

## CHAPTER 2

### **FAMILY THERAPY THEORY AND THE INTERVENTION PROCESS**

#### 2.1 INTRODUCTION

Scientific theories define the boundaries of a discipline and provide parameters with regard to the subject matter and intervention process. In traditional theoretical approaches to intervention in human behaviour, primarily influenced by Freud, the individual and intrapsychic phenomena were the focus of study. Freud acknowledged the often powerful impact of family dynamics on the individual (e.g. the Oedipus complex) but nevertheless chose to focus intervention on intrapsychic conflicts rather than on family processes (Goldenberg & Goldenberg, 1996:6).

While recognising the significance of individual internal processes and behaviour, the contemporary, broader view of human problems focuses on the family context in which behaviour occurs. According to Anderson (1999:1), the development of family therapy, although not a unified theory or practice, confronts the basic assumptions on which individual approaches were based. Such an interpersonal perspective suggests that human behaviour is part of complex, interactional and recursive patterns taking place within the family, and emphasises the nature and role of individuals within primary relationships (Goldenberg & Goldenberg, 1996:8).

A specific paradigm (i.e. a point of view or philosophy that dominates scientific thinking) defines how a problem is viewed. However, unexplained problems stimulate scientific efforts to develop alternative perspectives and result in scientific revolution (Goldenberg & Goldenberg, 2000:11). According to Goldenberg and Goldenberg (1996:8) and Anderson (1999:2), just such a revolution occurred in the 1950s when

family therapy began. Family therapy represented a new way of conceptualising human problems and of understanding human behaviour, resulting in a paradigm shift. Sluzki (in Goldenberg & Goldenberg, 2000:8) went so far as to consider family therapy an epistemological revolution in the human sciences. The family became the major focus of inquiry, problem explanation and treatment. Successful family therapy was deemed to alter restrictive, self-defeating and recurring patterns, and aimed at enriching family relationships.

Family therapy theory proposed a cybernetic epistemology, initially derived from mechanical systems theory on the regulation of feedback mechanisms operant in controlling both simple and complex systems (first-order cybernetics). Individual behaviour cannot be understood without attention to the context in which the behaviour occurs, i.e. the family. Symptoms function to stabilise the system and relieve family tension (Goldenberg & Goldenberg, 1996:12). According to Golann (1987:331), first-order cybernetics is the “...cybernetics of observed systems...”, whereas second-order cybernetics concerns the “...cybernetics of observing systems”.

Postmodern theorists advocate a second-order cybernetic view which contends that the individual in the family has a unique, separate, yet legitimate reality. Objective descriptions of families are merely social constructions that are agreed upon through social interaction. Symptoms are viewed as oppressive and the family are assisted to reclaim control and ‘reauthor’ their lives. This shift in thinking can be seen as a backlash against what were seen as the mechanistic, even manipulative techniques and strategies of first-order family therapists. Central to this perspective is the idea that one cannot observe or describe without modifying and being modified by the subject of observation (Golann, 1987:332).

Goldenberg and Goldenberg (1996:16) state that most family therapists subscribe to some form of cybernetic epistemology, but that a schism has developed between those operating from first-order models where the system is objectively observed and change is attempted from the outside, and those who see the family therapist as part of the

system and a participant in constructing a new reality. Worden (1999:8), on the other hand, views systems theory as a foundation on which to build a new treatment and intervention modality, one that can compliment postmodernist ideas, suggesting a both/and rather than an either/or perspective.

In the literature that follows, the researcher will consider the historical origins of family therapy and trace its development from inception to the present day. The evolution of family therapy, beginning in the 1950s to the present day, will be explored, including the growth of family therapy within the South African context. A concise yet detailed review of the different schools of family therapy will be undertaken. These schools will be categorised according to the central focus of concern, namely theories that focus on behaviour patterns, on belief systems, and on context. Intervention requires consideration of a family's readiness for change, and should be compatible with their culture, beliefs and values. Different forms of intervention will be considered, again using the categories of behaviour patterns, belief systems and context to provide some structure to the many interventions available to the family therapist. Finally, current literature on the notion of integration of modernist and postmodernist thinking will be explored.

The researcher would like the reader to note that the factual content of this chapter is deemed necessary in order to provide the theoretical basis for a better understanding of the epistemological shifts in family therapy. While it may appear to be 'dry' reading, it is an attempt to provide a consolidation of family therapy approaches and interventions, and documents the changes that have taken place over time.

## 2.2. AN HISTORICAL OVERVIEW OF FAMILY THERAPY

A discussion on the origins and history of family therapy follows.

