aspects of family therapy.

Part 1 introduces the reader to the foundations on which family therapy is built, such as general systems theory, and the history of the profession. It also acquaints readers with various types of families and family forms (e.g., nuclear, single parent, blended), characteristics of healthy and dysfunctional families, and cultural as well as ethical and legal considerations in working with families.

Part 2 examines the main theoretical approaches to working therapeutically with couples and families. For couples, these theories are behavioral couple therapy (BCT), cognitive–behavioral couple therapy (CBCT), and emotionally focused therapy (EFT). For families, major theories are psychodynamic, Bowen (or transgenerational), experiential (including feminist), behavioral, cognitive–behavioral, structural, strategic, solution-focused, and narrative approaches. Each theoretical chapter emphasizes the major theorist(s) of the approach, premises, techniques, process, outcome, and unique aspects of the theory, and a comparison with other approaches. Case illustrations are also provided.



Part 3 covers professional issues and research in family therapy, with a chapter specifically about working with substance-related disorders, domestic violence, and child abuse and another chapter on research and assessment in family therapy. This part of the book is the briefest, but it is also meaty in focusing on issues that are relevant to society and to the health and well-being of people and the profession.

As you read, consider Miller's (1990) four-level pyramid of clinical competence. In this conceptualization, the base of the pyramid is built on factual knowledge gained by reading and studying didactic information. One level up is "knows how," or the ability to apply the knowledge gained on the previous level. On top of that level is "shows how," which is represented by the person's ability to act appropriately in a practical or simulated situation. At the top of the pyramid is the "does" level, which is actual clinical work in regular practice (Miller, 2010). The present text can be considered as the base of the pyramid, with exercises to help you begin to reach the second and third levels, so that with advanced training you will be able to function effectively at the final level.

NEW TO THIS EDITION

The sixth edition of *Family Therapy* is considerably different from the fifth edition. Highlights of the differences are as follows:

- First, the organization of the book is different. There are now 16 instead of 17 chapters, which makes the book more suitable for a semester-based class.
- Second, to make the chapters better focused for the reader and more user-friendly, learning objectives are place at the beginning of each chapter, specifically a "chapter overview" and an "as you read consider" section.
- Third, the book has three new chapters and much fresh material. The second chapter is new and focuses on the theoretical context of family therapy. It highlights the importance of understanding general systems theory, cybernetics, individual and family developmental life cycles, and the most prevalent factors leading families to seek counseling over time. In addition, the chapter on healthy and dysfunctional families now covers types of families, as well as functionality. Furthermore, what were formerly separate chapters on working with single-parent families and blended families have been combined because of the overlap and the many similarities in

treatment related to them. Finally, the ethical codes of the American Association for Marriage and Family Therapy and the International Association for Marriage and Family Counselors (IAMFC) have been eliminated, since they are easily accessible online and are subject to change.

- Fourth, while the three-part format of the book has been kept, the content in these sections has changed in order to better lead the reader developmentally into understanding the field of family therapy. Specifically, the chapter on the history of family therapy has been moved into the first section of the book as Chapter 1, and the chapter on ethical, legal, and professional issues in family therapy is now included in the first section as Chapter 7.
- Fifth, a dozen new illustrations have been added to the text to visually enhance the concepts that are described in words. These illustrations are original drawings by Lindsay Berg, a graduate of the counseling program at Wake Forest University and my graduate assistant while this book was being revised.
- Sixth, while relevant and classic citations have been kept, less-important or dated references have been deleted. In addition, over 175 new sources have been added.
- Seventh, a chart giving models of family therapy that highlights the main points of the family therapeutic approaches covered in the book has been added as an appendix. This reference should be useful in helping readers to quickly grasp the essentials of these theories.
- Finally, 23 film clips pertinent to chapter content have been inserted into 11 chapters. By viewing them, readers will get a better understanding of how concepts in family therapy are actually carried out. This feature makes the book more lively and interesting to those interested in the reality of the profession.

Overall, the sixth edition of *Family Therapy* is a much different text than its predecessors. It is more developmental, better illustrated, and a more reflective book while not sacrificing content or scholarship. There is an emphasis on both the reader's family of origin and families he or she will work with. Overall, the sixth edition of *Family Therapy* takes a broader and more progressive approach to treating families while remaining rich in covering theories and ways of preventing families from becoming dysfunctional.

A PERSONAL NOTE

In undertaking the writing of this work, I have been informed not only by massive amounts of reading in the rapidly growing field of family therapy, but also by my experiences during the last 40 years of therapeutically working with families. Both my family of origin and current family of procreation have influenced me as well. In addition, as a member of both the American Association for Marriage and Family Therapy and the International Association for Marriage and Family Counselors, I have tried to view families and family therapy from the broadest base possible. Readers should find information in this work that will help them gain a clear perspective on the field of family therapy and those involved with it.

Like the authors of most books, I truly hope that you as a reader enjoy and benefit from the contents of this text. It is my wish that when you complete your reading, you will have gained a greater knowledge of family therapy, including aspects of prevention,

enrichment, and therapy that affect you personally as well as professionally. If such is the case, then you will have benefited and possibly changed. I, as an author, will have accomplished the task that I set out to do.

ACKNOWLEDGMENTS

I am grateful to the reviewers who spent many hours critiquing the first edition of this book: James Bitter, California State University at Fullerton; Donald Bubenzer, Kent State University; Harper Gaushell, Northeast Louisiana University; J. Scott Hinkle, University of North Carolina at Greensboro; Gloria Lewis, Loyola University of Chicago; Donald Mattson, University of South Dakota; Eugene R. Moan, Northern Arizona University; and Tom Russo, University of Wisconsin, River Falls.

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I especially want to thank my graduate research assistants for the academic year 2012–2013, Lindsay Berg, and the summer of 2009, Ned Martin, for their tireless efforts in helping me find updated statistics and articles for this and the previous edition of *Family Therapy* and for making excellent suggestions about individual chapters and the book as a whole. Ned even proofread a couple of chapters for this edition of the book, which helped me a lot. Similarly, Cassie Cox, my graduate assistant during the academic year 2008–2009, supplied me with valuable materials for this book, and I am most grateful to her. In addition, Trevor Buser, another graduate assistant back in 2006, helped me locate massive amounts of information for the fourth edition. He went on to earn his Ph.D. and is a professor of counseling at Rider University, which does not surprise me, because his work ethic and efficiency, like that of Lindsay, Ned, and Cassie, was exceptional. In addition, Virginia Perry of Winston-Salem, my former graduate assistants Michele Kielty-Briggs and Jenny Cole, and the current program manager of the Department of Counseling, Pamela Karr, of Wake Forest University, have been constructive and positive in their input on previous editions of this text as well. I am most grateful to them. Furthermore, I am indebted to my current editor at Pearson, Meredith Fossel, for her tireless effort,

support, and assistance on my behalf. She has been a pleasure to work, with as was Kevin Davis, my previous editor.

This text is dedicated to my family, especially my parents. My father died in April 1994, at the age of 84, soon after I completed the first edition of this text. My mother died in August, 2000, 2 months short of turning 90, just as I was finishing the third edition of the book. The love and courage of both my parents, along with the legacy left to me by previous generations of my family, have affected me positively. I know I am most fortunate.

Finally, and as important, I am indebted to my wife, Claire, for her encouragement and comfort during the writing process. She has insisted throughout this effort, as through our 28 years of marriage, that we talk and build our relationship as a couple. She has employed all of her communication skills, including a generous dose of humor, to help me be a better spouse. She has also been, throughout this time, my partner, friend, and lover in the raising of our three children: Ben, Nate, and Tim.

Samuel T. Gladding

PART 1

Foundations of Family Therapy

CHAPTER 1

The History of Family Therapy: Evolution and Revolution

In the lighting of candles and exchanging of vows
we are united as husband and wife.
In the holiday periods of nonstop visits
we are linked again briefly to our roots.
Out of crises and the mundane
we celebrate life
appreciating the novel
and accepting the routine
as we meet each other anew
amid ancestral histories and current reflections.

Families are a weaver's dream
with unique threads from the past
that are intertwined with the present
to form a colorful tapestry
of relationships in time.

Gladding, 1991a

CHAPTER OVERVIEW

From reading this chapter, you will learn about

- How family therapy has developed over the decades in an evolutionary and revolutionary way.
- What major factors and personalities have propelled family therapy into a profession.
- What recent trends have influenced the growth and development of family therapy.

As you read, consider

- What personal or development event in the history of family therapy you consider most significant, radical, or inevitable and why.

- How the change in a family is like that of a profession and how such change is different.
- The impact of change and new developments on the lives of family therapists and family therapy.
- What trends you see in society that you think will influence the future development of family therapy.

Family therapy is one of the newest forms of professional helping. In an evolutionary way it is an extension of the attempt by people throughout history to cure emotional suffering. "Over 2,000 years ago the first written accounts of an integrative system of treating mental illness were recorded" (Kottler, 1991, p. 34). Prehistoric records indicate that systematic attempts at helping were prevalent even before that time. Family members throughout history have tried to be of assistance to each other. This help initially took two forms:

1. Elders gave younger members of family clans and tribes advice on interpersonal relationships.
2. Adult members of these social units took care of the very young and the very old (Strong, DeVault, & Cohen, 2008).

However, despite a long history, as a profession family therapy is relatively recent in its formal development. Multiple events and personalities, some of them revolutionary in nature, have influenced and shaped the profession (AAMFT, 2010). Although all of the facts and personalities mentioned here had some impact on the growth of the field, some have been more pivotal than others. The exact importance of particular places, people, and actions sometimes changes in scope and magnitude according to who is recounting events. The order in which these developments occurred, however, can be charted chronologically. Some past facts and figures stand out regardless of one's historical orientation.

INHIBITORS OF THE DEVELOPMENT OF FAMILY THERAPY

Prior to the 1940s, family therapy in the United States had not evolved much beyond advice giving. It was almost a nonentity. Three social influences contributed to this phenomenon. The first involved myth and perception. The myth of rugged individualism was the predominant deterrent to the genesis of family therapy. Healthy people were seen as adequate to handle their own problems. Rugged individualism stemmed from the settling of the United States, especially the American West. Individuals were expected to solve their own problems if they were to survive. Intertwined with this myth was the perception, handed down from the Puritans and other religious groups, that those who prospered were ordained by God (Strong, DeVault, & Cohen, 2008). To admit one had difficulties, either inside or outside of a family context, was to also admit that one was not among the elect in addition to not being among the strong and rugged esteemed by the dominant culture.

A second social factor that deterred the development of family therapy was tradition. Historically, people usually confided with clergy, lawyers, and doctors, rather than with mental health professionals, when they discussed their marital and family concerns. These professionals knew the families in question well because they usually lived with

them in a shared community over many years. Seeking advice and counsel from these individuals was different from talking to a professional specialist.

A third factor that prevented family therapy from evolving much before the 1940s was the theoretical emphases of the times. The major psychological theories in the United States in the early part of the 20th century were **psychoanalysis** and **behaviorism**. Both were philosophically and pragmatically opposed to dealing with more than individual concerns. Proponents of psychoanalysis, for instance, believed that dealing with more than one person at a time in therapy would contaminate the transference process and prevent depth analysis from occurring. Likewise, behaviorists stressed straightforward work with clients, usually in the form of conditioning and counterconditioning. The social and political climate required for family therapy to develop and grow was almost nonexistent.

CATALYSTS FOR THE GROWTH OF FAMILY THERAPY

Despite this inhospitable environment, four factors combined, sometimes in explosive and surprising ways, to make family therapy accepted and eventually popular. The first was the growth of the number of women enrolled in colleges and their demand for courses in **family life education** (Broderick & Schrader, 1991). Educators from a number of disciplines responded to this need in groundbreaking ways. Among the most noteworthy was Ernest Groves (1877–1946), who taught courses on parenting and family living at Boston University and the University of North Carolina. Groves wrote the first college text on marriage, simply entitled *Marriage*, in 1933. His writings also appeared in popular periodicals of the day, such as *Look*, *Good Housekeeping*, and *Parents Magazine* (Dail & Jewson, 1986; Rubin 2008). Later Groves became instrumental in founding the **American Association of Marriage Counselors (AAMC)** in 1942 (Broderick & Schrader, 1991) and in establishing what is now the Groves Conference to study the impact of globalization on families (Rubin, 2008).

The second event that set the stage for the development and growth of family therapy was the initial establishment of **marriage counseling**. In New York City, Abraham Stone (1890–1959) and Hannah Stone (1894–1941) were among the leading advocates for and practitioners of marriage counseling in the late 1920s and 1930s. Emily Mudd (1898–1998) began the Marriage Council of Philadelphia in 1932, which was devoted to a similar endeavor. In California, Paul Popenoe (1888–1979) established the American Institute of Family Relations, which was in essence his private practice. Popenoe introduced the term *marriage counseling* into the English language. He popularized the profession of marriage counseling by writing a monthly article, "Can This Marriage Be Saved?" in the *Ladies Home Journal*—a feature that began in 1945 and continues today.

A third stimulus and initiative in the genesis of family counseling was the founding of the National Council on Family Relations in 1938 and the establishment of its journal, *Marriage and Family Living*, in 1939. This association promoted research-based knowledge about family life throughout the United States. Through its pioneer efforts and those of the American Home Economics Association, information about aspects of family life were observed, recorded, and presented.

The fourth favorable and unexpected event that helped launch family therapy as a profession was the work of county home extension agents. These agents began working educationally with families in the 1920s and 1930s and helped those they encountered to better understand the dynamics of their family situations. Some of the ideas and advice

offered by agents were advocated by Alfred Adler, who developed a practical approach for working with families that became widespread in the United States in the 1930s (Dinkmeyer, Dinkmeyer, & Sperry, 2000; Sherman, 1999).

Family Therapy: 1940 to 1949

Several important and robust events took place in the 1940s that had a lasting impact on the field of family therapy. One of the most important was the establishment of an association for professionals working with couples. As mentioned earlier, the AAMC was formed in 1942 by Ernest Groves and others. Its purpose was to help professionals network with one another in regard to the theory and practice of marriage counseling. It also devised standards for the practice of this specialty. With the founding of the AAMC, professionals with an interest in working with couples had a group with whom they could affiliate and exchange ideas.

A second landmark event of the 1940s was the publication of the first account of concurrent marital therapy by Bela Mittleman (1948) of the New York Psychoanalytic Institute. Mittleman's position stressed the importance of object relations in couple relationships. It was a radical departure from the previously held intrapsychic point of view.

A third significant focus during the 1940s was the study of families of individuals suffering from schizophrenia. One of the early pioneers in this area was Theodore Lidz (1910–2001), who published a survey of 50 families. He found that the majority of schizophrenics came from broken homes and/or had seriously disturbed family relationships (Lidz & Lidz, 1949). Lidz later introduced into the family therapy literature the concepts of **schism**, the division of the family into two antagonistic and competing groups, and **skew**, whereby one partner in the marriage dominates the family to a striking degree as a result of serious personality disorder in at least one of the partners. Now a new language, specific to working with families, was developing.

The final factor that influenced family counseling in the 1940s was the upheaval of World War II and its aftermath. The events of the war brought considerable stress to millions of families in the United States. Many men were separated from their families because of war duty. Numerous women went to work in factories. Deaths and disabilities of loved ones added further pain and suffering. A need to work with families experiencing trauma and change became apparent. To help meet mental health needs, the **National Mental Health Act of 1946** was passed by Congress. "This legislation authorized funds for research, demonstration, training, and assistance to states in the use of the most effective methods of prevention, diagnosis, and treatment of mental health disorders" (Hershenson & Power, 1987, p. 11). Mental health work with families would eventually be funded under this act and lead to new research, techniques, and professions.

Family Reflection: Prior to 1950 most of what would become family therapy was formulated on studying troubled marriages and families with a disturbed or distraught member. Imagine that instead family therapy had been based on researching healthy or culturally unique families. Had that been the case, how do you think it would have developed?

Family Therapy: 1950 to 1959

Some family therapy historians consider the 1950s to be the genesis of the movement (Guerin, 1976). Landmark events in the development of family therapy in the 1950s centered

more on individual, often charismatic, leaders than on organizations because of the difficulty of launching this therapeutic approach in the face of well-established opposition groups, such as psychiatrists.

IMPORTANT PERSONALITIES IN FAMILY THERAPY IN THE 1950s A number of creative, strong, and insightful professionals contributed to the interdisciplinary underpinnings of family therapy in the 1950s (Shields, Wynne, McDaniel, & Gawinski, 1994). Each, in his or her way, contributed to the conceptual and clinical vitality, as well as to the growth, of the field.

Nathan Ackerman (1908–1971) was one of the most significant personalities of the decade. Although he advocated treating the family from a systems perspective as early as the 1930s (Ackerman, 1938), it was not until the 1950s that Ackerman became well known and prominent. His strong belief in working with families and his persistently high energy influenced leading psychoanalytically trained psychiatrists to explore the area of family therapy. An example of this impact can be seen in Ackerman's book *The Psychodynamics of Family Life* (1958), in which he urged psychiatrists to go beyond understanding the role of family dynamics in the etiology of mental illness and begin treating client mental disorders in light of family process dynamics. To demonstrate that his revolutionary ideas were workable, he set up a practice in New York City, where he could show his ideas had merit through pointing out results in case examples.

Another influential figure was **Gregory Bateson** (1904–1980) in Palo Alto, California. Bateson, like many researchers of the 1950s, was interested in communication patterns in families with individuals who had been diagnosed with schizophrenia. He obtained several government grants for study, and, with Jay Haley, John Weakland, and eventually Don Jackson, Bateson formulated a novel, controversial, and powerful theory of dysfunctional communication called the **double-bind** (Bateson, Jackson, Haley, & Weakland, 1956). This theory states that two seemingly contradictory messages may exist on different levels and lead to confusion, if not schizophrenic behavior, on the part of some individuals. For example, a person may receive the message to "act boldly and be careful." Such communication leads to ignoring one message and obeying the other, or to a type of stressful behavioral paralysis in which one does nothing because it is unclear which message to follow and how.

