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THE ESSENTIALS OF FAMILY THERAPY
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CHAPTER 11

FAMILY THERAPY ENTERS THE TWENTY-FIRST CENTURY

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

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

EROSION OF BOUNDARIES

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

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

narrative-strategic? Eclectic? Or maybe just "a family therapist"?

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

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

POSTMODERNISM

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

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

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

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

THE FEMINIST CRITIQUE

Feminism was family therapy's rudest awakening. In an eye-opening critique heralded by an article of Rachel Hare-Mustin's in 1978, feminist family therapists not only exposed the gender bias inherent in existing models, they also advocated a style of therapy that called into question systems theory itself.

It became painfully clear that cybernetics and functionalism had led us astray. Cybernetics encouraged us to view a family system as a flawed machine. Judith Myers Avis (1988) described this family machine as one that

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

The Batesonian version of cybernetics had claimed that personal control in systems was impossible because all elements are continually influencing one another in repetitious feedback loops. If all parts of a system are equally involved in its problems, no one is to blame. This idea appealed to family therapists because family members often enter therapy pointing fingers at each other, and failing to see their own role in the problems that plagued them.

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

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

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

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

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

Only when therapists become more gender sensitive will they stop blaming mothers and looking to them to do all of the changing. Only then will they be able to fully counter the unconscious bias toward seeing women as ultimately responsible for childrearing and housekeeping; as needing to support their husbands' careers by neglecting their own; as needing to be married or at least to

have a man in their lives (Anderson, 1995). Only then can they stop relying on traditional male traits, such as rationality, independence, and competitiveness, as the standards of health and stop denigrating or ignoring traits traditionally encouraged in women, like emotionality, nurturance, and relationship focus.

As one might anticipate, the feminist critique wasn't exactly welcomed by the family therapy establishment. The early to mid 1980s was a period of polarization and tension between male and female therapists, as feminists tried to exceed the establishment's "threshold of deafness." By the 1990s, that threshold had been exceeded. The major feminist points are no longer debated and the field is evolving toward a more collaborative, but socially enlightened, form of therapy.

SOCIAL CONSTRUCTIONISM AND THE NARRATIVE REVOLUTION

Constructivism was the crowbar that pried family therapy away from its belief in objectivity—the assumption that what one sees in families is what *is* in families. Understanding behavior is never simply a process of seeing it, grasping it, or decoding it. Human experience is fundamentally ambiguous. Fragments of experience are understood only through a process that organizes it, selects what's salient, and assigns meaning and significance.

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

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

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

What these collaborative therapists shared was the conviction that too often clients aren't heard because therapists are doing therapy *to* them rather than *with* them. To redress this authoritarian attitude, Harlene Anderson (1993) recommended that therapists adopt a position of **not-knowing**, which leads to genuine conversations with clients in which "both the therapist's and the client's expertise are engaged to dissolve the problem" (p. 325).[1]

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

From a hermeneutic perspective, whatever it is that a therapist knows, it's not simply discovered or revealed through a process of free association and analysis—or enactment and circular questioning—it's organized, constructed, fitted together by the

1. Collaborative therapists distinguish these conversations from the nondirective, empathic Rogerian style because they don't just reflect but also offer ideas and opinions, though always tentatively.

therapist alone, or collaboratively with the patient or family. Although there's nothing inherently democratic about hermeneutic exegesis, its challenge to essentialism went hand in hand with the challenge to authoritarianism. In family therapy, therefore, the hermeneutic tradition seemed a perfect partner to efforts to make treatment more collaborative.

It's hard to give up certainty. A lot is asked of a listener who, in order to be genuinely open to the speaker's story, must put aside his or her own beliefs and, at least temporarily, enter the other's world. In so doing, the listener may find those beliefs challenged and changed. This is more than some therapists are willing to risk.

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

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

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

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

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

FAMILY THERAPY'S ANSWER TO MANAGED CARE: SOLUTION-FOCUSED THERAPY

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

The popularity of the solution-focused model exploded in the 1980s during a period in which agency budgets were slashed and managed care started dictating the number of sessions for which practitioners could be reimbursed. This produced a tremendous demand for a brief, easy to apply approach, and solution-focused therapy seemed like the perfect answer.