### 2.2.1 Historical Roots of Family Therapy

According to Goldenberg and Goldenberg (1996:65), it is difficult to pinpoint accurately the beginning of a scientific endeavour. It appears that the 1950s is identified as the period when researchers and practitioners began to focus on the family's role in the creation and maintenance of psychological disturbance in one or more family members. The cessation of World War II resulted in the reunification of families but escalated a number of social problems for which solutions were sought. People experienced stress as a result of delayed marriages, hasty wartime marriages, the loss of loved ones to death and a boom in the birth rate. Mental health professionals, previously focusing on the individual, were expected to deal with an array of problems associated with families (Gladding, 2002:64; Carr, 2000:48).

Rather than viewing the source of human problems or the appearance of symptoms in one family member as the outcome of one 'sick' person, the family therapist sees that individual as the **symptom bearer**, in other words, the person who expresses the family's disequilibrium or dysfunction (Goldenberg & Goldenberg, 2000:15).

Change in the social environment, such as divorce and sexual liberation brought both freedom and conflict. Concomitant change in the economic, educational and work environments created new tensions for the family. Psychosocial intervention had become more accessible to a wider range of clients and practitioners from a number of disciplines, such as psychologists, social workers, pastoral counsellors and psychiatrists began to offer family intervention processes (Goldenberg & Goldenberg, 1996:66). The scope of intervention was broadened to include such issues as marital conflict, divorce, delinquency and problems with extended family members. Various forms of family intervention were deemed to be effective in treating many disorders, ranging from alcoholism to schizophrenia. More and more practitioners began to recognise the need for family intervention to alleviate family dysfunction and distress (Gladding, 2002:60; Carr, 2000:49).

Sprenkle, Blow and Dickey (1999:329) believe that the field of family (and marriage) therapy began as a “...maverick discipline...”, one that was “...oppositional, even defiant...” when compared to the prevailing psychotherapy of the times. Many of the field’s founding members were rebels, dynamic and charismatic, who created theories that fitted with their personalities. The various schools accentuated their differences, as well as a belief in the superiority of their approach.

According to Goldenberg and Goldenberg (1996:69), five scientific and clinical developments laid the foundation upon which family therapy was constructed. They are: psychoanalysis; general systems theory; the role of the family in schizophrenia etiology; marital counselling and child guidance; and group therapy techniques. Carr (2000:49-57) concurs, identifying these same developments in the history of the family therapy movement. In order to arrive at a better understanding of the interdisciplinary roots of family therapy, a brief exploration of these developments follows.

#### 2.2.1.1 Psychoanalysis

Psychoanalytic theory and intervention was the work of Sigmund Freud and the dominant ideology in Western psychiatry after World War II, gaining ascendancy within various professions, namely, medical specialities, psychology, social work and sociology. Freud acknowledged the impact of family relationships on the personality formation of the individual, in particular the development of symptomatic behaviour (Goldenberg & Goldenberg; 1996:69). Psychoanalytic theory conceptualised the psychosexual development of children and the use of defence mechanisms as protection from anxiety. Therapeutically, Freud worked with individuals and intrapsychic phenomena rather than with interpersonal family dynamics. Contact with family members was strongly opposed, in the belief that it would ‘contaminate’ the therapist. This belief changed slowly, mainly for research purposes, and the family came to be seen therapeutically as a group.

Other significant psychoanalytic theorists, such as Alfred Adler and Harry Stack Sullivan began to stress interpersonal influences upon the individual, although it was Nathan Ackerman who has been credited with adapting psychoanalytic concepts to the study of the family (Goldenberg & Goldenberg, 1996:71).

#### 2.2.1.2 General systems theory and cybernetics

This theory, originally presented by biologist Ludwig von Bertalanffy, was an attempt to provide a comprehensive theoretical model encompassing all living systems, and a framework for understanding the interrelatedness of components of larger systems. The traditional view of the time (derived from physical science) was reductionist and linear, while systems theory focused on circular causality and process (Carr, 2000:59; Goldenberg & Goldenberg, 1996:73). In an article that defends linear causality, Dell (1986:513) believes that the insistence on the distinction between linear and circular causality breeds confusion in the mind of the therapist and how they should talk about families. In his view, linear causality refers to two “...distinct and incompatible domains; description (of experience) and explanation”. While concurring with Bateson’s claim that linear causality is not only impossible but an epistemological error, Dell believes that this does not account for what therapists know experientially, i.e. circular causality does not ‘describe’ our everyday experiences – Bateson’s epistemology ‘explains’ our experience.

Gregory Bateson, an anthropologist, is viewed by most authors as the single most influential figure in the history of family therapy (Carr, 2000:56). Bateson was not a practitioner of family therapy but researched and developed a unified framework within which mind and material substance could be coherently explained. He formed the Palo Alto group which included Haley, Weakland, Jackson and Fry, who together developed MRI brief therapy. Of particular importance to family therapy were the developments of the double bind theory of schizophrenia, communication as a multi-level process and cybernetics (Gladding, 2002:65; Carr, 2000:57).