Bateson left the field of family research in the early 1960s after he and his team had published "more than 70 profoundly influential papers, including 'Toward a theory of schizophrenia' [and] 'The question of family homeostasis'" (Ray, 2007, p. 291). Although the Bateson group disbanded in 1962, much of the work of this original group was expanded on by the **Mental Research Institute (MRI)** that **Don Jackson** (1920–1968) created in Palo Alto in 1958. Jackson was an innovative thinker and practitioner who helped lead the family therapy field away from a pathology-oriented, individual illness concept of problems to one that was relationship oriented (Ray, 2000). Among the later luminaries to join MRI with Jackson were Virginia Satir and Paul Watzlawick. A unique feature of this group was the treatment of families, which was resisted by Bateson. In fact, the MRI established **brief therapy**, an elaboration of the work of Milton Erickson and one of the first new approaches to family therapy (Haley, 1976a).

A third major figure of the decade was **Milton Erickson** (1901–1980). The discovery of Erickson and his process of conducting therapy were almost accidental. He was sought out as a consultant for the Bateson group, and, while interacting with them, especially Jay Haley, Erickson's distinctive therapeutic work was noted. Shortly thereafter

Haley began writing about it and using it in the formulation of his approach to therapy. Erickson, who was largely self-taught, had a powerful impact on those with whom he did therapy. His focus on the unconscious and his procedure for making direct and indirect suggestions and prescribing ordeals gained fame, most notably in the 1960s and 1970s. Through Haley, Erickson became known, as did family therapy.

A fourth leading professional in the 1950s was **Carl Whitaker** (1912–1995). Whitaker "risked violating the conventions of traditional psychotherapy" during this time by including spouses and children in therapy (Broderick & Schrader, 1991, p. 26). As chief of psychiatry at Emory University in Atlanta, Whitaker (1958) published the results of his work in **dual therapy** (conjoint couple therapy). He also set up the first conference on family therapy at Sea Island, Georgia, in 1955.

A fifth key figure of the 1950s was **Murray Bowen** (1913–1990). Beginning in the mid-1950s, under the sponsorship of the National Institute of Mental Health (NIMH), Bowen began holding therapy sessions with all family members present as part of a research project with schizophrenics (Guerin, 1976). Although he was not initially successful in helping family members constructively talk to each other and resolve difficulties, Bowen gained experience that would later help him formulate an elaborate theory on the influence of previous generations on the mental health of families.

Other key figures and innovative thinkers in family therapy who began their careers in the 1950s were **Ivan Boszormenyi-Nagy** (1920–2007), at the Eastern Pennsylvania Psychiatric Institute (EPPI), and his associates, including James Framo and Gerald Zuk. The work of this group eventually resulted in the development of Nagy's novel **contextual therapy**. "At the heart of this approach is the healing of human relationships through trust and commitment, done primarily by developing loyalty, fairness, and reciprocity" (Anderson, Anderson, & Hovestadt, 1993, p. 3).

Family Reflection: The "double-bind theory" states that when two contradictory messages are conveyed simultaneously, the receiver of this communication is stressed and may become mentally unbalanced. Think of times when you have received incongruent verbal and nonverbal messages, whether in your family or not. What did you think? How did you feel? What did you do? What was the outcome?

Family Therapy: 1960 to 1969

The decade of the 1960s was an era of rapid growth and expansion in family therapy. The idea of working with families, which had been suppressed, was now embraced by more professionals, a number of whom were quite captivating and energetic. Four of the most prominent of these figures were Jay Haley, Salvador Minuchin, Virginia Satir, and Carl Whitaker. Other family therapists who began in the 1950s, such as Nathan Ackerman, John Bell, and Murray Bowen, continued contributing to the concepts and theories in the field. Another factor that made an impact at this time was the widespread introduction of systems theory. Finally, in the 1960s, training centers and academic programs in family therapy were started, strengthened, or proposed.

MAJOR FAMILY THERAPISTS OF THE 1960s Numerous family therapists emerged in the 1960s. They came from many interdisciplinary backgrounds and, like their predecessors

of the 1950s, most were considered "mavericks" (Framo, 1996). The following therapists are discussed here because of their significant radical impact in shaping the direction of family therapy.

Jay Haley (1923–2007) was probably the most important figure in family therapy in the 1960s. During this time, he had connections with the main figures in the field, and through his writings and travels, he kept professionals linked and informed. Haley also began to formulate what would become his own version of strategic family therapy by expanding and elaborating on the work of Milton Erickson (Haley, 1963). He shared with Erickson an emphasis on gaining and maintaining power during treatment. Like Erickson, Haley often gave client families permission to do what they would have done naturally (e.g., withhold information). Furthermore, Haley used directives, as Erickson had, to get client families to do more within therapy than merely gain insight.

From 1961 to 1969, Jay Haley edited *Family Process*, the first journal in the field of family therapy, which helped shape the emerging profession. In the late 1960s, Haley moved from Palo Alto to Philadelphia to join the Child Guidance Clinic, which was under the direction of Salvador Minuchin. His move brought two creative minds together and helped generate new ideas in both men and the people with whom they worked and trained.

The psychiatrist **Salvador Minuchin** (1921–) began his work with families at the Wiltwyck School for Boys in New York State in the early 1960s. There he formulated a new approach to therapy based on structure and used it with urban slum families he encountered because it reduced the recidivism rate for the delinquents who comprised the population of the school. The publication of his account of this work, *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), received much recognition and led to his appointment as director of the Philadelphia Child Guidance Clinic and to the formulation of a fresh and influential theory of family therapy: **structural family therapy**.

Like most pioneers in the field of family therapy (e.g., Whitaker, Haley), Minuchin did not have formal training in how to treat families. He innovated. Likewise, he had an idea of what healthy families should look like in regard to a hierarchy, and he used this mental map as a basis on which to construct his approach to helping families change. Another innovative idea he initiated at the end of the 1960s was the training of members of the local Black community as paraprofessional family therapists. He believed this special effort was needed because cultural differences often made it difficult for White, middle-class therapists to understand and relate successfully to urban Blacks and Hispanics. Overall, Minuchin began transforming the Philadelphia Child Guidance Clinic from a second-rate and poor facility into the leading center for the training of family therapists on the East Coast of the United States.

Virginia Satir (1916–1988) was the most entertaining and exciting family therapist to emerge in the 1960s, perhaps because she was tall, with a strong voice, and used props in her work. Satir, as a social worker in private practice in Chicago, started seeing family members as a group for treatment in the 1950s (Broderick & Schrader, 1991). However, she gained prominence as a family therapist at the MRI. There she collaborated with her colleagues and branched out on her own. Satir was unique in being the only woman among the pioneers of family therapy. She had "unbounded optimism about people . . . and her empathic abilities were unmatched" (Framo, 1996, p. 311). While her male counterparts concentrated on problems and building conceptual frameworks for theories and power, she touched and nurtured her clients and spoke of the importance of self-esteem, compassion, and congruent expression of feelings.

Satir gained national recognition with the publication of her book *Conjoint Family Therapy* (1964). In this text, she described the importance of seeing both members of a couple together at the same time, and she detailed how such a process could and should occur. Her clear style of writing made this book influential. "Satir's ability to synthesize ideas, combined with her creative development of teaching techniques and general personal charisma, gave her a central position in the field" of family therapy (Guerin, 1976, p. 8).

The male contemporary counterpart to Satir, Carl Whitaker, can be described in many ways. He dared to be different and, at his best, was creative as well as wise (Framo, 1996). He was never "conventional." Whitaker, a psychiatrist, became interested in working with families in the 1940s. As already mentioned, he was chair of the psychiatry department of Emory University in the early 1950s. In 1955, he resigned to begin a private practice.

His main influence and renown in the field, however, came following his move to become a professor of psychiatry at the University of Wisconsin in 1965. It was at Wisconsin that Whitaker was able to write and lecture extensively. Beginning in 1965, his affectively based interventions, which were usually spontaneous and sometimes appeared outrageous, gained notoriety in the field of family therapy. In the 1960s, Whitaker also nurtured the field of family therapy by connecting professionals with similar interests.

CASE ILLUSTRATION

Jodi Ortiz, a graduate student in family therapy, was fascinated to read that some major theorists of the 1960s literally learned their clinical skills by trial and error. She was particularly struck by how Carl Whitaker worked. She thought that some of his "antics," as she called them, were outrageous but effective. Jodi was impressed that he seemed to deeply care about families, though, and that he tried to have three generations in the room during the times he did therapy.

It occurred to Jodi that she might become a better therapist if she started relying on her drama background as well as her caring nature. Therefore, she asked several of her fellow students to come to an experimental family therapy session she would conduct. She informed everyone that she would have them play roles and that she would "do" therapy in a different way. Jodi's friends were skeptical, but they agreed.

When time for the role play came, Jodi had her friends assemble as a family of five. After asking preliminary information and gathering a few facts, Jodi excused herself from the mock family and came back later wearing a cape and carrying a wand. She then informed the family of friends she was going to do some magic in their lives.

If you were a part of Jodi's family, what would you think of her appearance and announcement? Would it matter what age you were (or that you were role playing)? Why do you think Jodi's performance might work? Why do you think it might not work? How would it differ from the approaches of therapists you have just read about?

CONTINUING LEADERS IN FAMILY THERAPY DURING THE 1960s Nathan Ackerman continued to be a leader of the family therapy movement throughout the 1960s. In 1961, with Don Jackson, he cofounded *Family Process,* the first journal devoted to family therapy and one that is still preeminent in the field. It was a bold step. One of Ackerman's most significant books during this decade was *Treating the Troubled Family* (1966). In this text, he

elaborated on how to intervene with families and "tickle the family's defenses" through being involved with them, being confrontive, and bringing covert issues out into the open.

John E. Bell (1913–1995), like Carl Whitaker, began treating families long before he was recognized as a leader in the field of family therapy. Bell's work began in the 1950s when he started using group therapy as a basis for working with families (Gurel, 1999; Kaslow, 1980). He published his ideas about family group therapy a decade later (Bell, 1961) and proposed a structured program of treatment that conceptualized family members as strangers. Members become known to each other in stages similar to those found in groups. His thinking was in sync with the group movement of the time and caused others to question how a family is similar and different from a group.

Bell taught his natural family group approach at the University of California, Berkeley, in 1963 in one of the first graduate courses on family therapy offered in the United States. From 1968 to 1973, he directed the MRI in Palo Alto. It was Bell's belief that "all children 9 years or older and all other adult family members living in the home should be included in family therapy and should be present for all sessions" (Nichols & Everett, 1986, p. 43). As noted, Bell's ideas were distinctive and received considerable criticism, thus generating a good deal of discussion about family therapy (Hines, 1988).

Murray Bowen gained considerable insight into the dynamics and treatment of families during the 1960s. Part of the reason was that he was able to successfully deal with problems within his own family of origin. Another reason was that he began to see a connectedness between working with families that had a family member diagnosed with schizophrenia and working with families that had other problems.

One of his most significant discoveries was the "**emotional reactivity**" of many troubled families when brought together to solve problems. In these situations, family members had difficulty maintaining their identities and their actions. They were absorbed in a world of feelings that would often resemble what Bowen (1961) called an **undifferentiated family ego mass**; that is, they were fused and confused. In working with these families, Bowen found that by being cognitive and detached, he could help them establish appropriate relationship boundaries and avoid projecting (or triangulating) interpersonal dyadic difficulties onto a third person or object (i.e., a scapegoat).

SYSTEMS THEORY With the emergence of new ideas came a novel theoretical perspective from which to center these concepts: systems theory (Bertalanffy, 1968). In **systems theory**, a system is a set of elements standing in interaction with one another. Each element in the system is affected by whatever happens to any other element. Thus, the system is only as strong as its weakest part. Likewise, the system is greater than the sum of its parts. Whether the system is a human body or a family, it is organized in a particular manner with boundaries that are more or less open (i.e., permeable) depending on the amount and type of feedback received. Systems can be self-regulating, too, because "the tendency of a system is to seek homeostasis or equilibrium" (Walsh & McGraw, 2002, p. 6).

By viewing the family in this manner, clinicians in the 1960s focused less on **linear causality** (direct cause and effect) and more on **circular causality** (the idea that events are related through a series of interacting loops or repeating cycles). Subsequently, family therapists began to claim their role as specialists within therapy. They were different! This position was reinforced in 1963 when the first state licensure law regulating family counselors was passed in California. This legislation was just the beginning of family therapy's increasing prominence.

INSTITUTES AND TRAINING CENTERS Along with the rise of dynamic figures in family therapy and systems theory in the 1960s, training institutes and centers also came into prominence. In California, the MRI in Palo Alto flourished even after Jay Haley's departure for Philadelphia in 1967 and Don Jackson's death in 1968. The Family Institute of New York (headed by Ackerman) thrived during this time, as did the Albert Einstein College of Medicine in New York City and the affiliated Bronx State Hospital (Broderick & Schrader, 1991).

In Philadelphia, the Philadelphia Child Guidance Clinic opened its facilities to surrounding neighborhoods and to aspiring family therapists. Innovative techniques, such as the "bug in the ear" form of communication, were devised at the clinic during this time. In 1964, the Family Institute of Philadelphia emerged. This institute was a merger of the EPPI and the Philadelphia Psychiatric Center and fostered such notable practitioner/theorists as Gerald Zuk and Ross Speck (Broderick & Schrader, 1991).

In Boston, the Boston Family Institute was established in 1969 under the direction of Fred Duhl and David Kantor (Duhl, 1983). This institute focused on expressive and dramatic interventions and originated the technique of **family sculpting**, that is, arranging family members as a sculpture in the way they acted or responded to a significant event.

Overseas, the Institute for Family Studies in Milan, Italy, was formed in 1967. This institute was based on the MRI model and came into prominence in the 1970s with many inventive, short-term approaches to working with families (Selvini Palazzoli, Cecchin, Prata, & Boscolo).

Family Reflection: The 1960s was a decade of contrasts, with the adoption of systems theory becoming prominent as a distinctive feature of family therapy amid competing ideologies. This defining approach propelled family therapy into prominence. In your family, have there been defining moments that solidified you as a family? What were they, and how did they make a difference? What do you think would have happened had systems theory not been so widely adopted by family therapy?

Family Therapy: 1970 to 1979

The 1970s were marked by several nodal events in regard to family therapy. These events centered around many expansive and exciting activities, including a major membership increase in the American Association for Marriage and Family Therapy (AAMFT), the founding of the American Family Therapy Academy (AFTA), the refinement of theories, the influence of foreign therapies and therapists (especially the Milan Group), the growth of family enrichment, and the introduction of feminism into the family therapy field.

MEMBERSHIP IN THE AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY In 1970, the membership of the AAMFT stood at 973. By 1979, membership had increased more than 777% to 7,565 (Gurman & Kniskern, 1981b). The dynamic and rapid growth of the association can be explained in many ways, including the fact that it was recognized by the U.S. Department of Health, Education, and Welfare in 1977 as an accrediting body for programs granting degrees in marriage and family therapy. In addition, at about the same time, the association changed its name from the American Association of Marriage and Family Counselors to the **American Association for Marriage and Family Therapy**.

In addition, the AAMFT benefited from increased focus placed on families and therapeutic ways of working with them as a result of the upheavals in family life in the 1960s. Furthermore, many of the pioneers of the family therapy movement, such as Virginia Satir, James Framo, Carl Whitaker, Salvador Minuchin, Jay Haley, and Florence Kaslow, reached their prime and began making a greater impact on therapists across the nation with their exciting, thought-provoking, and inviting workshop presentations and writings. To add to this impact, in 1974, the AAMFT began publishing its own professional periodical, the *Journal of Marital and Family Therapy,* with William C. Nichols, Jr., as the first editor. Later in the decade, it made plans to move its headquarters from Claremont, California, to Washington, D.C. (an event that occurred in 1982).

ESTABLISHMENT OF THE AMERICAN FAMILY THERAPY ACADEMY The AFTA was founded in 1977 by a small group of mental health professionals who were active and involved during the early years when the field of family therapy was emerging. Initially, it strove to represent "the interests of systemic family therapists as distinct from psychodynamic marriage counselors" (Sauber, L'Abate, & Weeks, 1985, p. 180). Leaders of AFTA included Murray Bowen and James Framo. As a "think tank," AFTA's annual meeting brought together professionals to address a variety of clinical, research, and teaching topics.

In 1981, a joint liaison committee made up of AAMFT and AFTA representatives was formed to address the respective roles of the two organizations within the profession. AFTA was identified as an academy of advanced professionals interested in the exchange of ideas; AAMFT retained government recognition for its role in providing credentials to marriage and family therapists. Since that time, AFTA has focused almost exclusively on clinical and research issues in family therapy.

REFINEMENT OF FAMILY THERAPY THEORIES The 1970s marked the growth and refinement of family therapy theories outside the psychoanalytical tradition. It is symbolic that Nathan Ackerman, who carried the banner of psychoanalytical family therapy, died in 1971 (Bloch & Simon, 1982). It is also interesting to note that the works of Salvador Minuchin (structural family therapy), Gerald Patterson (behavioral family therapy), Carl Whitaker (experiential family therapy), and Jay Haley (strategic family therapy) increased in frequency, scope, and influence during this decade. The new ideas generated in the 1960s bore fruit in the 1970s.

One major example of this phenomenon was the writing of Salvador Minuchin. In a clearly outlined and articulated book, *Families and Family Therapy,* Minuchin (1974) presented a practical guide for conducting structural family therapy. He followed this publication later in the decade with a complementary coauthored text entitled *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin, Rosman, & Baker, 1978), which showcased in a dramatic way the power of the therapy he had created. These texts, combined with his well-staffed training center in Philadelphia, made structural family therapy a major theoretical force in family therapy circles in a relatively brief period of time.

INFLUENCE OF FOREIGN THERAPIES AND THERAPISTS The development of family therapy grew rapidly in Europe in the late 1960s and early 1970s. By the mid-1970s, theories and theorists, especially those from Italy and Great Britain, became influential in the United States. The influx of ideas from family therapists outside the United States led

many American professionals to question "particular ethnocentric values about what is good and true for families" (Broderick & Schrader, 1991, p. 35).