FAMILY VIOLENCE

In the early 1990s family therapy took a hard look at the dark side of family life. For the first time, books and articles on wife-battering and sexual

abuse began appearing in the mainstream family therapy literature (e.g., Trepper & Barrett, 1989; Goldner, Penn, Sheinberg, & Walker, 1990; Sheinberg, 1992). Almost overnight, the field was shaken out of its collective denial regarding the extent of male-to-female abuse in families.

Judith Myers Avis (1992) delivered a barrage of shocking statistics about the number of women who have experienced sexual abuse before the age of 18 (37 percent), percent of abusers who are men (95 percent), number of women abused each year by the man they live with (1 in 6), percent of male college students who had coerced sex from an unwilling partner (25 percent), and those who said they would commit rape if guaranteed immunity from punishment (20 percent). After reiterating the indictment of theories that call for therapist neutrality and that treat the abused as partially responsible for their abuse, she concluded that:

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

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

> In working with family violence, how do we balance a relativistic world view with values about human safety and the rights of men and women to self-determination and protection? When is the clinical utility of neutrality limited or counterproductive? When is conviction essential to the change process? How do we confront the batterer about the destructive nature of his behavior without condemning him? How strongly and passionately do we employ our values to therapeutic advantage while maintaining a caring and respectful connection with family members struggling with the trauma of violence? (pp. 248, 249)

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

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

MULTICULTURALISM

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

Monica McGoldrick and her colleagues (McGoldrick, Pearce, & Giordano, 1982) dealt the first blow to our ethnocentricity with a book describing the characteristic values and structure of a host of different ethnic groups. Following this and a spate of related works (e.g., Falicov, 1983, 1998; Boyd-Franklin, 1989; Saba, Karrer, & Hardy, 1989; Mirkin, 1990; Ingoldsby & Smith, 1995; Okun, 1996; McGoldrick, 1998), we are now more sensitive to the need to know something about the ethnic background of our client families, so we don't assume they're sick just because they're different.

As Monica McGoldrick (1993) writes,

> Ethnicity patterns our thinking, feeling, and behavior in both obvious and subtle ways, although generally operating outside our awareness. It plays a

> major role in determining what we eat, how we work, how we relate, how we celebrate holidays and rituals, and how we feel about life, death, and illness. (p. 335)

In the 1990s, multiculturalism became a dominant theme in family therapy, as reflected in conference agendas, journal articles, and graduate school curricula. The attention to these issues represents a welcome sensitizing to the influence of ethnicity.

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

As we suggested in Chapter 4, ethnic sensitivity does not require becoming an expert—or thinking you're an expert—on every culture you might conceivably work with. If you don't know how a rural Mexican family feels about their children leaving home or what Korean parents think about their teenage daughter dating American boys, you can always ask. Curiosity and respect for other people's ways of doing things is probably a more useful aspiration than encyclopedic knowledge.

RACE

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

White therapists still, of course, have the option to walk away from these issues. Nonwhite therapists and clients don't have that luxury (Hardy, 1993):

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

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

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

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

The task of therapists working with nonwhite families is to understand their reluctance to engage in treatment and distance or hostility (particularly if the therapist is white) in the context of their environment and their history of negative interaction with white people, including the many social service agents they encounter. In addition, the therapist must recognize the family's strengths,

draw from their networks or, if the family is isolated, help them create networks of support.

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

POVERTY AND SOCIAL CLASS

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

Despite decreasing fees due to managed care, most therapists are able to maintain a reasonably comfortable life style. They have little appreciation of the obstacles their poor clients face and of the psychological impact of those conditions. When poor clients don't show up for appointments or don't comply with directives, some therapists are quick to see them as apathetic or irresponsible. In many cases, this is also the way poor people come to see themselves—and that negative self-image can be the biggest obstacle of all.

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

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

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

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

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

GAY AND LESBIAN RIGHTS

Family therapy's consciousness was raised about gay and lesbian rights in the same way it was for race. After a long period of neglect and denial, family therapy in the late 1980s began to face the discrimination that a sizable percentage of the

population lives with (Krestan, 1988; Roth & Murphy, 1986; Carl, 1990; Laird, 1993; Sanders, 1993). The release in 1996 of a major clinical handbook (Laird & Green, 1996) and magazine (*In the Family*, edited by Laura Markowitz) indicates that these issues are finally out of family therapy's closet.