The double bind theory proposed that schizophrenic behaviour occurs in families characterised by rigid and repetitive patterns of communication and interaction. Communication as a process conceptualises paradoxical interactions that maintain abnormal behaviour, an example being the double bind theory (Gladding, 2002:65; Carr, 2000:58; Goldenberg & Goldenberg, 2000:86).

Bateson's group combined the concepts of systems theory with insights from cybernetics, the latter being founded by Norbert Wiener, as a framework in which to conceptualise family organisation and processes. From a family organisation perspective, the entire family influences and is influenced by the other members. At the same time a family is part of larger social systems, all being mutually influential (Carr, 2000:59). According to Bertrando (2000:89), the idea of Bateson's cybernetic metaphor has not, as many believe, been to use the analogy of computer science to explain human behaviour within the family system. Rather it is descriptive language to describe human interaction, and possibly to free Bateson and his followers from the psychoanalytic language of the day, and specify their own approach.

Systems theory was historically significant to the emerging family therapy movement, emphasising multiple causality in dysfunction, rather than defining problems as individual intrapsychic conflicts. Of importance too, was the shift from the study of the mind to the study of observable manifestations and behaviours in interpersonal relationships.

General systems theory addressed the question (Carr, 2000:60-67):

How is it that the whole is more than the sum of its part?

Cybernetics addressed the question:

How do systems use feedback to remain stable or adapt to new circumstances?

Significant aspects of general systems theory and cybernetics include seeing the family as a system with boundaries, organised into subsystems; the boundary must be semi-

permeable to allow for adaptation and survival; the behaviour of each family member determines the patterns of interactions that connect the family; these patterns are recursive and may be associated with problematic behaviour; the patterns are circular in causality; family processes both prevent and promote change (i.e. homeostasis and morphogenesis); within the family one member (the identified patient) may develop problematic behaviour which functions to maintain family homeostasis; negative feedback maintains homeostasis and sub-serves morphogenesis; individuals and factions within the systems may show symmetrical and complementary behaviour patterns – exclusive engagement in either pattern may threaten the integrity of the family; positive and negative feedback is “...news of difference” that may enhance change; and, a distinction is made between first- and second-order change (Carr, 2000:66). In the former, the rules of interaction within the system remain unchanged but there may be some alteration in the way they are applied – in the latter the rules within the system change; a distinction is made between first- and second-order cybernetics – the former assumes the therapist is an objective outsider of the family system – the latter assumes the therapist, with the family, forms a new therapeutic system which is influenced by homeostasis and morphogenesis that may impede change or lead to problem resolution; recursive patterns in one part of the system replicate isomorphically in other parts of the system – patterns of family interaction may be replicated across generations and even across social systems. A theory of multigenerational transmission is discussed later in the chapter.

### 2.2.1.3 The role of the family and schizophrenia

Early studies into the role of family dynamics in the development of psychopathology focused on deficient parenting, specifically the schizophrenogenic mother (cold, domineering, rejecting and possessive) and the detached, ineffectual father, in creating and maintaining pathological behaviour. This was later replaced with the view that pathological interactions occurred within the family context and the connection between family environment and schizophrenia remains at the forefront of family systems research (Carr, 2000: 57; Goldenberg & Goldenberg, 1996:75).

As previously mentioned, one of the major influences in family research into schizophrenia was the work of Gregory Bateson, who together with Haley, Weakland and Fry examined communication patterns in humans and animals. These researchers introduced the concept of the ‘double bind’, whereby an individual received contradictory messages from significant people, creating an impossible situation of confusion, and hence withdrawal from the relational world. According to Dell (1989:3), there was a deep difference of opinion between Bateson and Haley during the double bind project, with Haley believing that power was central to all human relations, whereas Bateson insisted that the notion of power was “...an epistemological abomination”. This disagreement proved irreconcilable and remained unresolved between the two men, although Dell (1989:7) believes that the disagreement on power has been overstated. Bateson’s view of power as lineal control and therefore inconsistent with a systemic view fails to acknowledge his complex view that power in any ecosystem or social system will “...inevitably culminate in destructiveness and pathology”. Dell (1989:8) believes that when Bateson speaks of power and lineal control he is speaking of a different aspect of power, namely, scientific explanation, whereas most people are speaking of power as experience and description.

At around the same time as Bateson was researching the family/schizophrenia link, Theodore Lidz was exploring the dynamics of the parent’s relationship in schizophrenia etiology. Two patterns of marital discord were identified, namely ‘marital schism’ and ‘marital skew’. The former refers to a situation of disengagement and ongoing threats of separation/divorce, while the latter evidences ongoing, destructive marital patterns. This research highlighted the detrimental effects for children growing up in dysfunctional family situations (Gladding, 2002:64; Carr, 2000:55; Goldenberg & Goldenberg, 2000:88; Goldenberg & Goldenberg, 1996:79).