Particularly influential was the Milan Group in Italy headed by Mara Selvini Palazzoli and staffed by three other psychoanalytically trained psychiatrists, Gianfrano Cecchin, Giulana Prata, and Luigi Boscolo. Their avant-garde book, *Paradox and Counterparadox* (1978), was influenced by the work of Bateson and Watzlawick in Palo Alto. This group was original in its emphasis on **circular questioning** (asking questions that highlight differences among family members) and **triadic questioning** (asking a third family member how two others members of the family relate). The Milan approach also emphasized developing a hypothesis about the family before their arrival and taking a neutral stance on presenting symptoms. Furthermore, it prescribed homework assignments that were often ritualistic and difficult. "Although first appearing revolutionary," the Milan Group lost its attractiveness over time because of its signature piece, **paradoxical intentions**. "A large part of the difficulty seemed to reside in the detached, one-up expert position assumed by therapists" in this approach and the fact that when "a paradoxical intention is handled poorly, it can be destructive" (Kuehl, 2008, p. 18).

Two British leaders in the helping profession who influenced the development of family therapy in the United States were R. D. Laing and Robin Skynner. Laing (1965) coined the term **mystification** to describe how some families mask what is going on between family members by giving conflicting and contradictory explanations of events. His complicated but interesting book *Knots* (1970) further enhanced his status as an original thinker in understanding universal family dynamics in dysfunctional families. Skynner (1981) developed a brief version of psychoanalytic family therapy in the 1970s that helped complement and enrich the work done by Ackerman and Boszormenyi-Nagy.

CASE ILLUSTRATION

Nonna Caliva was fascinated to learn about the Milan Group and their adaptation of strategic family therapy to Italy. She was disappointed, however, to find that after some promising early results the approach was largely abandoned, and the hype it received worldwide, especially in the United States, died because the research did not support it as an effective means of change in many circumstances.

Nonna wondered whether this was because the clinicians in this approach had not been as careful as they could have been in substantiating their results. So she decided she would work with some of her clients using a modified Milan Group strategy. First, she spaced their appointments so that, as in the original work, her clients only saw her once a month instead of once a week. She then gave them homework to do every day in the form of rituals. She took a neutral stance toward the presenting problem also, no matter what it was. Finally, she employed a lot of circular and triadic questions in her sessions, along with the use of paradox.

While there was some movement in the families on which Nonna used the modified Milan Group techniques, she wondered whether there would have been more had she employed her straightforward strategic therapy approach. Nonna also wondered after her experiment whether she had acted prudently or ethically; after all, she did not tell the families they were her guinea pigs. What do you think about what Nonna did? What would have been more prudent and ethical? Why?

FEMINIST THEORY AND FAMILY THERAPY "Feminist thinking explicitly entered the family therapy field in the 1970s and has increasingly influenced the theory and practice of family therapy" (Framo, 1996, p. 303). As an approach, **feminist family therapy** "is an attitude, a lens, a body of ideas about gender hierarchy and its impact rather than a specific model of therapy or a grab bag of clinical techniques. Feminists recognize the overriding importance of the power structure in any human system" (Carter, 1992, p. 66). They question, among other things, whether some concepts in family therapy, such as complementarity, circularity, and neutrality, are oppressive to women (May, 1998). Table 1.1 lists some characteristics of gender-sensitive family therapy.

The challenge to family therapy by feminist theory began in 1978 when an article by Rachel Hare-Mustin, entitled "A Feminist Approach to Family Therapy," was published in *Family Process*. Hare-Mustin took the position that family therapy discriminated against women because it basically promoted the status quo that women were unequal in regard to their duties and roles within families.

After Hare-Mustin's paper was published, a number of other pieces on the adequacy of family therapy from a systemic perspective began to be published. Among the most consistently voiced view from the perspective of feminist therapists is that historic sexism and structural inequalities cannot be corrected by improving relationships among family members or creating a new family hierarchy. Rather, the goals of working with a family are "to facilitate the growth of a strong, competent woman who has enhanced control over resources" and "to increase the ability of women to work together politically to change society and its institutions" (Libow, Raskin, & Caust, 1982, p. 8).

Although feminist family therapists "represent a wide range of theoretical orientations," they are "drawn together by their recognition that sexism limits the psychological well-being of women and men, by their advocacy of equality in relationships and society, and by their refusal to use any counseling methods or explanatory concepts that promote bias" (Enns, 1992, p. 338). Training models developed by feminist family therapists that

TABLE 1.1 Characteristics of Gender-Sensitive Family Therapy

Nonsexist Counseling	Empowerment/Feminist/Gender-Aware Counseling
Does not reinforce stereotyped gender roles.	Helps clients recognize the impact of social, cultural, and political factors on their lives.
Encourages clients to consider a wide range of choices, especially in regard to careers.	Helps clients transcend limitations resulting from gender stereotyping.
Avoids allowing gender stereotypes to affect diagnoses.	Recognizes the degree to which individual behaviors may reflect internalization of harmful social standards.
Avoids use of sexist assessment instruments.	Includes gender-role analysis as a component of assessment.
Treats male and female clients equally.	Helps clients develop and integrate traits that are culturally defined as "masculine" and "feminine."
Avoids misuse of power in the counseling relationship.	Develops collaborative counselor–client relationships.

J. Lewis, "Gender sensitivity and family empowerment," *Family Psychology and Counseling*, 1993, 1:1. Used with permission of Judith Lewis.

place gender at the heart of educating family therapists have been and will continue to be developed (e.g., Storm, 1991).

Family Therapy: 1980 to 1989

Several important events marked the emergence of family therapy in the 1980s as the profession continued to develop and evolve. One was the retirement or death of leading pioneers in the movement and the emergence of new leaders. A second was the growth in the number of individuals and associations devoted to family therapy. A third was an increase in research in family therapy (Miller, 1986; Sprenkle & Piercy, 2006) and an explosion in publications devoted to family therapy. A fourth significant happening was the introduction of **multisystemic therapy** (MST) as an intensive family- and community-based treatment for working with serious antisocial behaviors of children and adolescents. Finally, further recognition of marriage and family therapy came about on the national level.

CHANGE IN FAMILY THERAPY LEADERSHIP In the 1980s, new leadership began to emerge in family therapy. One reason was the aging of the pioneers in the field. Another reason was the maturity of clinicians who studied in the 1960s and 1970s with the founders of the movement. The second and third generations of family therapists had new ideas and abundant energy (Kaslow, 1990). They basically preserved the best of the founders' influences while moving out in different directions. Some of the more established leaders in the field, such as Jay Haley, switched emphases at this time and maintained their leadership roles.

Within the growth of this movement, many women came to the forefront. Among them were Monica McGoldrick, Rachel Hare-Mustin, Carolyn Attneave, Peggy Papp, Peggy Penn, Cloe Madanes, Fromma Walsh, and Betty Carter. These women began to create novel theories and to challenge older ones. Cloe Madanes was especially prolific and creative during the last part of the 1980s. Overall, the work of new women leaders in family therapy contributed much to the profession and gave it a positive and productive rebirth.

Many of these women realized the need to "include women's voices and experiences" within the family therapy field in order to gain a richer and more evenly balanced perspective on family life and to discern what changes are needed in families (Carter, 1992, p. 69). The **Women's Project in Family Therapy** (Walters, Carter, Papp, & Silverstein, 1988) was a major undertaking of these researchers and practitioners who sought to emphasize the absence of gender in the formation of systems theory. Their presence and prominence altered the view that a professional panel of family therapists consisted of four men and Virginia Satir. Indeed the group had a transformative impact on the thinking about gender in families and in the field of family therapy (McGoldrick, 2013).

GROWTH IN THE PROFESSION OF FAMILY THERAPY Family therapy grew significantly as a profession in the 1980s. The membership of the AAMFT, for instance, almost doubled to a total of 14,000 members. At the same time, two new associations devoted to the study and practice of family therapy were formed. The first was **Division of Family Psychology 43, American Psychological Association (APA)**, which was established within the American Psychological Association in 1984. The division was established because of the desire by some family practitioners to maintain their identity as psychologists (Kaslow, 1990). Such noted individuals as James Alexander, Alan Gurman, Florence Kaslow,

Luciano L'Abate, Rachel Hare-Mustin, Duncan Stanton, and Gerald Zuk were among those who became affiliated with this division.

The second new professional association formed in the 1980s was the **International Association of Marriage and Family Counselors (IAMFC)**, which was established initially as an interest group within the American Counseling Association (ACA) in 1986. The IAMFC grew from an initial membership of 143 in 1986 to more than 4,000 in 2001. In 1990, the IAMFC became a division of the ACA.

The initial goals and purposes of the IAMFC were to enhance marriage and the family through providing educational programs, conducting research, sponsoring conferences, establishing interprofessional contacts, and examining and removing conditions that create barriers to marriages and families. Since its formation, the IAMFC has broadened its vision to include work in promoting ethical practices, setting high-quality training standards, helping families and couples cope successfully, and using counseling knowledge and systemic methods to ameliorate the problems confronting marriages and families (Maynard & Olson, 1987). Overall, the IAMFC provides a base for training, research, collaboration, and support for counselors who work with families (Pietrzak & L'Amoreaux, 1998).

DEVELOPMENT OF RESEARCH TECHNIQUES IN FAMILY THERAPY Until the 1980s, research techniques and solid research in family therapy were scarce. It was implicitly assumed that other research methodologies could be translated to the family therapy field or that case study reports were sufficient in validating the impact of family therapy. In the 1980s, however, this changed.

A foretaste of the increased emphasis on family research came in 1982 when the *Journal of Marriage and the Family* devoted an entire issue to family research methodologies. A parallel occurred in the *Journal of Family Issues* in 1984 (Miller, 1986). In addition, a book on research methods by Adams and Schvaneveldt (1991) was among the first to use examples involving families. A breakthrough and breakout in research came when studies indicated that certain forms of family therapy—for example, behavioral and systems approaches—were effective in working with families (Gurman, Kniskern, & Pinsof, 1986).

PUBLICATIONS IN FAMILY THERAPY The growth in the number of individuals and associations involved in family therapy was paralleled by an increase in publications in this area. Some major publishing houses, such as Guilford, Sage, and Brunner/Mazel, began to specialize in books on family therapy. Almost all publishers of texts in counseling, psychology, and social work added books on marriage and family therapy. In addition, new periodicals were established, and older ones grew in circulation.

The *Family Therapy Networker*, a periodical with a subscription list of greater than 50,000, was the success story of the 1980s. The triumph of the *Networker* is attributable to its timely and interesting articles and its journalistic (as opposed to scholarly) form of writing. The magazine format and its featured information on professional conferences across the country were undoubtedly additional factors in its success.

MULTISYSTEMIC THERAPY MST was born out of frustration and necessity. It was an attempt to stem the tide against a dismally low success rate for working with at-risk adolescents. The first controlled research on this intensive family- and community-based approach for working with juvenile offenders with serious antisocial behaviors was conducted by a team led by Scott Henggeler in the mid-1980s (Henggeler et al., 1986). Initial

results were promising, and the program has shown long-term results since, with a sharp reduction in rearrest of juvenile offenders and improvement in family functioning (Finn, 2004). MST is particularly focused on empowering parents and other important members of a youth's ecology. The goal then as now is to help youth develop the necessary skills and competencies to reduce problematic behavior and function more effectively (Ronan & Curtis, 2008).

MST uses well-validated treatment strategies derived from pragmatic family therapies, behavioral parent training, and cognitive–behavioral therapy. It directly addresses intrapersonal (e.g., cognitive problem solving), familial (e.g., inconsistent discipline, low monitoring, family conflict), and extrafamilial (e.g., association with deviant peers, school difficulties) factors that are associated with serious youth antisocial behavior (Letourneau et al., 2009). Overall, families, schools, and communities benefit from this cost-effective, home-based 60 hours of therapeutic intervention, as do the juvenile offenders, ages 12 to 17, who are its target.

NATIONAL RECOGNITION OF FAMILY THERAPY The main national event for family therapy in the 1980s was the listing of the profession as one of the four core mental health professions eligible for mental health traineeships (Shields et al., 1994). This appeared as part of the Public Health Service Act, Title III, Section 303(d)(1). It basically placed the profession, in the eyes of the federal government, on a par with psychology, psychiatry, and other professions vying for federal training grants.

Family Reflection: Two new family therapy associations were formed during the 1980s: one in psychology and one in counseling. In families, even professional families, whenever anyone enters or leaves a system, there is some disequilibrium. How do you suppose leaders of the AAMFT initially reacted to these new additions to the profession? How do you suppose these two associations reacted to the AAMFT? What might have been communicated on verbal and nonverbal levels?

Family Therapy: 1990 to 1999

The 1990s proved as much an exciting time in the field as the previous decade. Family therapy was on the move and became a more global phenomenon as new theories and specialty areas emerged. The number of professionals who primarily identify themselves as family therapists continued to grow, and academic curriculums and experiential components in family therapy were refined. The issues of the 1990s concerned professional recognition, affiliation, accreditation, and licensure, that is, matters related to power and influence. These issues also involved identification and influence specifically regarding whether family therapy would continue to be interdisciplinary and potent or if it would be "marginalized" (Shields et al., 1994).

NEW THEORIES AND SPECIALTIES WITHIN FAMILY THERAPY The 1990s saw several new theories of family therapy either emerge or gain added attention. Feminist family therapy, for instance, gained increased recognition as a powerful trend in the field, and issues surrounding the importance of gender grew (Norsworthy, 2000). Family therapy also began concentrating more on examining **gender-sensitive issues in therapy** rather than feminine or masculine issues per se (Smith & Stevens-Smith, 1992b). Thus, differences in

genders were recognized in a less emotionally or politically volatile way. Solution-focused and narrative theories developed in the Midwest by Steve deShazer (1988) and Bill O'Hanlon (O'Hanlon & Weiner-Davis, 1989) and in Australia and New Zealand by Michael White and David Epston (1990), respectively, also received much publicity. These theories are characterized by their brevity and creativity and are covered in Chapter 14 of this book.

Other emerging theories for the treatment of families in the 1990s include the following:

- The **reflecting team approach** of Tom Andersen (1991), a democratic and collaborative model of working with couples and families, in which clinical observers of a therapeutic session come out from behind a one-way-mirror observing room to discuss with the therapist and client couple/family their impressions so that an open environment is created and, through dialogue, the couple/family is made a part of the larger treatment team (Brownlee, Vis, & McKenna, 2009; Parker & O'Reilly, 2013). The premise behind the reflecting team approach is that multiple realities exist (Harrawood, Parmanand, & Wilde, 2011). "The team comments in a way that highlights the couple or family's strengths and helps identify new ways to view or understand the existing problem" so that the couple or family's dominant stories are challenged (Pender & Stinchfield, 2012, p. 117).
- The **therapeutic conversations model** of Harlene Anderson and Harry Goolishian (Anderson, 1994), a postmodern approach in which the family therapist relates to the couple or family in a more egalitarian partnership.
- The **psychoeducational model** of Carol Anderson (1988), an approach to working with families that have a schizophrenic member, in which attention is given to teaching family members about multiple aspects of mental illness in a day-long "Survival Skills Workshop" focusing on boundaries, hierarchy, and maintaining the integrity of subsystems.
- The **internal family systems model** of Richard Schwartz (1994), which considers both individual intrapsychic dynamics and family systems.

Of these theories, some were considered radically different from their forerunners because they were based on **social constructionism**, a philosophy that states that our experiences are a function of how we think about them instead of objective entities. This viewpoint is different from systemic assumptions and has caused many family therapists to reexamine their basic assumptions (Piercy & Sprenkle, 1990).

Related to these developments in theory and emphasis was the **Basic Family Therapy Skills Project**, which was established in 1987 and focused on determining, defining, and testing "the skills essential for beginning family therapists to master for effective therapy practice" (Figley & Nelson, 1990, p. 225). Four basic family therapy skills research reports were prepared in the 1990s. In these reports, structural, strategic, brief, and transgenerational family therapies were examined from the perspective of distinctive and generic skills critical for beginning therapists (Nelson, Heilbrun, & Figley, 1993). The identified skills generated from this project continue to be researched and refined as educators, practitioners, and researchers seek to determine what therapeutic interventions are most important and when.

Along with the work in specific theories was an increased emphasis on the **new epistemology**—the idea that the cybernetic approach of Bateson (1972, 1979) and others must be incorporated in its truest sense into family therapy. Among other things, the new

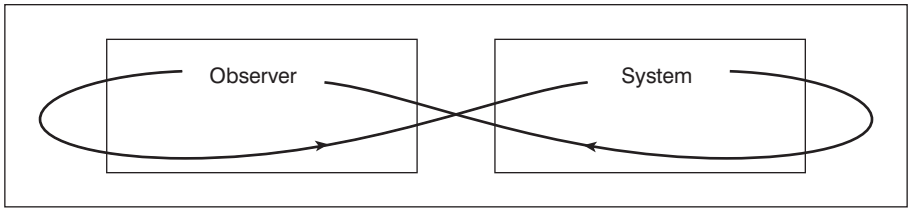

FIGURE 1.1 Cybernetics of cybernetics.

From D. S. Becvar and R. J. Becvar, *Family Therapy: A Systemic Integration*. Boston, MA: Allyn & Bacon, 2006. © 2006 Pearson Education. Reproduced by permission.

epistemology emphasizes **second-order cybernetics**—the **cybernetics of cybernetics**—which stresses the impact of the family therapist's inclusion and participation in family systems (Keeney, 1983) (see Figure 1.1). On its most basic level, second-order cybernetics emphasizes positive feedback in system transformation. It extends first-order cybernetic foci beyond the homeostatic and adaptive properties of family systems in general. The new epistemology also concentrates on the importance of family belief systems in treatment and on **ontology** (i.e., a view of the world) that stresses the circularity and autonomy of systems (in contrast to linear causality).