Despite gains in tolerance in some segments of our society, however, gays and lesbians continue to face humiliation, discrimination, and even violence because of their sexuality. Because of the lack of social support, the bonds in gay and lesbian relationships can be strained, generating stress, jealousy, and the pressures of isolation. After a childhood of confusion, shame, and fear of discovery, many gays and lesbians are rejected by their families once they come out.

Parents often feel guilty, in part because early psychoanalytic studies blamed them for their children's sexual orientation. Parental reactions range from denial, self-blame, and fear for their child's future, to hostility, violence, and disowning (LaSala, 1997). Therapists should remember that a gay or lesbian child may have struggled for years to come to grips with his or her identity, the parents may need some time to catch up after the initial shock.

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

SPIRITUALITY

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

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

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

TAILORING TREATMENT TO POPULATIONS AND PROBLEMS

As family therapist have come down from the ivory towers of their training institutes to grapple with the messy problems of the real world, they find it increasingly necessary to fit their approach to the needs of their clients, rather than the other way around. The maturing of family therapy is reflected in its literature. Once most of the writing was about one of the classic models and how that model applied to families in general (e.g., Haley, 1976; Minuchin & Fishman, 1981). In the 1980s, books no longer tied to any one school began to focus on how to do family therapy with a host of specific types of problems and family constellations.

Books are now available on working with families of people who abuse drugs (Stanton, Todd, & Associates, 1982; Barth, Pietrzak, & Ramier, 1993), alcohol (Steinglass, Bennett, Wolin, & Reiss, 1987; Treadway, 1989; Elkin, 1990), food (Root, Fallon, & Friedrich, 1986; Schwartz, 1995), and each other (Trepper & Barrett, 1989; Friedrich, 1990; Madanes, 1990).

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

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

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

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

There are practical guides to family therapy not connected to any one school (Taibbi, 1996; Patterson et al., 1998), and edited books that include contributions from all of the schools but that are focused on specific problems or cases (Dattilio, 1998; Donovan, 1999). Thus, as opposed to the 1960s and 1970s, during which the followers of a particular model read little but what came out of that school, this trend toward specialization by content rather than by model has made the field more pluralistic in this postmodern age.

CONCLUSIONS

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

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

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

went too far in one direction, the same may be true of some of its critics.

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

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

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

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

The headline story of family therapy's evolution from first- to **second-order cybernetics**, from MRI to solution-focused therapy, from Milan systemic to Hoffman and Goolishian, and from constructivism to social constructionism and now narrative—is what's been in the forefront of intellectual discussion. While these front-page developments were taking place, family therapists practicing less trendy approaches (behavioral, psychoanalytic, structural, Bowenian, and experiential) have continued their work. So it can be a mistake to think that what's new and gets attention is the only or even major thing going on in the field.

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

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

KEY CONCEPTS

collaborative model A more egalitarian view of the therapist's role; a stance advocated by critics of what they see as the authoritarianism in traditional approaches to family therapy.

constructivism A relativistic point of view that emphasizes the subjective construction of reality. It implies that what we see in families may be based as much on our preconceptions as on what's actually going on.

deconstruction A postmodern approach to exploring meaning by taking apart and examining taken-for-granted categories and assumptions, making possible newer and sounder constructions of meaning.

hermeneutics The art of analyzing literary texts or human experience, understood as fundamentally ambiguous, by interpreting levels of meaning.

managed care A system in which third-party companies manage insurance costs by regulating the terms of treatment. Managed care companies select providers, set fees, and control who receives treatment and how many sessions they are entitled to.

not-knowing Anderson and Goolishian's term for approaching families with as few preconceptions as possible.

postmodernism Contemporary antipositivism, viewing knowledge as relative and context-dependent; questions assumptions of objectivity that characterize modern science. In family therapy, challenging the idea of scientific certainty, and linked to the method of deconstruction.

reflecting team Tom Andersen's technique of having the observing team share their reactions with the family at the end of a session.

second-order cybernetics The idea that anyone attempting to observe and change a system is therefore part of that system.

social constructionism Like constructivism, challenges the notion of an objective basis for knowledge. Knowledge and meaning are shaped by culturally shared assumptions.

solution-focused therapy Steve de Shazer's term for a style of therapy that emphasizes the solutions that families have already developed for their problems.

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