Another researcher during this time, Murray Bowen, was interested in identifying symbiotic mother-child interaction and parental emotional distance in the development of schizophrenia. Gladding (2002:66) describes how Bowen went on to formulate an elaborate theory on the influence of previous generations on the mental health of

families. Succeeding Bowen, Lyman Wynne concentrated on ambiguous and confused communication patterns in family interaction and the concept of ‘pseudomutuality’ whereby families conceal an underlying distance to defend a sense of meaninglessness and emptiness. In the United Kingdom (UK), R.D. Laing explored the concept of ‘mystification’ whereby an overt false self develops alongside a private real self which, if reaching a critical level, may result in schizophrenia in families where a person’s experiences are consistently distorted, denied and invalidated (Carr, 2000:56).

The commonality in all of the above research is disturbance in family relationships as a major etiological factor in psychopathology. However, as Goldenberg and Goldenberg (1996:81) point out, an obstacle to testing these hypotheses is the fact that the families were studied long after the appearance of mental disorder has disturbed the family system.

#### 2.2.1.4 Marital counselling and child guidance

Goldenberg and Goldenberg (2000:90) describe marital counselling and child guidance as the “...precursors of family therapy”, based on the concept that psychological disturbance arises from relationship conflicts as well as inner conflicts. A pioneer in this field of counselling was Emily Mudd (1951), who started the American Association of Marriage Counselors which brought together a number of professionals interested in marital intervention, and led the way for the development of training and practice. Research by Gurin, Veroff and Feld (in Goldenberg & Goldenberg, 1996:82) indicated that while few people sought professional help, (one in seven according to a survey on mental illness and mental health done in this era) of those who did, the majority cited marriage and family problems as the reason for doing so.

Originally a practice without a theory, marital counselling gradually became more formalised. Initially focusing on here-and-now, conscious and pragmatic issues rather than deeper, more intensive psychotherapy, it came to address the affective, cognitive and behavioural aspects of marital relationships within the context of family systems.

The current method for treating marital discord is conjoint therapy, where the couple are seen together by the same therapist (Carr, 2000:50). In the past however, spouses were either seen separately by the same counsellor, or even by different counsellors. In his summary of the developments in family therapy, Carr (2000:50) also identifies the work of Masters and Johnson in the field of sex therapy as becoming integrated into psychodynamic and systemic marital therapy.

Historically, the study of child development really only began around the turn of the 20<sup>th</sup> century. Changes in social reform and the legal status of children occurred (i.e. compulsory education, restrictions on child labour) and interest grew in providing professional intervention for emotionally disturbed children. Of significance was the innovation of a multidisciplinary team to assess the child and family, usually consisting of psychiatrist, clinical psychologist and social worker. The goals of working with disturbed children and their families were to establish an alliance with the parents to support the child's growth in therapy; gain pertinent information on the family dynamics; and, assist change in the environment (Goldenberg & Goldenberg, 2000:93; Goldenberg & Goldenberg, 1996:85). Such intervention implied family disturbance as a cause of a child's emotional problems.

#### 2.2.1.5 Group therapy

Various forms of group therapy have been practiced since the beginning of the 20<sup>th</sup> century, but the main thrust of its expansion came from the need for clinical intervention in the period following World War II. Psychodrama techniques were practiced by Jacob Moreno (in Austria) to assist people to recreate situations that may have resulted in psychological problems in front of an 'audience'. These practices were introduced to the USA, and were called group therapy. Similar developments were apparent in the UK, as well as group analysis which focused on helping people understand their self-defeating behaviour patterns, a technique that was included in family therapy (Carr, 2000:52; Goldenberg & Goldenberg, 2000:94).

In Britain at the Tavistock Institute, a number of therapists began to experiment with group intervention techniques. The focus was on dealing with current problems rather than searching the past for trauma and causal factors. Group therapy was seen as a briefer, more efficient way to work with people, and the human potential movement with its use of encounter groups, gained in acceptance and approval by the upper middle classes in the USA - to an extent, therapy was 'normalised' (Goldenberg & Goldenberg, 1996:86). The parallel with family therapy was the fundamental view of group intervention as an agent of change through the influence of its members upon each other.

Gibney (1999:32) believes that while family therapy grew out of a dissatisfaction with previous therapies, it has portrayed itself as a major advancement in practice, ignoring the similarities shared with other therapies, as well as the debt it owes to the influences and origins that have shaped it. His suggestion is that to mature and consolidate its value as a therapeutic discipline, family therapy theory should search for and demonstrate its incongruencies, encourage dialogue, borrow knowledge respectfully, and recognise its influence on our consciousness.