Equally pervasive in the 1990s was the redirection of family therapy education from a focus on producing narrowly trained, theory-specific clinicians to a focus on training practitioners who know how to work with special types of families (Broderick & Schrader, 1991). With this change also came a transformation in regard to the way the term *family therapist* is used. It is now better defined in regard to course work, competencies, and clinical experience. Furthermore, there are now a number of well-respected and well-researched theories that practitioners in the field can use (Piercy, Sprenkle, Wetchler, & Associates, 1996). This shift in definition and scholarship resulted in a plethora of new books in family therapy and an emphasis on distinct types of family problems and families. For instance, books have been written and specialized courses offered on working with families comprising individuals who abuse drugs, alcohol, food, or other family members. Literature and academic offerings have also become available for treating single-parent families, remarried families, aging families, and intact families who have young children, adolescents, or members with disabilities. Further opportunities for reading about or studying culturally diverse families, as well as families headed by same-sex couples, have emerged.

CASE ILLUSTRATION

Deo Gupta and her husband, Raj, were referred to Chelsea Aaron by Deo's obstetrician/gynecologist because the couple was having difficulty conceiving. Chelsea, who had three young children and a very hectic life, was sympathetic to the couple's plight up to a point, but she really did not know how to help them. The theoretical approaches she practiced were not exactly in line with the problem the couple brought.

Finally, Chelsea started asking the Guptas why they wanted children. From experience she revealed to them the hard work she put in daily just to get her children to eat

properly, go to bed on time, learn social skills, and get dressed. Deo reacted angrily and accused Chelsea of being narcissistic and racist. Chelsea denied the charges. She then recommended four books for Deo and Raj to read along with a support group for them to attend.

What do you think of Chelsea's response to this situation? How might she have handled the situation better? Why are personal narratives, recommended books, and topical support groups sometimes coolly accepted by couples and families?

Family Therapy: 2000 to 2009

The beginning of the new millennium saw family therapy expand and change in a number of ways. International growth on different continents, accreditation developments, licensure recognition, expanded research, and the formulation of new stories and emphases by professionals in the field were five of the major developments in its expansion.

THE GLOBAL GROWTH OF FAMILY THERAPY Beginning slowly in the 1970s with the development of family therapy in Italy and England, the growth and influence of family therapy spread around the world. Family therapy associations in Europe, Asia, Africa, Australia, and South America sprang up or flourished in the early 2000s (Ng, 2005; Trepper, 2005). For instance, Canadian couple/marital and family therapists (C/MFT), a relatively small but vibrant and growing group, grew in number and influence. These practitioners report themselves competent to treat couple/marital issues, depression, anxiety, and posttraumatic stress disorder—the most common reasons clients seek therapy (Beaton, Dienhart, Schmidt, & Turner, 2009). As a group, C/MFT practitioners describe themselves as similar in many ways to clinicians in the United States, except that they are drawn more to postmodern theories. The International Family Therapy Association, with its periodical *Journal of Family Psychotherapy* (IFTA; http://www.ifta-familytherapy.org/), also flourished. Family therapy grew fast and took root in a number of countries during the start of the century.

IMPACT OF FAMILY THERAPY ASSOCIATIONS, NUMBER OF MARRIAGE AND FAMILY THERAPISTS, AND LICENSURE IN 50 STATES The major professional associations for family therapists in North America (i.e., AAMFT, IAMFC, AFTA, and Division 43 of APA) continued to have considerable impact on the profession through their publications, educational emphases, and services in the early 2000s. The AAMFT, the largest and oldest association, maintained the most diverse line of services, educational opportunities, and publications during this time, including the launching of the *Family Therapy Magazine* in 2006. Second in membership was the IAMFC, a division of the ACA, followed by Division 43 (Family Psychology), which required APA membership. The AFTA, although smaller than any of the three previously mentioned associations, continued to be influential because of the status and expertise of its members.

Licensing of marriage and family therapists grew even faster than the influence of professional associations. Under the regulations published in the *Federal Register* (Vol. 57, No. 14), marriage and family therapists officially became the fifth "core" mental health profession, along with psychiatrists, psychologists, social workers, and psychiatric nurses (Shields et al., 1994). This regulation meant that by 2004 there were more than 50,000 state-licensed marriage and family therapists in the United States. As of April 2009, all 50 states and the District of Columbia either licensed or certified family therapy professionals.

ACCREDITATION OF FAMILY THERAPISTS Two associations, the AAMFT and the IAMFC, continued to accredit programs in family therapy during the early 2000s as they had previously. Both did so under accrediting commissions that operated independent of their association. The AAMFT standards were drawn up and administered by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Those for IAMFC were similarly handled through the Council for Accreditation of Counseling and Related Educational Programs (CACREP) (Clawson, Henderson, Schweiger, & Collins, 2007). A minimum of a master's degree was required as the credential for becoming a marriage and family therapist, although there was debate between the two groups over the exact content and sequencing of courses.

Both the AAMFT (through COAMFTE) and the IAMFC (through CACREP) worked hard to increase the number and quality of programs they accredited. Health care reform influenced educational programs and the work of family therapists as well. Being recognized as a core mental health area became crucial to the status of educational programs in family therapy during this decade. In subtle and overt ways, training programs became linked to legislative regulations.

DEVELOPING CULTURALLY EFFECTIVE FAMILY-BASED RESEARCH A fourth development in the marriage and family therapy field in the 21st century was more and better research on the effectiveness of family therapy with different cultural groups. Some states, such as California and Texas, reached the point at which no one cultural group constituted a majority within that state. Thus, there was renewed interest and renewed efforts to determine what theories and forms work best for what distinct populations under what circumstances and when.

Continued Development of the Profession

Blume (2008) noted that while the stories of the emergence of marriage and family therapy are centered on tales of healers and discoveries in the 1950s, 1960s, and 1970s, those narratives were less relevant to new audiences in the 21st century because social conditions changed. There was a distinctly new culture and a need to create new stories as well as honor older ones. Thus professionals within family therapy formulated new versions of what it was like to work with couples and families.

Family Reflection: Family therapy is now recognized worldwide, with recognition being a mixed blessing. What do you think are the downsides of this kind of recognition, as well as the upsides?

Family Therapy: 2010 to the Present

The decade of the 2010s has only begun to take shape, yet there have been changes in family therapy already. One of the major changes has been the increased use of technology. *The Journal of Marital and Family Therapy*, the flagship journal of the AAMFT, is now offered only online. Scholarly printed journals appear to be going the way of the dinosaur. AAMFT also regularly updates its membership through a monthly electronic *Therap-eNews*,

which contains stories and announcements about family therapy. IAMFC has also made good use of electronic media and now offers webinars to members and other interested professionals at a very reasonable price. The "Net Generation" (individuals born between 1980 and 1994) enjoy and benefit from the shift to more use of technology, including Internet-based communications such as electronic blackboards, discussion boards, and online streaming, while older MFTs are having to work hard to renegotiate rules, roles, and professional interactions (Blumer & Hertlein, 2011). Online therapy is becoming more prominent, and it is likely to grow (Reeves, 2011).

A second noteworthy change in family therapy during the decade so far was the revision of the code of ethics of both the AAMFT and the IAMFC in 2012. These updates were needed to keep pace with the times. The AAMFT has revised and reissued its *Users Guide to the AAMFT Code of Ethics*, and the IAMFC has published articles on its ethical code in its scholarly flagship periodical *The Family Journal*.

A third important change that occurred is the publication of the fifth edition of the *Diagnosis and Statistical Manual of Mental Disorders* (*DSM-5*) in 2013. While many therapy groups, including those representing family therapists, made comments concerning this new edition of the DSM, the final product was decided on by a committee mainly composed of psychiatrists. The result is the elimination of several disorders and the redefinition and addition of others. The importance of this document cannot be overstated, for it is the primary source that insurance companies use in reimbursing therapists for their work. Unfortunately, the *DSM* is based on an individualistic, medical model, and interpersonal and relationship difficulties are not given prominence. Thus, the new decade presents additional challenges to family therapists in treating couples and families and being reimbursed for their work.

Finally, family therapy has been and will be affected by Supreme Court of the United States (SCOTUS) decisions on marriage and family life. In 2013, the Supreme Court made two important decisions in this regard. In the first, *United States v. Windsor*, SCOTUS ruled that Section 3 of the Defense of Marriage Act (DOMA) was unconstitutional under the Due Process Clause of the Fifth Amendment. This ruling lifts the restriction placed on the federal definition of a "spouse," making it applicable to all legally married couples. In the second ruling, *Hollingsworth v. Perry*, SCOTUS ruled that the sponsors of Proposition 8, the 2008 California ballot initiative that barred same-sex marriage in that state, did not have standing to appeal to the courts in California when California public officials refused to do so. This lifted the ban on same-sex marriage within the state of California (AAMFT, 2013, July 12).

Summary and Conclusion

This chapter has given a brief history of the dynamic evolution of family therapy (outlined in the Summary Table at the end of this chapter), primarily seen from the perspective of its development within the United States. Notable events and personalities in the development of family therapy have been traced through the decades. Before the 1940s, this form of treatment was virtually nonexistent because of prevailing beliefs within American culture that stressed the importance of the individual. A further factor prohibiting the development of family therapy was historical tradition. Individuals in need of assistance in their relationships consulted first with other family members, then with clergy and physicians.

Family therapy grew, however, due to a number of quiet but revolutionary events in the culture of the

United States, such as growth in the number of women in higher education and increased demand for more courses in family life. Likewise, the founding of associations (e.g., the National Council of Family Relations), the pioneering work in marriage counseling, the growth in the role of county home extension agents, and the socially disruptive effects of World War II influenced the formation of the profession.

The 1940s saw the formation of the American Association for Marriage Counselors (AAMC) and initial treatment of individuals with schizophrenia through working with their families. The 1950s saw the emergence of strong personalities who advocated for family therapy, such as Nathan Ackerman, Gregory Bateson, Don Jackson, Carl Whitaker, and Murray Bowen. Their work was expanded in the 1960s, and important new figures who became pioneers at this time included Jay Haley, Salvador Minuchin, Virginia Satir, and John Bell. In retrospect, all of these professionals began their therapeutic journeys in the 1950s, but some came into prominence before others. These individuals were forceful and at times fearless in their promotion of family therapy. Their ideas were seen as revolutionary.

In the 1970s, family therapy began to be seen as less radical and more respectable. The AAMFT grew rapidly and was recognized by government agencies. New journals and books appeared on a range of family therapy topics. In addition, established family therapies were refined, and practitioners from Great Britain and Italy began to have greater influence on the profession throughout the world. Complementing these developments was an emerging emphasis on marriage and family enrichment, the increasing influence of feminist theory in family therapy, and the development of assessment techniques geared to families.

From the 1980s through the first decade of the 21st century, the number of professionals involved in working with couples and families increased. Two new associations were established in the mid-1980s: Division 43 (Family Psychology) of the APA, and the IAMFC, a division of the American Counseling Association. There was and continues to be considerable excitement, growth, and federal as well as state governmental recognition and regulation of family therapy. Electronic media are now pervasive in family therapy, as are governmental regulations, such as those related to the Health Insurance Portability and Accountability Act (HIPAA), and diagnostic manuals such as the *DSM-5*.

Overall, family therapy appears to be basically healthy and growing in the 21st century. More women have emerged as leaders, and feminist theory has grown in influence and impact to make the entire field reexamine itself. As in the 1970s, the proliferation of publications, especially online periodicals, in family therapy has increased. New theoretical approaches are also having an impact, as are international efforts to promote family counseling. Health care reform is now and will be an issue in the future, as will the growth of online therapy, revised ethical codes, and court decisions concerning marriage and family life.

Summary Table

FAMILY THERAPY THROUGH THE DECADES

Before 1940

Cultural beliefs that stress the individual, the use of community resources, and psychoanalytic theory stymied the development of family therapy.

Ernest Groves, Alfred Adler, and county home extension agents begin teaching family living/parenting skills.

Abraham and Hannah Stone, Emily Mudd, and Paul Popenoe begin to provide marriage counseling.

National Council on Family Relations is founded (1938).

1940 to 1949

The American Association of Marriage Counselors (AAMC) is established (1942).

First account of concurrent marital therapy is published by Bela Mittleman (1948).

Theodore Lidz and Lyman Wynne study dynamics of families with individuals in them who are diagnosed with schizophrenia.

World War II brings stress to families.

The National Mental Health Act of 1946 is passed by Congress.

1950 to 1959

Nathan Ackerman develops a psychoanalytical approach to working with families.

Gregory Bateson's group begins studying patterns of communication in families.

Don Jackson creates the Mental Research Institute (1958).

Carl Whitaker sets up the first conference on family therapy at Sea Island, Georgia (1955).

Murray Bowen begins the National Institute of Mental Health (NIMH) project of studying families with individuals in them who are diagnosed with schizophrenia.

Ivan Boszormenyi-Nagy begins work on contextual therapy.

1960 to 1969

Jay Haley refines and advocates the therapeutic approaches of Milton Erickson. He moves from Palo Alto to join the Philadelphia Child Guidance Clinic (1967).

Family Process, the first journal in family therapy, is cofounded by Nathan Ackerman and Don Jackson in 1961 and edited by Jay Haley from 1961 to 1969.

Salvador Minuchin begins the development of structural family therapy at Wiltwyck School and continues at the Philadelphia Child Guidance Clinic. He coauthors *Families of the Slums*.

Virginia Satir publishes *Conjoint Family Therapy* (1964) and gains a national following.

Carl Whitaker moves to the University of Wisconsin and begins to write and lecture extensively.

Nathan Ackerman publishes *Treating the Troubled Family* (1966).

John Bell publishes the first ideas about family group therapy (1961).

Murray Bowen begins to formulate his theory of family therapy.

General systems theory, formulated by Ludwig von Bertalanffy (1934/1968), becomes the basis for most family therapy.

The first state licensure law regulating family counselors is passed in California (1963).

Training centers and institutes for family therapy are established in New York, Philadelphia, and Boston.

1970 to 1979

Membership in the American Association for Marriage and Family Therapy grows by 777% to 7,565 members.

The American Association of Marriage and Family Counselors becomes the American Association for Marriage and Family Therapy (1979). Its degree-granting programs are recognized by the U.S. Department of Health, Education, and Welfare.

The *Journal of Marital and Family Therapy* is founded (1974).

The American Family Therapy Academy (AFTA) is created (1977).

Nathan Ackerman dies (1971).

Families and Family Therapy and *Psychosomatic Families* are published by Salvador Minuchin and associates.

The *Family Therapy Networker* is created (1976).

Paradox and Counterparadox is published by the Milan Group (1978).

European family therapists become influential in the United States.

Feminist theorists, led by Rachel Hare-Mustin, begin questioning the premises of family therapy.

1980 to 1989

New leaders, many of them women, such as Monica McGoldrick, Rachel Hare-Mustin, Carolyn Attneave, Peggy Papp, Peggy Penn, Cloe Madanes, Fromma Walsh, and Betty Carter, come to the forefront in the family therapy movement.

Membership in the AAMFT grows to 14,000.

Division 43 (Family Psychology) of the American Psychological Association (APA) is established (1984).

The International Association of Marriage and Family Counselors (IAMFC) is established within the American Counseling Association (1986).

Research procedures in family therapy are developed and refined.

Publications in family therapy increase. The *Family Therapy Networker* reaches a circulation of 50,000.

Multisystemic therapy (MST) is developed to address poor outcomes with at-risk adolescents.

Through the Public Health Service Act, Title III, Section 303(d)(1), family therapy is placed on par with psychiatry, psychology, and other professions in seeking federal training grants.

1990 to 1999

Family therapy becomes more global as an approach to helping others. Solution-focused family therapies of deShazer and O'Hanlon and the narrative approach of White and Epston become popular.

Other new theories are developed for working with couples and families, including constructionist theories. They challenge systems thinking.

The Basic Family Therapy Skills Project focuses on determining, defining, and testing the skills necessary for novice therapists to master, generically and specifically.

The integration and merger of family therapy theories occurs, with less emphasis on specialization.

The new epistemology, which involves second-order cybernetics, emphasizes positive feedback in system transformation.

2000 to 2009

Marriage and family therapy becomes a global phenomenon, with professional associations in countries throughout the world and comparisons made between clinicians such as in Canada and the United States.

The influence and impact of professional associations, such as the AAMFT, IAMFC, AFTA, and Division 43 of APA, grow.

All 50 states and the District of Columbia license marriage and family therapists.

Accreditation of MFT programs grows.

Health care reform and mental health care provider status become increasingly important.

Research on the efficacy of family therapy with different cultural groups increases.

2010 to the Present

Professional associations make greater use of technology to deliver journals,news, and webinars to member.

The AAMFT and the IAMFC revise their codes of ethics.

Online therapy becomes more popular.

The *DSM-5* is published, with the elimination of some disorders and the revision and addition of others. The new *DSM* requires family therapists to update their knowledge of disorders and what insurance companies will reimburse them for.

The U.S. Supreme Court declares the Defense of Marriage Act (DOMA) unconstitutional and lifts the ban on same-sex marriage within the state of California.

CHAPTER 2

The Theoretical Context of Family Therapy

All those ancestors who now live in me
through pictures, stories, and memories
Have come to life collectively
as I walk the streets of Arlington.
Some tightly knit together and others estranged
these men and women politely arrange
themselves in different groups in my mind
as I envision
who they were as persons
and who they hoped to be.
In the silence of my stride
I reflect and quietly meet
my heritage in the colorful couples
from whom I am descended.

Gladding, 2004

CHAPTER OVERVIEW

From reading this chapter, you will learn about

- What factors have generally played a part in defining a family.
- The significance in family therapy of systems theory, cybernetics, positive and negative feedback loops, and linear versus circular causality.
- How the development of individuals and families overlaps during the lifespan and how Erikson's stages of individual development are related to family development.
- The six-stage cycle of most middle-class families: (1) single young adult leaving home, (2) the new couple, (3) families with young children, (4) families with adolescents, (5) families launching children and moving on, and (6) families in later life.
- The most prevalent factors leading families to seek counseling.

- The importance of the fit of the therapist's life stage with that of the family; the influence of the therapist's ethnic background on working with a family; the influence of the unexpected on family life, such as an acute or chronic illness; the effects of special-needs children on a family; and the impact of poverty or professionalism on a family.