In conclusion, a number of scientific and clinical developments set the stage for the emergence of family therapy. Awareness of the role of the family in personality development, a systemic focus on the family organisation and interaction, marital and family influences on mental health and the development of psychological disturbance, and group processes for therapeutic gain combined to provide a model for family therapy.

### 2.3 THE EVOLUTION OF FAMILY THERAPY: 1950 – PRESENT

As the developments described in the previous section converged, the field of family therapy embarked on a journey of growth that has yet to reach its peak. Alongside growth, controversy has challenged the assumptions and theories of the field. According to Sprenkle *et al.* (1999:330), the growth of family therapy depended more

on its “...intuitive or emotional appeal...” than on research findings. These authors state that until the mid-1980s family therapy could be described as a “...coterie of competing religions...” and that family therapy consolidated around the charismatic personalities of various theorists. Sprenkle *et al.* (1999:330) quote Lebow who describes the revolution in family therapy that leans towards integration and the move from modernist beliefs to a postmodern understanding of multiple understandings. The following section explores the evolution of family therapy, with attention given to the South African context.

### 2.3.1 The 1950s:

Consensus identifies the 1950s as the founding decade of the family therapy movement. The motivation for observation of the family was scientific research and the success of this research facilitated the development of therapeutic techniques. This period in the history of family intervention is filled with the names of people who made enormous contributions to the field, and who have become familiar to present day practitioners. These include: Bateson, Haley, Erickson, Whitaker, Satir and many more. From the researcher’s perspective it is interesting to note that Carl Whitaker, a psychiatrist, was interested in the use of the self as a tool in the treatment process to achieve more caring and intimate therapeutic relationships, an aspect that was not of noted significance at this time. By the end of the decade the Mental Research Institute (MRI) in Palo Alto was founded, with many well-known family therapists on its staff, while in New York the Ackerman Institute for Family Therapy was organised, both institutes playing a significant role in the field of family therapy (Gladding, 2002:65-68; Goldenberg & Goldenberg, 1996:90).

### 2.3.2 The 1960s

According to Gladding (2002:66), the decade of the 1960s was an era of rapid growth in family therapy. Interest in the cybernetic concepts grew and many therapists in the 1960s began to work with the entire family in the treatment of psychological disorders.

Those therapists with a more family oriented perspective focused on family structure and interactions, rather than on individual perception, behaviour or affect. The range of family therapy extended to the community and was no longer restricted to the treatment of hospitalised people diagnosed with schizophrenia and their families.

Significant developments in this decade were the founding of the first family therapy journal (i.e. *Family Process*), a number of conferences on family therapy, and growing acceptance of it as an intervention process. In the “...rush to practice...” many practitioners attempted solutions to family issues using the concepts from individual psychotherapy (Goldenberg & Goldenberg, 1996:93). An exception to this was the work of Salvador Minuchin in his pioneering study of urban slum families. His work resulted in the development of a structural family therapy approach that was practical, solution focused and integrative of the social context. A highly productive period followed, with the work of Virginia Satir contributing to the popularisation of the family approach (Gladding, 2002:67; Goldenberg & Goldenberg, 1996:94).

The Brief Therapy Project began at the MRI, geared towards problem resolution and using a primary therapist in consultation with a team observing the session from behind a one-way mirror. Another approach to family therapy was behavioural in orientation, relying on learning theory and derived from empirical studies.

Developments in family therapy outside the United States were of significance. The work of Mara Selvini-Palazzoli, together with Boscolo, Prata and Cecchin, was taking place in Italy and had a worldwide impact on family therapy (Gladding, 2002:69; Goldenberg & Goldenberg, 1996:94).

### 2.3.3 The 1970s

According to Goldenberg and Goldenberg (1996:95), technique outdistanced theory in family therapy well into the 1970s. A number of therapy approaches were attempted, for example, multiple family therapy, multiple impact therapy and family crisis therapy.

Videotape technology enabled therapists to tape sessions for training and supervision purposes. Gladding (2002:70) sees the 1970s as marked by the growth and refinement of family therapy theories.

It was in this decade that the first attempts at self-examination were made in the field of family therapy. The GAP report (Group for the Advancement of Psychiatry) acknowledged the increased awareness of the family's role in symptom formation, as well as the limitations of traditional emphases on intrapsychic processes. The GAP survey identified the three disciplines mostly involved in family therapy at this time, namely, psychiatry, psychology and social work. Family therapists reported some dissatisfaction with individual interventions, and were interested in more efficient approaches. Some of the goals identified by therapists for treatment included improved family communication, improved autonomy and individuation, and reduced conflict.

The GAP report also explored the influence of major figures in the family therapy field on family therapists. In ranked order were identified: Satir, Ackerman, Jackson, Haley, Bowen, Wynne, Bateson, Bell and Boszormenyi-Nagy (Goldenberg & Goldenberg 1996:96).

As the role of the therapist came to be recognised as significant, a study was made of videotaped family sessions to enhance self-awareness in the practice of family therapy. Two types of family therapists were identified, i.e. conductors and reactors. The former are active, forceful and charismatic, whereas the latter are more subtle, indirect, and less central to the process. Research contended that both categories are effective in family therapy. A further analysis of therapist intervention initiated in the 1970s was neurolinguistic programming, a study of language processes and how these produce change in people.

It would seem however, that most family therapy approaches were never empirically tested or systematically evaluated. A powerful force in the critique of family therapy was the feminist movement, which maintained that a male developmental bias was

insidious in family therapy (Gladding, 2002:71). The social, political and economic context of family life was minimised or even ignored, as were power dynamics between men and women. According to Dell (1989:3), feminists harshly criticised Batesonian epistemology for its failure to address power differences in patriarchal societies, stating that to dismiss power is to deny inequality. A call for conceptual reform forced many family therapists to explore their value system with regard to sex-role stereotypes, and gender based rules and roles.

#### 2.3.4 The 1980s

The 1980s heralded phenomenal growth in the field of family therapy, with a large number of journals published and many family centres in operation (Gladding, 2002:74; Goldenberg & Goldenberg, 1996:100). Goldenberg and Goldenberg (1996:100) state that the social work profession, with its focus on marital and family relationships, can be viewed as an originator of family intervention within the broader field of social casework. In the United States, the professions of social work, clinical psychology and psychiatry formed the basis of many associations connected with the family therapy arena. This view is shared by Carr (2000:51) who identifies the same three disciplines as central to the emergence of family therapy with social work being “...historically privileged...” in identifying family work as an important part of clinical work.

Competing models of family therapy, mostly based on systemic thinking but with differing emphases and perspectives continued the evolutionary process. Videotaped material and workshops facilitated a cross-pollination of ideas. Goldenberg and Goldenberg (1996:101) identify a significant event in 1982 which had far reaching implications for family therapy. This event was a publication of three articles by different authors in the journal *Family Process* that raised important epistemological questions about the theoretical foundation, research models and practice of family therapy. Criticism centred on the acceptance of terminology that failed to define explanation, and on the cybernetic notion of the observer being outside the system being observed. In addition, an overly pragmatic approach which narrowly focused on

behavioural and strategic techniques failed to consider the wider social context in which families live. Hoffman (1990:2) describes how the work of Maturana, Varela, von Foerster and Von Glaserfeld began to filter into the consciousness of family therapists. According to Reimers and Treacher (1995:181), these major challengers to the first-order approach have come from outside the family therapy arena. Maturana (a biologist) believed that human systems are unable to influence one another directly, while von Foerster (a cybernetician) claimed that humans are not mechanistic and cannot be instructed what to do. Von Glaserfeld (a linguist) argued that therapist and client can hope only to create a 'fit' that is adequate for therapeutic purposes. This shift in thinking led the way to a new epistemological challenge, namely second-order cybernetics that was to gain prominence in the next decade.

### 2.3.5 The 1990s

This decade saw a shift to integration and eclecticism, with the different schools of thought becoming less mutually exclusive. Theories overlapped and there was a degree of 'borrowing' from each other (Goldenberg & Goldenberg, 1996:102). According to Worden (1999:8), systems theory is a fundamental knowledge base that most family therapists share, but theories require refinement and revision, and established perspectives need to be questioned. New and controversial epistemologies, such as constructivism forced family therapists to re-examine systemic assumptions. The new epistemology emphasised second-order cybernetics which extends the focus beyond homeostatic properties of families to belief systems and a worldview. The view of subjective construction and multiple versions of reality suggest that no absolute reality exists, therefore any attempt to change patterns in the family is unpredictable and inexact. Family therapy becomes a collaboration in the context of which family members share their constructions of reality in the hope that increased awareness will facilitate change (Gladding, 2002:75-76; Goldenberg & Goldenberg, 1996:102).

The move to focus on creating meaning through language and having a conversation with families about their problems was led by Paul Watzlawick, Michael White and

Lynn Hoffman, as well as Harlene Anderson and Harry Goolishian. Tom Andersen, a Norwegian psychiatrist, began to use an egalitarian technique called the **'reflecting team'** as a means to stimulate new conversations within the family and to enhance self-awareness and family relationships.