As you read, consider

- How the family you grew up in is similar to or different from the open definition of a family.
- The strengths and limitations of systems theory in assessing and working with families.
- How your family of origin used positive and negative feedback loops to promote and prevent behaviors.
- How you have developed through different dimensions—individual, social, and historical—as well as through distinct stages of life.
- The advantages and difficulties to each stage in the family life cycle.
- What challenges and opportunities you face in your present stage of life as an individual and a member of a family.
- How your ethnic identity may affect your work as a family therapist.
- How special or unexpected events may affect families at various socioeconomic levels.

Two families, the Johnsons and the Jones, live near each other in the suburbs of a large city. Each family consist of the maternal grandmother in her late 80s, a mother of age 50 years, a father of age 55 years, a daughter of age 17 years, and a son of age 15 years. The maternal grandmothers die after a long illness on the same day. The Johnsons are saddened by the loss, and the father and children comfort the mother and plan for the funeral. The Jones have a different reaction. Mrs. Jones becomes hysterical and swears she cannot go on without her mother, while Mr. Jones berates her for acting in "a childish manner." The children flee the house and go to stay with friends, hoping that the brewing storm between their parents will blow over in a few hours. Sadness, anger, and fear are the dominant feelings surrounding the death. Chaos reigns. No one plans for the funeral, and there is a noticeable absence of empathy, sympathy, and constructive behavior.

Although this scenario of maternal grandmothers dying simultaneously in parallel families is improbable, the reactions of the Johnsons and the Jones are quite real. Some families pull together during times of stress or distress, while others seem to disintegrate and fall apart. In essence, families have personalities, just as individuals do. They form a system that either works well or breaks down. Thus, it is not surprising that society and those who work directly with families see them in this way—as interrelated entities. Families, like individuals and groups, either flourish or flounder by using or abusing the resources they have within them. To understand families better, we first examine the nature of families and how they function as systems.

FAMILIES, SYSTEMS, AND SYSTEMS THEORY

Families have historically played an important part in the life and development of people and nations. The origin of families "dates back to prehistoric times when our hominid ancestors developed the original family unit. Although the family has evolved, it has

maintained many of its original functions. It produces and socializes children, acts as a unit of economic cooperation, gives us significant roles as children, husbands, wives, and parents, and provides a source of intimacy" (Strong & DeVault, 1986, p. 4). Furthermore, a family provides some of the deepest and most satisfactory emotional experiences of life, such as love, devotion, attachment, belonging, fun, and joy (Framo, 1996). The family can also be therapeutic, with members listening, sympathizing, assisting, and reassuring each other (Sayger, Homrich, & Horne, 2000).

The early Egyptians considered the royal family so important that they encouraged marriage among kin. In Chinese dynasties, family life was crucial to the accrual of power and survival of empires; consequently, marriages were arranged. In medieval Europe, powerful families such as the Hapsburgs intermarried in order to rule and maintain wealth. As a result, certain families enjoyed great success in accumulating wealth and power (Klein, 1992), whereas others declined.

Throughout history, social and economic factors have forced modifications in the customs governing family life (Coontz, 2006). Rules have been established and/or abandoned as a result of societal changes from such events as revolutions, economic turmoil, or natural disasters. For example, in the late 1800s the United States underwent a major transition from an agricultural society to an industrial one. This socioeconomic change altered the lives of American families:

> Industrial workers of agricultural backgrounds exchanged their rural "freedom" of flexible schedules, lack of control over environmental uncertainties on their work effort, and social isolation of rural living for regimented time schedules, lack of control over extreme and tedious work conditions, and city living. . . . In large measure, this shift resulted in an exchange of independence and economic self-reliance for social and economic dependence within families. (Orthner, Bowen, & Beare, 1990, p. 18)

In examining families and how to work with them, a professional must explore historical, societal, economic, and governmental factors that have had an impact on family life over time. "Families do not dance alone or in isolation" from the communities in which they reside or from the way they are organized (Stevenson, 1994, p. 39).

What Is a Family?

Ideas about the nature of family and how it should be structured vary across cultures and are constantly changing (Coontz, 2000, 2008). In the Americas, "families have been changing since the first settlers arrived on the shores of the new world" (Bird & Sporakowski, 1992, p. xiv) and even before that among indigenous people. For some groups, such as many European Americans, the family includes only blood-related kin and is "nuclear." For other groups, such as many African Americans, the family tends to focus on a "wide informal network of kin and community" (Hines, Garcia-Preto, McGoldrick, Almeida, & Weltman, 1999, p. 70). In such cases, the family includes anyone who is psychologically connected, such as close, long-term friends (Hines & Boyd-Franklin, 1996). For yet others, such as for some Asian Americans, the family includes ancestors and all descendants. The definition of a family is not monolithic. It varies according to cultural group. Reaching a consensus on what constitutes a family is difficult at best.

Thus, in formulating a definition of a family, inclusive as well as exclusive elements need to be considered. The U.S. Census Bureau (2011d) defines a family as "two or more

people (one of whom is the householder) related by birth, marriage, or adoption residing in the same housing unit." This broad definition includes people who never marry, those who marry and never have children, and those whose marriages end in divorce or death, as well as a variety of nontraditional family arrangements. In essence, this definition of a family is geared toward one's family of origin, that is, the family in which a person grew up. The definition, however, excludes some forms of living arrangements that a number of people consider a family too, such as those that include close friends or ancestors.

In this book, the definition of a family is even broader in order to promote an understanding of the different available forms of family life. A **family** is considered to be those persons who are biologically and/or psychologically related, are connected by historical, emotional, or economic bonds, and perceive themselves as a part of a household. In the United States and worldwide, families are increasingly formed through nonbiological means. By broadly defining a family, one can gain a better appreciation of persons in family units. Greater insight into the ways families govern themselves may also be obtained.

Overall, families in whatever form they come are characterized by economic, physical, social, and emotional functions. There is a dual emphasis on fostering the development of individuals within families and simultaneously offering family members stability and protection, as well as preserving the family unit structure (Burr, Hill, Nye, & Reiss, 1979; Strong & Cohen, 2013). An example of these multiple emphases and what they foster can be seen in the Tempe family.

CASE ILLUSTRATION

The Tempe Family

The Tempe family is composed of a stepfather, a biological mother, and two daughters, of ages 11 and 9 years, respectively. Both the mother and stepfather work outside the home to provide economic and physical support for themselves and the children. Thus, all family members rise early in the morning, and it is often late at night before the parents get to bed.

Within this structure, the mother and father take joint responsibility for making sure that the daughters behave properly, by monitoring the time they spend doing homework and the children with whom they socialize. Both parents listen in the morning and at night to the children's plans or recollections of the day. They pay attention to what the children need for school, such as poster board, pencils, and paper, so they are not caught at the last minute going out late at night to get needed supplies. They let the children follow their own interests in regard to most activities but enrolled them in Girl Scout programs, on soccer teams, and in music classes.

The family routine at night for both the parents and the children is supper, homework, and computer or television time. This last recreation is run by the clock and strictly monitored. Because of the demands of the week, the parents take a night out once a week to bowl, see a movie, or go out to dinner and generally enjoy themselves as a couple. They also assess how their days have been and how the children are doing each night before they go to bed. Although there are disagreements and frustrations in the family due to unexpected events, there is usually balance. The children are well monitored, and the couple takes time to be together to have fun as well as to vent and to plan.

What Is a System, and What Is Systems Theory?

Although some individuals might consider the Tempes in the example just given to have a system for living, it is important to define what a system is rather than talk about it in generalities. There are a number of definitions, but here a **system** is defined as an interacting set of units, parts, or persons that make up a whole arrangement or organization. Each unit, part, or person in the system is affected by whatever happens to others within the arrangement, the group, or, in this case, the family. This definition is based on the work of Ludwig von Bertalanffy (1934, 1968), a biologist, who in the 1940s attempted to explain how organisms thrive or die in accordance with their openness or closeness to their environments. Von Bertalanffy's work was a response to the scientific trends of his day that focused on reductionism and isolation of elementary units. He sought to "promote unification and a focus on the 'whole' versus the individual," in the process placing "greater emphasis on organization rather than reduction among the sciences" (Meyer, Wood, & Stanley, 2013, p. 163). Individuals were seen in the context of a larger, dynamic system that could evolve, adapt to environmental stimuli, and engage in self-preservation. Put succinctly, systems are internally interdependent as well as subject to outside forces and changes.

From von Bertalanffy's (1969) work, social scientists conceptualized that all living systems, such as plants, animals, and even families, operate on a similar set of principles:

1. The whole is greater than the sum of its parts.
2. A system is a compilation of subsystems arranged in a hierarchical structure.
3. Systems adapt self-stabilizing mechanisms to maintain homeostasis and equilibrium.
4. Systems have the capacity to adapt and change in response to environmental conditions.

Systems Theory

Systems theory, sometimes known as **general systems theory**, further elaborates on what a system is and how it operates. It focuses on the interconnectedness of elements within all living organisms. An **organism** is defined as a form of life "composed of mutually dependent parts and processes standing in mutual interaction" (von Bertalanffy, 1968, p. 33). Thus, in a family, members are constantly interacting and mutually affecting one another as they are in relationship to each other. When change or movement occurs in any of the members or circumstances that make up the family system, all aspects of the family are affected, for better or worse. Thus, the family's well-being and ability to function are influenced by the activity and health of each of its members. Unlike nonliving objects, which are predictable and can be manipulated, such as cue balls on a pool table, living substances are more unpredictable and complex. They have cognitions and emotions that influence their actions.

Systems theory is the lens through which the majority of family therapists have traditionally viewed families. It is around seeing families as systems that most clinicians organize their interventions, taking into consideration concepts such as cybernetics, circular causality, and feedback. In this video, Dr. Paul Anderson explains systems theory and how it works with a family in a conversation with Dr. Nancy Murdock concerning a client named Helen.

Cybernetics and Causality

The term **cybernetics** was coined by Norbert Weiner (1948) to describe systems that regulate themselves though means of feedback loops. The family stabilizes or changes

and maintains its **homeostasis** (state of equilibrium) through cybernetics. Cybernetics can refer to an inorganic system, such as a furnace, or an organic system, such as a family. "The basic elements in a cybernetics system are a receptor, a center and effector, and a feedback system" (Nichols, 1984, p. 129). Information comes into the system through the *receptor* (e.g., a person's ears), which passes it on to the *center,* where it is amplified (e.g., through talk) and carried to the *effector,* which reacts to it by discharging an *output* (e.g., avoidance or engagement).

Cybernetics is an especially helpful concept in family therapy "because it introduces the idea of **circular causality** by way of feedback loops" (Nichols, 1984, p. 128). Circular causality recognizes that human behavior is complex and always occurs within a system of relationships. Therefore, unlike simple interactions between two objects, like a cue stick and a cue ball, circular causality describes how complex actions are a part of "a causal chain, each influencing and being influenced by the other" (Goldenberg & Goldenberg, 2002, p. 25). For instance, in circular causality, a man who abuses alcohol and is having marital difficulties might say, "I drink because my wife doesn't trust me." At the same time, his wife may argue, "I don't trust him because he drinks." Rather than one behavior causing the other to happen, each behavior interacts with the other as both cause and effect. This idea is the opposite of linear causality, in which forces are seen as moving in one direction with each action causing another. "I move the cue stick and the cue ball strikes the other balls on the pool table."

In family systems, cause and effect are often circular, like the argument between husband and wife just cited. One behavior feeds the other, which continues to feed the previous one, and on and on. In this illustration, the circular causes loop back on one another. Because family interactions are more complex than a game of pool, it is crucial that family therapists use concepts capable of describing and influencing those interactions. Although linear causality is a useful concept when two or more objects are linked together by interactions moving in one direction (A causes B, B causes C, and so forth), circular causality offers better insight into the nature of the complicated and interconnected dynamics of family systems (Figure 2.1).

Circular causality does not deny the usefulness of linear causality. However, family life is usually more complicated than linear causality can explain. There is no one cause behind a behavior and no one person to blame or praise for an interaction occurring the way it does. Rather, a family's behavior is a series of moves and countermoves dependent on relationships that foster repeating cycles based on the stability or instability of relationships. Another way to think about this is in terms of the difference between kicking a rock and kicking a person. Kicking a rock is linear. The rock moves a certain distance depending on how hard it is kicked. In kicking a person, a number of reactions may occur, depending on the relationship. These may range from running away to kicking back.

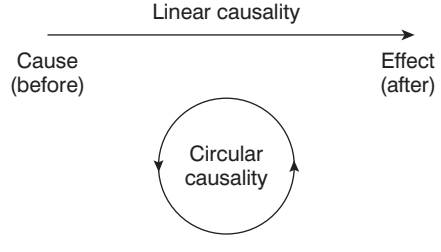

FIGURE 2.1 Linear versus circular causality.

Feedback and Feedback Loops

Feedback refers to the communication process within a system. Feedback loops either keep behaviors in check or promote change. If one takes the husband and wife example mentioned earlier, taking another drink would be the equivalent of a **negative feedback loop**, which is also called an **attenuating feedback loop** (or a loop that promotes a return to equilibrium). In this case, the wife would continue to be suspicious of her husband. On the other hand, a decision to stop drinking by the husband may engender some trust in his wife and would be seen as a **positive feedback loop**, which is also called an **amplifying feedback loop**. It would lead to change in the system and possibly to more trust and less difficulty in the relationship over time.

These loops, like a thermostat in a home heating system, allow families a range of contractions and expansions of behavior repertoires within certain limits. For example, an adolescent who violates her curfew will most likely upset her parents, as pictured in the cartoon below. Her actions will result in a negative feedback loop according to which she would be grounded for a week in order to establish boundaries and promote homeostasis so she would be less likely to break curfew again (Figure 2.2).

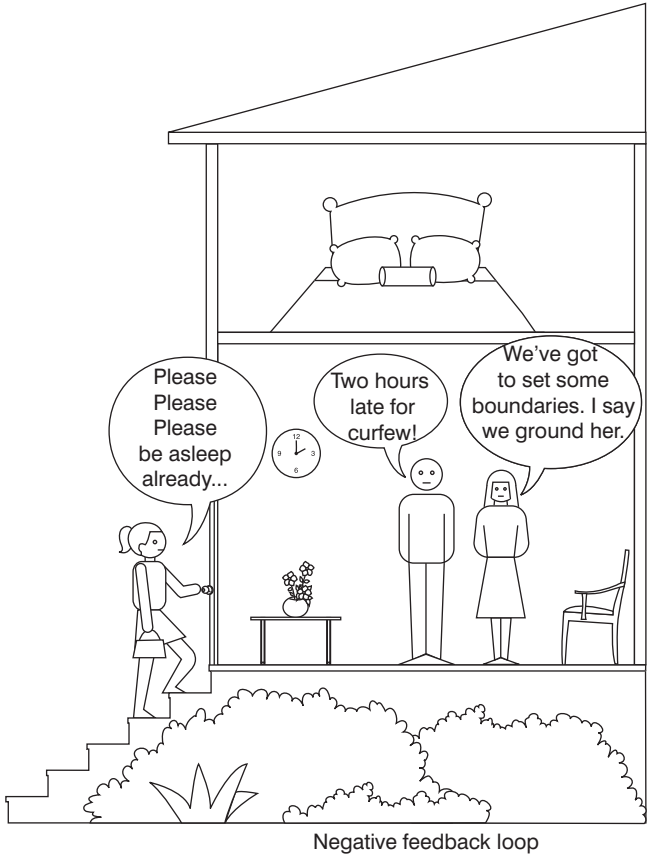

FIGURE 2.2 Negative feedback loop.
Illustration by Lindsay Berg. Copyright © 2013 by Lindsey Berg. Used with permission.

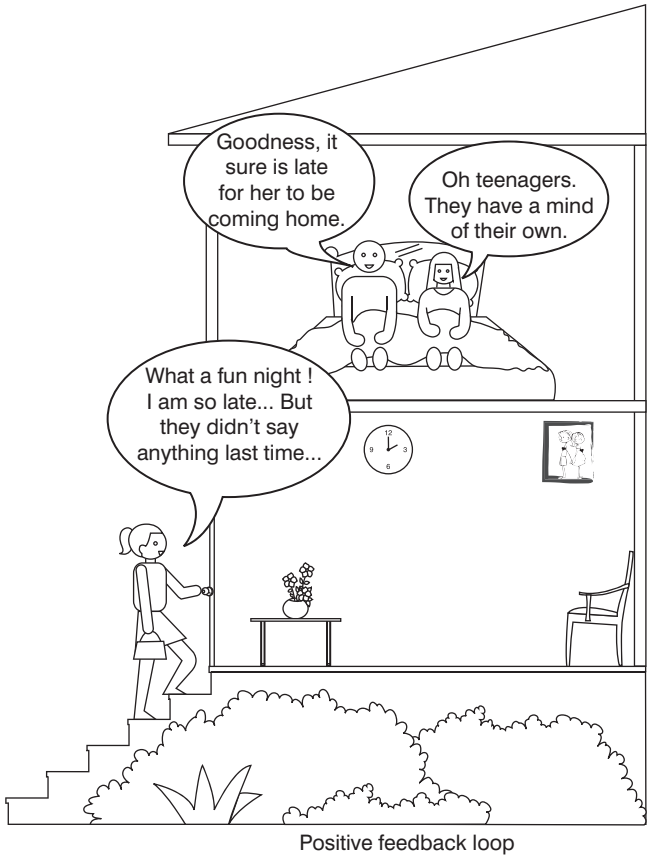

FIGURE 2.3 Positive feedback loop.
Illustrated by Lindsay Berg. Copyright 2013 by Lindsay Berg. Used with permission.

A contrast to a negative feedback loop would be a family with positive feedback (or a loop that promotes change). In such a situation, the adolescent who starts staying out late would increase the number of nights she stays out late over time, as seen in the cartoon in Figure 2.3.

"Periodic imbalance is inevitable," and feedback loops are called into play that restore a behavior or escalate one (Goldenberg & Goldenberg, 2013, p. 98). Times of change, stability, and homeostasis are temporary. Thus, a **major task for families is to maintain a balance between steadiness and change**. If there is too much permanence, the family may become stagnant; if there is too much change, the family may become chaotic. Developmental concerns must be taken into consideration in purposely choosing to operate from a positive feedback loop perspective.