According to Goldenberg and Goldenberg (1996:104), the decade of the 1990s emphasised the fact that family therapy was "...far from monolithic..." and that few beliefs and clinical methods of intervention were universally accepted. The challenge has become to integrate the different approaches in ways that fit with specific client populations.

The phenomenon that was family therapy grew internationally, with training programs and conferences in the United Kingdom, Europe, Israel, Australia and South Africa. According to Kaslow (2000:31), the developments in each country have paralleled those in the United States, with psychoanalysis and behavioural therapy initially dominating theories and interventions. Over time, systemic, strategic and narrative approaches have been introduced and become major approaches to family intervention. Family therapy is influenced by the traditions, needs, beliefs and context of the country in which it is practiced, and in the opinion of the researcher, the complexity of the South African context requires consideration of an 'indigenous' model that suits the requirements of a multi-cultural population. Normative (i.e. Western) ideas of family life and family issues will be relevant to only a small sector of the South African population, requiring consideration by the family therapist of the approach to intervention that will reflect their world view and thus enhance effectiveness.

### 2.3.6 The History and Evolution of Family Therapy in South Africa

Kaslow (2000:1) writes about the history and evolution of family therapy outside of the United States, with the intention of providing a universal overview of the field which may appear to be dominated by developments in the USA. Kaslow's view is that the current family therapy field "...exhibits a multihued patchwork quilt of many different,

though interconnected, philosophic and theoretical schools of thought”. The evolution of family therapy in various countries has followed a similar course, with some deviations reflecting the differing social, political and cultural contexts.

Family therapy in South Africa began in the decade of the 1960s and was conducted by a few professionals who had been influenced by developments around the globe. Mason and Shuda (1996:5) describe how social work in particular became concerned with the plight of the multi-problem family and began to attempt family intervention. According to Kaslow (2000:17), it was initially the academic departments of psychiatry and social work that began to apply the models and techniques of family therapy. In various parts of the country the professions of social work, psychology, psychiatry and psychiatric nursing formed interdisciplinary groups with an interest in family intervention. Landau and Griffiths (in Kaslow, 2000:17) state however, that organisation and communication between professionals was not formalised, and some opposition and resistance to the concept of family based approaches was evident in professional circles.

In 1974, Dr Donald Bloch from the Nathan Ackerman Family Therapy Institute, New York, conducted introductory workshops in family therapy at Tara: The H.Moross Centre, Johannesburg and in Cape Town. The credibility of his analytic background, together with his experience and expertise opened the way for acceptance of family therapy, and lessened opposition. Mrs Jackie Meyerowitz, a social worker from The Johannesburg Marriage Guidance Society, later Family Life Centre, represented the organisation and attended the Johannesburg workshop. Dr Bloch’s workshop stimulated interest in family therapy and motivated participants to initiate the South African Institute of Marital and Family Therapy (SAIMFT).

Mrs Meyerowitz was responsible for inviting Dr Bloch to run further workshops at Family Life Centre in 1976. Personal reasons prevented his conducting the planned workshop, however his replacement, Dr Jessie Turberg, stimulated enormous interest in this form of intervention. Coinciding with an expansion of offices from the city centre

of Johannesburg to Parkwood, Family Life Centre was able to specifically designate a suite of rooms for family therapy, with television, video and one way mirrors, in a new wing built onto the existing house (Meyerowitz, 2006).

The University of Cape Town invited Avner Barcai, from the Family Therapy Institute, Israel, to conduct training programs for post-graduate students and practitioners, which heightened interest in the field. By 1976 regional family therapy groups had been formed in the Cape, Transvaal and Natal – the aim of these groups was to foster communication among practitioners and trainees, to provide a review of the literature, and to organise seminars with visiting and local experts (Meyerowitz, 2006: Kaslow, 2000:17-18). Clinical training was dependent on the availability of supervisors within academic departments, although the scarcity of experienced therapists delayed expansion. In addition, certain aspects contributed to a reluctance to refer families for therapy. According to Kaslow (2000:18-19), these included a reluctance on the part of medical aid societies and health care workers, perhaps due to lack of awareness of the benefits of early intervention, or of a perspective of problems existing in a family context, to consider the potential of this form of intervention. At Family Life Centre, family therapy came to be viewed as a much needed form of intervention, and the organisation was fortunate to have the services of Norma Altman, and later Julian Rubenstein, for training and supervision (Meyerowitz, 2006).

The years from 1976 to 1981 saw consolidation and growth in the field of family therapy in South Africa. Since the 1980s extensive education in the form of workshops, conferences and supervision have taken place, bringing a wealth of international knowledge and experience to South Africa. The first international conference of the South African Institute (now Association) of Marital and Family Therapists (originally SAIMFT, now SAAMFT) was held in Durban in 1981, enhancing the credibility and visibility of family therapy. Training continued to be provided at universities, and several professionals visited conferences overseas and presented their work (Kaslow, 2000:20; Mason & Shuda, 1996:6). *Family Therapy in South Africa Today* was the first publication in South Africa of indigenous family therapy research and clinical and

community practice, raising questions regarding the relevance of family therapy in third world communities in South Africa, and the impact of the therapist's stance towards the political aspects of family life (Mason & Shuda, 1996:10).