"A major difference between cybernetics and general systems theory is that cybernetics is a more mechanical model. . . . People are not like machines . . . but are active and creative, exerting control over their surrounds not only in their motor output, but also in perceptual selection and cognitive structuring of their sensory input" (Nichols, 1984, p. 129). Viewing families as systems involves recognizing that the relationships formed

among family members are extremely powerful and account for a considerable amount of behavior, emotion, values, creativity, and attitudes. Moreover, like strands of a spider web, each family relationship, as well as each family member, influences all other family relationships and all other members (Figley, 1989, p. 4).

Only when families are seen as systems in which the family members interact with each other, the family as a whole, and the external environment can appropriate and lasting interventions take place. Family dynamics impacts individuals, and individuals in turn impact the dynamics of the family in multiple dimensions. For instance, the movement of each person inside and outside the family environment has an effect on every family member and the way the family functions. The interrelatedness of the family, which is governed by rules, sequences, and feedback, is crucial to knowing how to work with families.

CASE ILLUSTRATION

Milek and Berrak Tuzman had been married for 25 years when Milek developed brain cancer. By the time it was discovered, it had spread throughout his body, and doctors gave him just over 1 year to live. The Tuzman household had usually been a gathering spot in the New York neighborhood where they lived. However, after the diagnosis became known, neighbors stopped coming for visits, and even the Tuzman's grown children, Besir and Fidan, began spacing their visits further apart.

To counter their increased isolation, Milek and Berrak strung colorful blinking lights around their windows and started visiting their neighbors and children. They brought different treats, such as breads or fruits, with them every time they made a visit. Soon everyone was coming to their house again.

What do you think of their positive feedback loop strategy? Can you think of other ways they might have reversed the isolation they faced from family and friends?

INDIVIDUAL DEVELOPMENT AND FAMILY LIFE CYCLE DEVELOPMENT

In addition to understanding that systems, cybernetics, causality, and feedback increase insight into the nature of a family, it is important to be aware of individual and family life cycles. Understanding the developmental and dynamic nuances of an individual's life and of a family's life is another crucial step in the process of becoming a family therapist.

Individual and Family Development

Development (i.e., predictable physical, mental, and social changes over life that occur in relationship to the environment) is a powerful dynamic in individuals and in families. The process is often uneven, with alternating times of growth and regression. In examining the concept of development, the factors of time and stages must be addressed.

In the broadest sense, development is a "life course." As such, it refers to three different time dimensions in human life: individual time, social time, and historical time (Elder, 1975). **Individual time** is defined as the span of life between one's birth and death. Notable individual achievements are often highlighted in this perspective, for example, being recognized as "employee of the year." **Social time** is characterized by landmark social events such as marriage, parenthood, and retirement. Family milestones are a central focus here. **Historical time** is the era in which people live, that is, the culture.

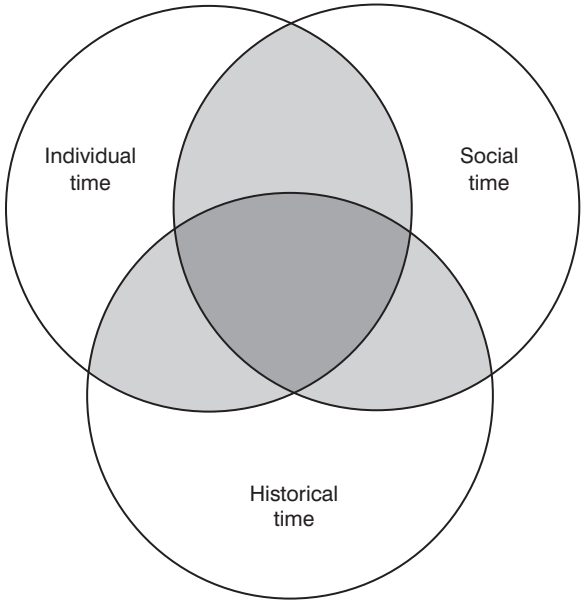

FIGURE 2.4 Three different time dimensions in human life.

It consists of forces that affect and shape humanity at a particular point in time, such as during economic depression or war. For example, a Vietnam veteran may still be angry about government decisions involving the Vietnam War, and a survivor of an economic downturn, such as in 2008, may hoard money and be distrustful of banks. In both cases, memories influence present lifestyles (Figure 2.4).

Everyone is influenced by the three dimensions of time, both concurrently and sequentially. The term **life cycle** is used in this text to describe life events. A life cycle represents an active way to conceptually picture time in human development because it denotes the continuous development of people over time in multiple contexts of their lives.

Life cycles have been formulated for both individuals and families. Neither people nor families develop or interact in isolation from each other or from the society in which they live (Schwartz, 1999). Rather, life cycles often juxtapose and intertwine within a particular social framework. Such interactions with family members, both living and dead, influence the course of life (Bowen, 1978; Okun, 1984). For example, the choice of career and professional development is frequently connected with one's family life and history (Savickas, 2011).

CASE ILLUSTRATION

Life Development Factors in Personal/Family History

Ada Knapp

Ada Knapp is a 39-year-old single woman who was named after her maiden aunt, a former schoolteacher. At multiple levels, Ada always valued education. She turned down dates in college in order to devote more time to her studies. Now her primary focus has paid off. She was promoted to be a full professor at a major public university. Her life up to this point parallels that of her aunt, who remained single.

In examining her life after her latest academic achievement, Ada continues to take her cues from the life of her namesake. Yet, she may wonder about getting married or adopting a child. If she were to elect either of these routes, she would deviate from the life pattern she set in motion. Such a change would not be impossible but would require more effort because she has no namesake family role model to follow.

Still, in her evaluation of where she is now and where she is headed, Ada begins to broaden her consideration of possibilities. She thinks of her mother, a businesswoman, and of her sister, a physician. Both are married; her mother had two children, and her sister now has one. She realizes, as she reflects, that she most likely closed out her options prematurely until now, but she still has possibilities, especially considering the environment in which she works and her natural gregariousness.

Individual Life Cycle Development

Until the 1970s, the word development usually referred to an individual. Part of the reason is attributable to the popularization of Erik Erikson's (1950, 1959, 1968) theory on human growth and development. Erikson was a pioneer in describing human life in terms of **stages**, that is, sequential developmental occurrences. Following Erikson's lead, Daniel Levinson (1978), Roger Gould (1972, (1978), Gail Sheehy (1977, 1981), and Bernice Neugarten (1976) proposed adult developmental stages that focus on the individual. Indirectly reinforcing this personal emphasis has been the concentration in the helping professions on counseling individuals. With the exceptions of social work and marriage and family therapy, most helpers have traditionally worked on a one-to-one basis (Gladding, 2013).

From an individual point of view, people face predictable **developmental crises** (i.e., times of turmoil and opportunity) throughout their lives. These times involve such events as aging, retirement, birth, and marriage. The therapist should recognize how people handle and adjust to these events. The early and later phases of life and the tasks that are faced during these times result in either failure or success on many levels. Erikson's (1950, 1959, 1968) first five stages of life specifically focus on the formation of the person into a competent individual with adequate skills and identity. Each stage is marked by its unique challenge/challenges, resulting from biological, psychological, and cultural influences. These stages are sequential, with individuals having to achieve a percentage of accomplishment in one stage before they can proceed to take on the goals of the next (Allen, 1990). **The first five stages and their tasks** are as follows:

Stage	Age	Task
1. Trust vs. mistrust	Year 1	Emphasis on satisfying basic physical and emotional needs
2. Autonomy vs. shame/doubt	Years 2–3	Emphasis on exploration and developing self-reliance
3. Initiative vs. guilt	Years 4–5	Emphasis on achieving a sense of competence and initiative
4. Industry vs. inferiority	Years 6–12	Emphasis on setting and attaining personal goals
5. Identity vs. role confusion	Years 12–18	Emphasis on testing limits and achieving a self-identity

Gilligan (1982), McGoldrick and Carter (1999b), and feminist family therapists have criticized this conceptualization of development because they believe it is centered more on men than on women and that it leaves out the importance of relationships and connectedness in individuals' lives. Their points are well made and need to be considered in evaluating Erikson's model.

The last three stages of Erikson's developmental scheme are more interpersonally based and, until recently, have not been elaborated on much. The processes involved in these final stages are intimacy versus isolation, generativity versus stagnation, and integrity versus despair. They are tied to and dovetail with family life processes. The satisfaction people receive from intimate relationships goes a long way in influencing what they will do to help prepare the way for the next generation. Intimacy and generativity consequently relate to the total quality of life and how persons integrate overall life experiences in a healthy or unhealthy manner (Allen, 1990). Briefly, these stages can be described as follows:

Stage	Age	Task
6. Intimacy vs. isolation	Years 18–35	Emphasis on achieving intimate interpersonal relationships
7. Generativity vs. stagnation	Years 35–65	Emphasis on helping the next generation and on being productive
8. Integrity vs. despair	Years 65+	Emphasis on integrating life activities and feeling worthwhile

According to Erikson (1968), other factors in addition to the initial achievement of identity are also important to the formation and well-being of a family. These factors, which typically increase as a person matures, are intimacy, productivity, and integration. As individuals grow into adulthood, they are challenged and tested by new conflicts that must be mastered. These conflicts come in the form of interactions with others in family, leisure, and work settings. For instance, in most families there is some intergenerational ambivalence, namely the coexistence of mixed sentiments between the pressure that parents feel to help adult children and the desire to be freed from their demands and the desire of adult children to be independent and yet accept needed assistance.

Family Life Development

The **family life cycle** is the term used to describe developmental trends within the family over time (McGoldrick, Carter, & Garcia-Petro, 2011). This model includes all dimensions of the individual life course but emphasizes the family as a whole. Inherent in this model is tension between the person as an individual and the family as a system. Like other models, the family life cycle emphasizes some stages and aspects of life more than others. Note that what is considered an appropriate family life cycle is a social/cultural variable. Therefore, the family life cycle of many families in the United States outlined here is not universally accepted worldwide and is subject to change as society changes.

The initial version of the family life cycle was proposed by Evelyn Duvall (1977) in 1956. This model has lost some of its potency over the years as the traditional nuclear families exemplified in it have decreased in number and influence. New models have replaced Duvall's original concept and are more relevant for conceptualizing family life today. Among these are the life cycle of the intact middle-class, nuclear family; the life cycle of the single-

parent family; and the life cycle of the blended family. The life cycle of the intact middle-class, nuclear family is highlighted here, with the realization that numerous families differ.

McGoldrick, Carter, and Garcia-Petro (2011) outline a six-stage cycle of the intact middle-class, **nuclear family** that begins with the unattached adult and continues through retirement. It includes (1) *single young adults leaving home*; (2) *the new couple*; (3) *families with young children*; (4) *families with adolescents*; (5) *families launching children and moving on*; and (6) *families in later life*. Each of the stages of this life cycle involves key adjustments, tasks, and changes that must be accomplished if the individual, family as a whole, and specific family members are to survive and thrive. Not all intact nuclear families go through all of the stages in this model. For those that do, the crucial aspects of their lives and the issues they face that might bring them into family therapy are as follows.

SINGLE YOUNG ADULTS: LEAVING HOME The proportion of single young adults in the United States (those 15 years of age and older) is rising. According to the U.S. Census Bureau (2009), approximately 30% of the total population in the United States age 15 years and older is composed of never-married adults. Never-married single adults, together with a large number of divorced, separated, and widowed persons, make single unmarried persons a significant part of the adult population in the United States (slightly less than half of all people older than age 15 years). Singles at various stages of life have been depicted in such popular television shows as *Friends* and *Seinfeld* (for young single adults) and *Golden Girls* and *Frasier* (for older single adults).

With an increase in **singlehood** (i.e., being single), lifestyles within society are changing, with a greater emphasis on individual events. Societal institutions that have been bastions for family-sponsored activities, such as churches, are being reshaped to be more accommodating to singles. The field of family therapy must change by necessity in response to the steady rise of singles. For instance, the importance of treating the individual from a family systems perspective will take on increased importance.

Being a single young adult and leaving home is one stage that individual and family life cycle theorists both emphasize. A major task of this period is to disconnect and reconnect with one's family on a different level while simultaneously establishing one's self as a person (Haley, 1980). Developing such an identity—what Murray Bowen (1978) calls "a **'solid self'** (i.e., a sense of one's own beliefs and convictions that are not simply adaptive to others)"—is difficult at best and requires emotional maturity (Gerson, 1995, p. 96).

Being single requires a person to strike a balance between a career and/or marriage ambitions and a desire for personal autonomy. An increasing number of adults in all age ranges have in recent years tried to achieve such a balance through cohabitation, that is, living together without being married. For instance, in 2012 there were 15.3 million people living with an unmarried partner of the opposite sex, which translates into 6.5% of all adults 18 years and older (Jayson, 2012). Compared to earlier times (i.e., before the 1980s), there is increasingly more diversity. For instance, 41% of cohabiting couples have children living with them, and 47% are 35 years and older. In addition, there are college-age cohabiters, prenuptial cohabiters, "testers" (those less certain than prenuptial cohabiters of marriage), and alternative cohabiters (those who prefer the sexual, domestic, and legal freedoms in cohabiting) (Gold, 2012).

Cohabitation is prelude to marriage for many young adults and is sometimes characterized as a "**trial marriage**," while for older adults cohabitation is often a "long-term alternative to marriage" (Jayson, 2012; Phillips & Sweeney, 2005). Cohabiting relationships

tend to be "both more vibrant and more volatile than marital relationships" (Hsueh, Morrison, & Doss, 2009, p. 236). The decision to cohabitate has an effect on the lives of single adults and other choices they may wish to make. It has positive, neutral, and negative aspects to it. On the positive side, it allows adults the freedom to leave a relationship that is not working without becoming involved or embroiled in the legal system. It also allows more individual freedom for the persons involved in the relationship because there is no legal commitment to it. On the neutral side, cohabitation does not seem to have a disruptive effect on some cultural and ethnic groups. For instance among African Americans and Mexican Americans, the majority of individuals in these groups who cohabitate eventually marry (Phillips & Sweeney, 2005).

On the negative side, cohabitation can undermine marriage and the parenting of children (Jayson, 2005; National Marriage Project, 2005). This phenomenon of lower marital quality, more negative communication, less dedication, and higher rates of divorce after marriage is known as the **cohabitation effect** (Rhoades, Stanley, & Markman, 2009). European American couples who cohabitate before marriage are more likely to divorce than those who do not (Peterson, 2000b; Phillips & Sweeney, 2005). Research suggests that the breakup of these relationships is due to a lack of trust and commitment to marriage, a more positive perception about divorce, and simply the fact that the marriage occurred in the first place, because of the barriers to ending the cohabitation relationship, for example, shared mortgage, pet(s), and furniture (Hsueh et al., 2009; Larson & Lamont, 2005). Furthermore, in regard to parenting, "children residing with unmarried cohabitating parents have been found to have more behavioral problems, poorer school performance, and higher levels of psychological distress than children living with parents who are married" (Klausli & Owen, 2009, p. 103).

Another alternative is to remain single, which is now more accepted than ever. Like cohabitation, its popularity as a lifestyle appears to be growing. Indeed, "the number of never-married men and women [has] doubled or tripled in various age groups since 1970. Among people 35 to 39 years old, the rate has more than doubled for women (from 5 percent to 13 percent) and tripled for men (from 7 percent to 19 percent)" (Carter & McGoldrick, 1999, p. 13). At the same time, fewer than 50% of adult Americans are now married, compared with a record high of 74% in 1960 (U.S. Census Bureau, 2010).

Singlehood is a viable alternative to marriage. Indeed, singles are usually the second-happiest group (married couples being the happiest), ranking above unmarried couples and others. Singlehood can be as fulfilling as marriage, depending on the needs and interests of the individual. Being single and mentally healthy requires that individuals establish social networks, find meaning in their work or avocations, and live a balanced life physically and psychologically. Singles must also develop coping strategies so as not to become distressed (Kleinke, 2002). Living a healthy single life requires making adjustments to cultural demands and realizing that culture is a phenomenon that one must accommodate.

Major challenges for singles to overcome are internal and external pressures to marry. They must also find ways to deal with loneliness. On the other hand, the personal freedom to choose one's actions is a major attraction and benefit to this style of life.

Issues that are likely to prompt singles to seek family therapy are those connected with the following:

- A weak personal sense of self.
- An inability to emotionally and/or physically separate from one's family of origin.
- A lack of social skills to establish significant relationships with others.

These qualities can be seen in this brief video of a young woman with her parents in therapy, in which she seems unable to let go of the security of living with them.

Family Reflection: Singlehood is both a transient and a permanent stage of life. It offers many opportunities. How have you experienced this stage? How have others you know experienced singlehood or having been single?

THE NEW COUPLE: JOINING OF FAMILIES THROUGH MARRIAGE The new-couple relationship begins with courtship, the period when individuals test their compatibility with another through dating. This process may involve a number of partners before one commits to marriage. "During courtship, partners are encouraged to present themselves as consistently attractive and desirable—while interacting frequently with each other" (Ponzetti, 2005, p. 133). Generally, individuals tend to be most comfortable with others who are at the same or similar developmental level (Santrock, 2013). Secure men tend to become involved with secure women, and anxious women tend to become involved with less-committed and more-disengaged men (Lopez, 1995). That is one reason why relationships between dissimilar people are prone to frequent breakups. Environmental, psychological, and situational factors can also hinder people's adjustment to marriage (see Figure 2.5). Nonetheless, "healthy couples appear to be a multidimensional, complex, nonsummative unit" (Eckstein, 2004, p. 414). They usually cope well with the transitions and challenges of everyday life.

The early stages of a couple relationship are characterized by **idealization**. Both men and women in marriage initially idealize each other and relate accordingly. This phenomenon dissipates to some degree over the course of a marriage. However, some

1. The couple meets or marries shortly after a significant loss.
2. One or both partners wish to distance from family of origin.
3. The family backgrounds of each spouse are significantly different (religion, education, social class, ethnicity, age, etc.).
4. The couple has incompatible sibling constellations.
5. The couple resides either extremely close to or at a great distance from either family of origin.
6. The couple is dependent on either extended family financially, physically, or emotionally.
7. The couple marries before age 20 or after age 30.
8. The couple marries after an acquaintanceship of less than 6 months or after more than 3 years of engagement.
9. The wedding occurs without family or friends present.
10. The wife becomes pregnant before or within the first year of marriage.
11. Either spouse has a poor relationship with his or her siblings or parents.
12. Either spouse considers his or her childhood or adolescence as an unhappy time.
13. Marital patterns in either extended family were unstable.

FIGURE 2.5 Factors that negatively influence marriage.

From B. Carter and M. McGoldrick, "Issues in marital adjustment," in *The Changing Family Life Cycle: A Framework for Family Therapy,* 2nd ed. Boston: Allyn & Bacon, 1999:231. ©1999, 1989 Allyn & Bacon. Reproduced by permission of Pearson Education, Inc.

evidence indicates that individuals who report a high level of marital satisfaction also maintain a high level of idealistic distortion about their marriages and spouses: They report them to be better than they actually are (Fowers, Lyons, & Montel, 1996). This quality of seeing each other positively, or through "rose-colored glasses," helps married couples endure. It is just the opposite of those most likely to divorce, who see each other through "fogged lenses" and are cynical and unable to say good things about each other (Peterson, 2000a).

Overall, the new-couple stage of the family life cycle is one of adjustment and adaptation. For example, new couples must learn how to share space and meals, as well as work, leisure, and sleep activities. They must accommodate each other's wishes, requests, and fantasies. This process takes time, energy, goodwill, and the ability to compromise. For example, Jose must understand that his new wife, Maria, takes longer to get dressed than he does. At the same time, Maria must take into consideration that Jose is more meticulous about the upkeep of the house than she is.

It is not surprising that this stage of marriage is one of the most likely times for couples to divorce due to an inability of individuals to resolve differences. It is also often seen as a time of life when couples experience the greatest amount of satisfaction, especially if they later have children (Glenn & McLanahan, 1982). The new couple is free to experiment with life and to engage freely in a wide variety of activities. Financial and time constraints are the two main limitations for couples at this time.

Issues that are likely to prompt new couples to seek family therapy are those connected with the following:

- An inability to adjust to living as a couple instead of as an individual.
- Difficulty with relatives, either family of origin or in-laws.
- An inability to work through interpersonal issues, such as developing adequate or optimal communication patterns.
- The question of whether (or when) to have children (Peterson & Jenni, 2003).

FAMILIES WITH YOUNG CHILDREN Becoming a parent is a physical, psychological, and social event that alters a couple's lifestyle dramatically. It is a joyful but tough experience (Renshaw, 2005). The arrival of a child has an effect on a couple's lifestyle (e.g., residence), marital relationship (e.g., sexual contact), and paternal/maternal stress (e.g., new demands) (Hughes & Noppe, 1991). Perhaps during no other time in the family life cycle is the necessity of restructuring more evident as couples divide their time and energy into parental and partner subsystems (Young, Negash, & Long, 2009).

When a newborn enters a family, the family becomes unbalanced and even distressed, at least temporarily (Cowan, Cowan, & Knox, 2010). Couples have to adjust the time they spend working outside the house, socializing with friends, and engaging in recreational activities. They also have to arrange between themselves who will take responsibility for the child, as well as when, where, and how this responsibility will be met. A crucial task in caring for an infant is ensuring that an enduring attachment bond is created (Bowlby, 1988). In the process of caregiving, a rebalancing occurs between husbands and wives in regard to their investment of time, energy, and focus (Carter, 1999). Husbands may be especially confused as to what they should do and when because "society today has given fathers confusing expectations" (Renshaw, 2005, p. 7).

After attachment tasks are settled, families with young children must accomplish other important undertakings. Those duties connected with meeting the physical and psychological demands involved in having preschool children are among the hardest. These challenges become especially great when both partners within a marriage are working outside the home. Mothers may especially feel overwhelmed because they still tend to be the primary caregiver in most families, even though 75% of them work in the labor force, with approximately two thirds of that number having preschool children (Saginak & Saginak, 2005).

Other aspects of family life in which adjustments must be made include relationships with extended family, demands of work, use of leisure, and finances. Often there are strains and tension in one or more of these areas. "The strength of the marital bond (i.e., marital satisfaction) goes a long way toward mediating stress and time constraints associated with the presence of children and work" (Giblin, 1994, p. 50). Overall, as a general rule, marital satisfaction tends to go down with each child that is added to a family (see Figure 2.6). However, it may be modified as couples adjust (Mattessich & Hill, 1987).

Issues that are likely to prompt families with young children to seek family therapy are those connected with the following:

- "The fallout that accompanies the necessary reorganization of relationships and activities" of the married couple.
- "The establishment of controls" for a young child (Minuchin, 1995, p. 115).

FAMILIES WITH ADOLESCENTS Couples who have adolescents must take care of themselves, their relationship, their teenagers, and often their aging parents. Because of the squeeze they may be in psychologically and physically, they are sometimes referred to as the **sandwich generation** (Zal, 2002). According to recent statistics, there are "twenty-two million families who have at least one person who is a caregiver for an older member of the family" (Riley & Bowen, 2005, p. 52), and the National Family Caregiver Association predicts that 59% of the U.S. population will become family or informal caregivers of aging adults in the future (Ramlo & Berit, 2013).

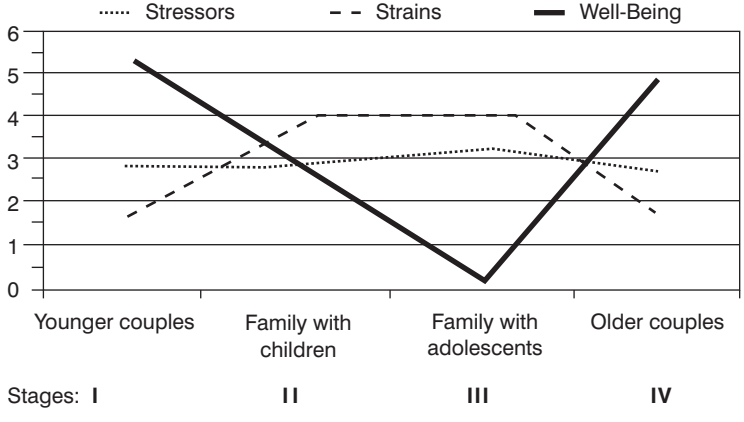

FIGURE 2.6 Stressors, strains, and well-being across the family life cycle.

From P. Mattessich and R. Hill, "Life cycle and family development," in *Handbook of Marriage and the Family*, M. B. Sussman and S. K. Steinmetz, eds. New York: Plenum Press, 1987:447. Reprinted with kind permission from Springer Science and Business Media.

Regardless of whether there is an aging parent to take care of or not, this period of family life is one of the most active and exciting times in the family life cycle. It is filled with turbulence, stress, and demands that vary across families (Ellis, 1986). Some families may have trouble setting limits, defining relationships, and taking adequate care of one another. Others do just fine because they are better organized, do not have as many responsibilities, or have individuals with more congenial personalities.

The most obvious sign of stress in families with adolescents is seen in the number and kinds of disagreements between parents and teens. Increased family conflict and tension often occur during the time adolescents are in the family (Renk, Liljequist, Simpson, & Phares, 2005; Worden, 1992). The reasons for this increased conflict and tension are numerous.

> For one, in families with adolescents, there seems to be a difficulty on the part of parents to make a distinction between what they want for their youngsters and what their youngsters want for themselves. This leads to parents' unwillingness to let youngsters make decisions for themselves even if they are good decisions. (Dickerson & Zimmerman, 1992, p. 341)

A second reason for the tension in these families is the process of adolescence. At this time of life, young adults express more of a desire and an assertiveness to be autonomous and independent (Collins, Newman, & McKenry, 1995; Fishman, 1988). Peer groups and siblings become more important for them, and parental influence decreases as conflicts with parents increase. Yet because adolescents are limited in experience, "they are restrained from seeing the multitude of possibilities available to them and are vulnerable to others' ideas . . . [which they] fight against" (Dickerson & Zimmerman, 1992, p. 344). In response to this situation, families "must establish qualitatively different boundaries. . . . Parents can no longer maintain complete authority" (McGoldrick & Carter, 1982, p. 183). Families with adolescents need to facilitate the recognition and acceptance of differences of family members and distinguish gender and age differences in parent–adolescent conflict. Generally, topics of parent–adolescent conflict include "everyday family matters, such as household rules and responsibilities," as well as "separation-individuation and autonomy issues, school-related issues, and the general values held by members of the family" (2005 Renk et al., 2005, pp. 148–149). Sometimes this leads to fights that are both verbal and even somewhat physical. This video illustrates how such conflict can get out of hand.

If all goes well during this time in the family life cycle, adolescents develop what is known as a **planful competence**, which entails having a reasonably realistic understanding of their intellectual abilities, social skills, and personal emotional responses in relationships with others (Clausen, 1993). No environmental influence in the preadolescent years is as important to the development of adolescent planful competence as parenting. "Significant influences include parents paying attention to the child, providing intellectual stimulation, being supportive rather than abusive, involving the child in decision making, and conducting consistent disciplining" (Nurse, 1994, p. 36). Fathers who are as involved with their adolescents as are mothers help raise psychologically healthier children who exhibit less delinquent behavior and obtain more education (Elias, 1996).

Parenting may change during this stage as the couple relationship changes. "In the early afternoon of life—the forties, usually—many couples' relationships undergo a kind of sea change. [Either] the partners start to move closer, in ways that were not possible

earlier in the marriage, or a huge amount of emotional distance begins to develop" (Scarf, 1992, p. 53). This change is related to the aging process and heightened feelings of vulnerability, "hers, about her desirability and attractiveness; his, about his virility and about physical survival itself" (Scarf, 1992, p. 53). If the couple treats each other with tenderness, empathy, and understanding, they become stronger partners and comfort each other. If, on the other hand, the couple misreads each other and does not understand the physiological changes occurring, they are likely to be rejecting and hostile toward each other.

Issues that are likely to prompt families with adolescents to seek family therapy are those connected with the following:

- Conflict between parents and their teenage offspring, such as the setting of limits and the expression of opinions.
- Detachment or anger over the couple relationship as partners age developmentally and psychologically and realize that dreams and opportunities are slipping away.
- Stress and pressure related to adequately balancing the care of aging parents with the demands of work and family life (spouse and child/children).

Family Reflection: Think of your time in childhood and in adolescence. How did your family cope with the transition you went through in going from one stage to another? How did you experience your family, for better or for worse, during those years?

LAUNCHING CHILDREN AND MOVING ON As children leave home for college, careers, marriage, the military, or other options, parents face the so-called **empty nest**—life without child-rearing responsibilities. This time is ideal for couples to rediscover each other and have fun together. It is also a stage of vulnerability in which couples may have problems over such issues as financial matters, sexual issues, and ways of dealing with in-laws and grown children (Henry & Miller, 2004).

Most middle-aged women at this stage "are likely to be energetically attending to their own interests and thankful for the freedom to pursue them at last" (Scanzoni & Scanzoni, 1988, p. 535). For some women who have mainly defined themselves as mothers and invested heavily in their children, the empty nest can be a time of sadness. In such situations, depression, despondency, and divorce may occur (Strong et al., 2008).

For men, the empty nest usually corresponds to midlife. At this time, men may focus on "their physical bodies, marriages, and occupational aspirations," as well as the new changes in the behaviors of their wives (Scanzoni & Scanzoni, 1988, p. 540). Because few studies have focused on men and the empty nest period, few data are available on how these men feel about the launching of their children. However, factors that correlate negatively for the happiness of men at the time of launching children are having few children, being older at the time of their children's leaving, experiencing unsatisfactory marriages, and being nurturant as fathers (Lewis, Freneau, & Roberts, 1979).

In recent years, a trend has developed in which children remain with their families of origin for longer periods of time. This failure to leave or their return to the family as **boomerang children** is usually due to financial problems, unemployment, or an inability or reluctance to grow up (Clemens & Axelson, 1985). When children do not leave home or return home after having left, the result is often increased tension between parents and

the young adult. Overall, as pointed out by Haley (1973), pathological behaviors tend to surface at points in the family life cycle when the process of disengagement of one generation from another is prevented or delayed.

Issues that are likely to prompt empty nesters to seek family therapy are those connected with the following:

- A sense of loss in regard to oneself, a marriage, or the moving out of a child.
- A sense of conflict with a child who is not becoming independent enough.
- A sense of frustration or anger with regard to one's marriage or career ambitions.

FAMILIES IN LATER LIFE The family in later life is usually composed of a couple in their final years of employment or in early retirement. The age range is about 65 years and older. This stage of family life can cover a span of 20 or 30 years, depending on the health of those involved. Within this stage are substages broken down into two or three groups: (1) older adulthood (ages 65–84) and the very old (85 and older) (Gold, 2013b), or (2) "the young old (65–74), the old old (75–84), and the oldest old (85 and after)" (Anderson, 1988, p. 19).

A general trend in these families is a physical decline of the individuals related to age (a gradual condition known as **senescence**) (Sharpe, 2003). In such cases dependence may become an issue (Goldin & Mohr, 2000). In addition, one of the major concerns of some members of this group relates to finances. Older couples often worry about whether they will have enough money to take care of their needs. This concern is heightened when retirement occurs. It may be especially crucial to men who stop working or women who live long lives.

A second, equally important concern of older couples involves loss: the loss of a driver's license, hearing, familiar surroundings (i.e., relocation), or a spouse. This last-mentioned loss, that of a spouse, is quite prevalent and can be devastating. Only about half of the men and women older than 65 years of age are married; most of the others are widowed (U.S. Census Bureau, 2010). Recovering from the loss of a spouse is a difficult and prolonged process. It is one that women are more likely to face than men. The absence or presence of extended family at such times can make a difference in how one adjusts, as can the possibility for recoupling, whether in cohabitation or remarriage (Gold, 2013a). The preservation of a coherent sense of self in the midst of loss is the best predictor of psychological and physiological resilience for older adults (Kaufman, 1986).

A third concern of the aging and their families is chronic illness:

> Among seniors age 65 to 84, arthritis, high blood pressure, and heart disease are most prevalent. For people over 85, the risk of cancer and the extent of disabilities increase, combined with intellectual, visual, and hearing impairment. Physical and mental deterioration may be exacerbated by depression and helplessness, reverberating with the anxiety of family members. (Walsh, 1999, p. 312) Keeping healthy is a major task of this group.

The aging family also has advantages. One of them is being a grandparent or foster grandparent. Interacting with their children's children or other children heightens the sensitivity of many aging couples and helps them become more aware of the need for caring (Mead, 1972). The ability to do what one wants at one's pace is another advantage of this family stage. The family of later life, like the newly married couple, has the most freedom to come and go as they wish. Finally, the aging family can experience the enjoyment of

having lived and participated in a number of important life cycle events. This is a time when couples can reflect on the activities they were too busy with previously.

Issues that are likely to prompt families in later life to seek family therapy are those connected with the following:

- A lack of meaning or enjoyment related to the loss of actively working or caring for children or the death of a spouse.
- A concern over adjustments in aging, such as diminished energy or facing one's mortality.
- An inability to establish good relationships with children, in-laws, or grandchildren.

A summary of family life cycle phases, stages, and crises is given in Table 2.1.

UNIFYING INDIVIDUAL AND FAMILY LIFE CYCLES

It would seem difficult to unite individual and family life cycles in more than a superficial way. The reason is that, outwardly, stages in the individual life cycle do not always parallel and complement those within a family's development (e.g., Erikson, 1959; Gilligan, 1982; Levinson, 1978, 1986; Sheehy, 1977). The two life cycle concepts are unique because of the number of people involved in them, the diversity of tasks required in each, and gender distinctions. Yet, the differences in these ways of viewing life may not be as sharp or contrasting as they first appear.

One unifying emphasis of both the individual and family life cycles is the focus within each on growth and development. In most types of growth there is "change in the direction of greater awareness, competence, and authenticity" (Jourard & Landsman, 1980, p. 238). Within individuals and families, growth can be a conscious process that involves courage, that is, the ability to take calculated risks without knowing the exact consequences. When planned strategies and activities are outlined and accomplished as a part of growth, persons understand the past more thoroughly, live actively and fully in the present, and envision possibilities of the future more clearly.

A second unifier of individual and family life cycles is that they can both be viewed as a system and from the perspective of systems. As noted before, systems theory focuses on the interconnectedness of elements within all living organisms, that is, systems. A person and a family are each more than the separate parts that compose them. Each is a whole—a system—that expresses itself through an organization, rules, and repetitive patterns.

Family Reflection: In families actions are the result of both circular and linear causalities. Think of times in your family when you were growing up when each was prevalent. Give examples.

A third unifying aspect of the individual and family life cycles is that they are complementary and competitive (McGoldrick, Gerson, & Petry, 2008). People within each cycle go through experiences for which they are usually developmentally ready. For example, children enter school at age 5 or 6 years. Most couples become parents in their late 20s or early 30s. Likewise, from interacting with their environments, the majority of individuals and families become aware of their skills and abilities. For example, from his play with peers, an adolescent may realize he is not as gifted an athlete as he previously

TABLE 2.1 Family Life Cycle Phases, Stages, and Crises

Phases	Family Life Cycle Stage	Practical Challenges	Emotional Challenges	Relational Challenges	Potential Crises
Coupling	Unattached young adult	Financial independence Caretaking of self	Secure sense of self Feelings of competency	Differentiation of self from family of origin	Failure to grow up
	Family formation through coupling	Finding potential mate Economic partnership Domestic cooperation Compatibility of interests	Commitment Balancing needs and expectations of self and partner	Form stable marital unit Shifting allegiances from family of origin to new family	Failure to find a mate or commit End of "honeymoon" In-law conflict
Expansion	Family with young children	Financial obligations Organizing household for raising children	Accepting new members Nurturance Parental responsibilities	Maintaining marital unit Integrating grandparents and other relatives	Marital dissatisfaction School and behavior problems
	Family with adolescents	Less predictable routines and schedules Adolescent unavailability	Flexibility with change Sense of irrelevance Loss of control	Maintaining contact between parents and adolescent Caring for elderly parents	Adolescent rebellion
Contraction	Launching children and moving on	Financial burdens (college, weddings, etc.) New financial resources Refocus on work	Loss of family life with children Aging and death of parents	Reestablishing primacy of marriage Adult relationship with children	"Empty nest" Children returning home
	Family in later life	Uncertainties of old age: economic insecurities Medical care	Coping with loss Maintaining dignity despite decline	Maintaining adequate support systems Reconciliation	Retirement Illness and death

From R. Gerson, "The family life cycle: Phases, stages, and crises," in *Integrating Family Therapy*, R. H. Mikesell, D. Lusterman, and S. H. McDaniel, eds. Washington, DC: American Psychological Association, 1995:91.

thought. Similarly, family members may appreciate each other more from having survived a natural trauma, such as an earthquake, a flood, a hurricane, or a fire (Figley, 1989). In this sense, the challenges and associated work of one life cycle complement the challenges and work of the other.

In the competitive realm, the needs and desires of individuals within the family often differ with the needs of the family to sustain itself. For example, a young couple might want to visit friends or relatives but be distracted by the demands of their toddler, who might prefer running around their host's house. A second area of conflict involves launching young people into the world. Sometimes these individuals are hesitant to go and resist leaving home (Haley, 1980). Both the family and the young adults suffer in the struggle that ensues.

IMPLICATIONS OF LIFE CYCLES FOR FAMILY THERAPY

Life cycles have a number of implications regarding family therapy. Some are subtler than others, but all are important.

Match of Life Cycles Between Family and Therapist

The "fit" between a family's and a therapist's life cycles plays a major role in the process of helping a family change. Fit is an ever-changing variable that fluctuates according to the ages and stages of all involved in the therapeutic process. If a therapist "brings unresolved issues from a past or current life cycle stage into the clinical work with a family that is struggling to navigate the same life cycle stage, predictable problems may emerge" (Lerner, 1999, p. 512). Basically, **the life cycles of a therapist and family can combine in three major ways**: "(1) the therapist has not yet experienced the family's stage; (2) the therapist is currently experiencing the same stage of the life cycle as the family; and (3) the therapist has already been through that stage of the life cycle" (Simon, 1988, p. 108). Although each of these global factors presents its unique challenge, specific variables have an impact too. "The match between the therapist and the clinical family on variables such as race, ethnicity, gender, class, sibling position, and sexual orientation" must be considered, for they also "influence the degree to which the life cycle issues become emotionally loaded in therapy" (Lerner, 1999, p. 513).

Particularly problematic areas include the ability to express empathy and understanding and to establish rapport. These difficulties may be especially prevalent in cases in which the therapist has not yet experienced the family's stage of development or lacks awareness of matters related to variables such as ethnicity, class, or sexual orientation. Contempt, anxiety, or jealousy may interfere with therapists whose life cycles parallel families with whom they work or who may be of the same race or gender. On the other hand, "fit with families gets a little easier" as therapists get older and past crucial life stages (Simon, 1988, p. 110). In such circumstances, families may feel that therapists recognize and understand their problems better. However, on the downside, therapists who are beyond the life stage of their client families may have difficulties in regard to acting too knowledgeable, being out of touch with current realities, dealing with ghosts of their own past, and being "distant, cynical, or patronizing" (Simon, 1988, p. 111).

To compensate for a lack of fit between themselves and the families they are working with, therapists of all ages and backgrounds can do several things. First, they can work on increasing their sensitivity to particular families and issues with such families.

Each family differs, and therapists, regardless of age and background, can usually be helpful if they are attuned to the specific concerns of a family. Second, therapists who do not ideally fit certain families can have their work supervised. Often, through peer consultation and clinical supervision, family therapists learn ways to overcome their deficits. Finally, a lack of fit can be addressed by continuing education programs that give therapists greater knowledge and skill in dealing with specific types of families or variables.

Ethnicity and Life Cycles

The ethnic background of families influences their concept of life cycles and their behaviors in regard to life events. It is important for clinicians to evaluate families in relation to their ethnic background and not judge them from a limited cultural perspective (Hines et al., 1999). For example, different ethnic groups place more value on certain events and rituals such as funerals, weddings, and transitions from childhood to adulthood. Types of interaction dominant in a majority culture, such as among European Americans, may not be considered appropriate in a minority culture, such as among African Americans or Asian Americans.

In therapeutic situations, families become more attuned to their ethnic backgrounds and values. In family therapy it is important to encourage families to use their life cycle transitions to strengthen individual, family, and cultural identities (Hines et al., 1999). Through such a process, families and their members gain a greater appreciation of and sensitivity to their heritage and the role of the past in present-day life.

Family therapists, regardless of their cultural backgrounds, can work with a variety of families if they attune themselves to learning about the culture and the circumstances whence these families came. Therapists must acquire special skills as well, through both formal training and continuing education. Finally, therapists must realize that, regardless of their best efforts, gender and ethnicity differences between themselves and their clients may enhance or detract from the therapeutic experience, at least initially (Gregory & Leslie, 1996).

Acute and Chronic Illnesses and Life Cycles

The onset of an illness in a family member can disrupt life cycles temporarily or permanently. The person and family may suffer only a mild setback if the illness is acute and of short duration. A chronic or progressive illness, such as chronic fatigue syndrome, can also change the way life cycle events are experienced (Sperry, 2012). However, an illness that is more severe, prolonged, or progressive, such as AIDS, a heart condition, cancer, chronic fatigue syndrome, deterioration in an older adult, or a mental disorder, will change the way life cycle events and relationships are experienced (Snyder & Whisman, 2004; Sperry, 2014). In such cases, families can expect changes in the quality of the couple and family relationship, roles, and responsibilities.

Often a chronic illness may wear down a family, leading to a deteriorated condition and finally to separation or divorce of a couple (Cloutier, Manion, Walker, & Johnson, 2002). On the other hand, a chronic illness may, "like any other life challenge, present an opportunity for growth" and bring a couple or family closer together (Kowal, Johnson, & Lee, 2003, p. 301). **Chronic illnesses go through four phases**, in which they may progress as well as regress (Fennel, 2003). These phases are as follows:

1. ***Crisis,*** in which the "basic task is to deal with the immediate symptoms, pain, or trauma associated with this new experience of illness" (Sperry, 2009, p. 180).

2. ***Stabilization,*** in which the "basic task . . . is to stabilize and restructure life patterns and perceptions" (Sperry, 2009, p. 180).
3. ***Resolution,*** in which the "basic task is to develop a new sense of self and to seek a personally meaningful philosophy of life and spirituality consistent with it" (Sperry, 2009, p. 180).
4. ***Integration,*** in which "the basic task is to find appropriate employment if able to work, to reintegrate or form supportive networks of friends and family, and to integrate one's illness within a spiritual or philosophical framework" (Sperry, 2009, p. 180).

In examining illness and life cycles, therapists must examine the onset of the disorder, its course, the outcome, and its degree of incapacitation, if any (Rolland, 1999). A progressive and chronic disease, such as Alzheimer's disease, can put a major strain on caretakers within a family and the family as a whole. The result may be the delay of life cycle transitions, such as marriage, and the blockage of unfinished business. On the other hand, a heart condition, while putting a strain on the family, may also give family members more of a chance to communicate and bond.

Therapeutically, it is imperative that those who work with families help them to assess present ways of functioning in relationships as compared with past coping strategies (Rolland, 1999). For example, a therapist may explore with family members how they previously dealt with a family illness. Thus, therapists and families may better understand present behaviors and the individuals within the family unit. Therapists may also assist families in resolving the developmental disruptions that occur in dealing with diseases. There is a growing movement in family therapy to focus on mental and physical issues in families (Cloutier et al., 2002; Wynne, Shields, & Sirkin, 1992). To work best in this domain and be effective, family therapists must prepare themselves through direct educational and supervisory experiences.

Special-Needs Children and Life Cycle

Special-needs children are those with disabilities that may or may not become more self-sufficient over time. For example, with autism, intellectual or physical delays, chronic health conditions, or Down syndrome there may or may not be improvements as the child develops. Parental and family adjustments vary widely in connection to these children, with a wide variety of coping strategies being displayed (Lightsey & Sweeney, 2008).

"A multisystems perspective is necessary to understand childhood disability and its effects on family life. . . . Child, family, ecological, and sociocultural variables intertwine to shape the ways families respond to disability and how they construct their realities, cope, and adapt" (Grossman & Okun, 2009, p. 15). Some parents of children with disabilities experience joy, greater sense of meaning and purpose in life, deeper spirituality, increased strength, and more cohesion, sensitivity, and tolerance (Lightsey & Sweeney, 2008). Others have an opposite reaction. A constant in the lives of these families is the stress of dealing with outside systems, such as treatment specialists, as well as the acceptance or denial of "the loss of their dreams of who and what their child is and may become" (Grossman & Okun, 2009, p. 15).

In a family with a special-needs child, parents may modify their work life to devote more attention to the needs of the child. They may also modify or renegotiate their relationship with each other and with other children in the family, if there are any. Furthermore, they may make special financial arrangements to ensure that their child is taken care of after

they are gone. In essence, the expected life cycle of raising children and launching them is put on hold, and the families, especially the parents, organize and reorganize around the child with special needs or they pull apart and dissolve—for example, the parents divorce.

Poverty, Professionalism, and Life Cycles

As indicated throughout this chapter, individuals and families are affected by economic as well as by social factors. Dual-career professional families and low-income families do not go through life cycle stages in the same way or at the same rate as other families. There is an "extreme elongation of the process of forming the family in the professional class and an extreme acceleration in the lower class" (Fulmer, 1988, p. 548).

Poverty and professionalism have several implications for family therapy. One of the most obvious is for therapists to realize that the structure and functioning of these two types of families differ (Mansfield, Dealy, & Keitner, 2013). Families in poverty are generally larger, more dependent on kin, and maternal. They struggle and are stressed to obtain the necessities of life and make ends meet (Brown, 2002). Continuing poverty

TABLE 2.2 Comparison of Family Life Cycle Stages

Age	Professional Families	Low-Income Families
12–17	a. Prevent pregnancy	a. First pregnancy
	b. Graduate from high school	b. Attempt to graduate from high school
	c. Parents continue support while permitting child to achieve greater independence	c. Parent attempts strict control before pregnancy; after pregnancy, relaxation of controls and continued support of new mother and infant
18–21	a. Prevent pregnancy	a. Second pregnancy
	b. Leave parental household for college	b. No further education
	c. Adapt to parent–child separation	c. Young mother acquires adult status in parental household
22–25	a. Prevent pregnancy	a. Third pregnancy
	b. Develop professional identity in graduate school	b. Marriage—leave parental household to establish stepfamily
	c. Maintain separation from parental household; begin living in serious relationship	c. Maintain connection with kinship network
26–30	a. Prevent pregnancy	a. Separate from husband
	b. Marriage—develop nuclear couple as separate from parents	b. Mother becomes head of own household within kinship network
	c. Intense work involvement as career begins	
31–35	a. First pregnancy	a. First grandchild
	b. Renew contact with parents as grandparents	b. Mother becomes grandmother and cares for daughter and infant
	c. Differentiate career and child-rearing roles between husband and wife	

From B. Carter and M. McGoldrick, "Comparison of family life cycle stages," in *The Changing Family Life Cycle: A Framework for Family Therapy*, 2nd ed. Boston: Allyn & Bacon,1999:551. ©1999, 1989 Allyn & Bacon. Reproduced by permission of Pearson Education, Inc.

pushes fathers away from their children and families because these men are often working two or three jobs and are simply not available (Elias, 1996). Regardless of race or cultural background, being poor or near poor brings with it a host of factors—chronic shortage of money; accumulating debts; low levels of literacy; high rates of unemployment; incarceration; substance abuse; depression and domestic violence; poor housing and unsafe neighborhoods—that places enormous stress on relationships (Johnson, 2012; Ooms & Wilson, 2004). In contrast, families of professionals are generally smaller, dependent on hired help, and often more individual or career focused. They can afford to buy services and engage in a number of enriching activities. Therefore, their levels of mental health and sense of well-being tend to be higher.

In addition to structural differences, symptom formation differs, with symptoms in poor families often connected with sudden shifts and changes in life cycle events, and symptoms in professional families often connected with delays in reaching developmental milestones. The comparison of family life stages for these two types of families from ages 12 to 35 years is shown in Table 2.2, as outlined by Fulmer (1988). Therapists must acquaint themselves with the issues of both types of families. To be of assistance to each, they must cognitively and psychologically learn to address their unique problems and possibilities.

Family Reflection: Reflect on families that were different from yours when you were growing up or that are different from yours now. How is their life cycle different from yours in regard to, for example, marriage, birth, death, entertainment, religious orientation, diet, and recreation choices?

Summary and Conclusion

The family is complex and dynamic across time and culture, and it can be thought of as a system: an interacting set of units, parts, or persons that together make up a whole arrangement or organization. Each unit, part, or person in the system is affected by whatever happens to others within the interconnected web of relationships. Thus, a system is only as strong as its weakest member. Likewise, a system is greater than the sum of its units, parts, or members because of the dynamic interaction of each with the others.

Different models of individual and family life cycles have been constructed over the years to explain the tasks and potential problems of people and family units. Erik Erikson first popularized the idea of an individual life cycle through his research and writings on the eight stages of life. His work has been praised for its innovation but criticized for its limited focus on males. The idea of a family life cycle was first proposed by Evelyn Duvall only a few years after Erikson's model was introduced. Duvall's model was based on the nuclear family of the 1950s. In more recent years, as families in the United States have become more diverse, varied models of family life cycles have been proposed. The cycles that cover many different forms of family life are among the most useful. This chapter presented the six-stage model of the intact, middle-class nuclear family. This model is used for comparison with other life cycle models, including Erikson's individual life cycle model.

Individual and family life cycles are constantly intertwining. Events in one affect those in the other. Individual and family life cycles are similar in their emphases on growth, development, and systemic interaction. However, they often differ in other ways, with individual life cycles focused more narrowly and family life cycles focused more systemically. Family therapists must be aware of individual issues, as well as family issues, that are brought before them.

As a rule, family therapists should be aware of how their individual and family life stages compare with those of their clients. They must also be sensitive to health, ethnic/cultural, and socioeconomic issues as they relate to families. A general systems perspective of individuals and families allows for such a broad-based view. It permits therapists to observe dynamics within the system of the person and family without blaming

or focusing on unimportant microissues. Family therapists can study and receive supervision to overcome deficits they may have in regard to issues surrounding a particular type of family. Overall, the family life cycle and the variables that compose it are exciting to study and complex entities with which to work.

Summary Table

FAMILIES, SYSTEMS, AND SYSTEMS THEORY

What is a family? Families date back to prehistoric times and have played an important part in the development of persons and nations. They have been influenced by forces of war, economics, government, and nature.

Families must be worked with from a systemic, developmental, and cultural perspective.

Systems Theory, Causality, and Feedback Loops

Systems theory was developed and refined by Ludwig von Bertalanffy.

A system is an interacting set of units, parts, or persons that together make up a whole arrangement or organization. Each unit, part, or person in the system is affected by whatever happens to others within the arrangement or organization.

A system is only as strong as its weakest member and is greater than the sum of its members because of the dynamic interaction of each with the others, and when change occurs in any part of the system, all other parts of the system are affected.

The notion of circular causality helps counselors understand the complex nature of family interactions.

Positive and negative feedback loops describe ways in which family systems can maintain homeostasis or begin to move toward change (for better or worse).

INDIVIDUAL DEVELOPMENT AND FAMILY LIFE CYCLE DEVELOPMENT

Development is an uneven and powerful factor in families.

Three different time dimensions affect personal and family life: individual time, social time, and historical time.

The term "life cycle" is used to describe personal and family life development. These two life cycles intertwine and are interactive. Dealing with them in isolation is artificial.

Individual life cycle development has been popularized in the work of Erikson and others who describe human life in terms of stages. People face developmental crises in each of these stages.

Erikson's first five stages deal with the formation of a person as a competent individual. His final three stages are more interpersonally based.

Developmental theories have focused mainly on men but are slowly being formulated for women as well.

The family life cycle is a social/cultural phenomenon that was first proposed by Duvall in 1956. It has been modified over the years, and currently life cycles are available that describe many types of families.

A family life cycle for middle-class, nuclear families proposed by Carter and McGoldrick (1999) outlines the following six stages:

1. ***Single young adults***—tasks: to develop personal autonomy, leave home, establish a career, and develop a support group.
2. ***The new couple***—tasks: to adjust and adapt, and learn to share with partner.
3. ***Families with young children***—tasks: to adjust time, energy, and personal schedules to take care of child/children, self, and other relationships.
4. ***Families with adolescents***—tasks: to physically and psychologically take care of self, the couple relationship, child/children, and aging parents and successfully handle increased family tension and conflict.
5. ***Families launching children and moving on***—tasks: to rediscover each other as a couple, deal with midlife events, and encourage their children to be independent.
6. ***Families in later life***—tasks: to adjust to aging, loss of a spouse, and decreased energy.

UNIFYING INDIVIDUAL AND FAMILY LIFE CYCLES

Individual and family life cycles are characterized by the following:

- Growth and development.
- Systemic interconnectedness of people.
- Complementary and competitive experiences occurring within a societal context.

IMPLICATIONS OF LIFE CYCLES FOR FAMILY THERAPY

Life cycles impact family therapy through the following:

- The matching or fitting of the therapist's life stage(s) with that of the family.
- The understanding, or lack thereof, between the therapist's ethnic background and that of the family.
- The influence of the unexpected, such as an acute or chronic illness.
- The effects on the family of having special-needs children.
- The uniqueness of poverty or degree of professionalism on the rate of recovery and the resources of the family as therapy progresses.

Family therapists can overcome developmental or systemic handicaps in regard to working with families through education, supervision, consultation, and experience.