Throughout the 1980s and 90s and into the next century, many of the distinguished names associated with family therapy theory practice visited South Africa, including Auwerswald, Cecchin, Boscolo, Whitaker, Sluzki, Andersen, White and more (Meyerowitz, 2006; Kaslow, 2000:21). Family Life Centre had the honour of hosting Tom Andersen, as well as Gianfranco Cecchin, and benefited from their experience and wisdom. While practice at the centre is eclectic in orientation, the influences of Michael White and Tom Andersen were strongly felt, and thus a shift to a postmodern paradigm was made. This was especially felt in the practice of the reflecting team, which gradually changed from the approach of the Milan School to one such as described and practiced by Tom Andersen (discussed in Chapter 3).

The past decade has seen major socio-political transformation in South Africa, which impacts on the professions of psychiatry, social work, psychology, law, and medicine. Kaslow (2000:21) believes that it is too soon to assess how family therapy will evolve in the rapidly changing climate that is South Africa.

South Africa is a society comprising many different social, ethnic and cultural groups with considerable socio-economic diversity. The population ranges from the educated and affluent, to the rural and illiterate. In the opinion of the researcher, this provides both opportunities and obstacles to intervention with families in distress, requiring an appreciation of a multi-cultural perspective to facilitate appropriate intervention with diverse client families. While family therapy is undertaken with diverse population groups at Family Life Centre, it is only at the Head Office in Parkwood which has the facilities and personnel resources to deliver this method of intervention. The geographical location attracts the Western or Westernised urban populations. Thus intervention of this nature is restricted to a small sector, and its universal application may not prove to be the most appropriate intervention. The researcher remains

convinced however, of the necessity of this type of family intervention for the population that it does reach. Difficulties concerning the availability of resources and services in wider communities and rural areas remain a challenge.

In conclusion, research into schizophrenia stimulated the family therapy movement which was later influenced by cybernetic ideas as a way of treating dysfunctional behaviour. In the fervour to work with distressed families, many new techniques and strategies were developed, and to a large degree outpaced theoretical development. Rapid growth in the field led to efforts aimed at self-awareness and self-evaluation, these being mainly challenged by feminist critique of sex role stereotyping and gender inequality. A brief period of unity in the 1980s was soon to be challenged by epistemological shifts towards postmodern concepts and a trend towards eclecticism and integration.

## 2.4 THEORIES OF FAMILY THERAPY

According to Pocock (1999:188), the field of family therapy is extensive and extremely complex, and no simple classification system exists that does not simplify, conceal or subdue many of its nuances. The available literature on the various theories of family therapy is extensive and is classified in diverse ways. For the purposes of this thesis, the researcher intends to follow the classification system of Carr (2000) which organises the many schools of family therapy according to the central focus of therapeutic concern, namely: theories that focus on behaviour patterns; theories that focus on belief systems; and theories that focus on context (Carr, 2000:69). Table 2.1 presents a brief overview of the classified theories.

Table 2.1: Classification of schools of family therapy according to central focus of therapeutic concern.

<b>Behaviour Patterns</b>	<b>Belief Systems</b>	<b>Context</b>
MRI Brief therapy	Constructivist	Transgenerational
Strategic therapy	Original Milan school	Psychoanalytic
Structural therapy	Social constructionist	Attachment-based
Cognitive-behavioural therapy	Solution-focused	Experiential
Functional therapy	Narrative	Multisystemic
		Psychoeducational

Adapted from Carr (2000:70)

The concise sketches of these schools of family therapy that follow may not do justice to the contributions each approach has made to the extensive and fascinating field that is family therapy intervention. For those readers interested in discovering an approach that has an authentic ‘fit’ with their sense of self, a more thorough exploration is recommended.

#### 2.4.1 Theories that focus on Behaviour Patterns

As can be seen from Table 2.1 the theories that fall into this category include the MRI brief therapy approach; strategic family therapy; structural family therapy; cognitive-behavioural family therapy; and, functional family therapy.

##### 2.4.1.1 MRI brief therapy

Carr (2000: 76) identifies the principal figures in this school as Weakland, Watzlawick, Segal, Bodin and Fisch. The Mental Research Institute was founded by members of Bateson’s group in the 1950s and the Brief Therapy project was set up in 1967. MRI

brief therapy is a pragmatic integration of cybernetic and systemic concepts, the hypnotherapy approach of Milton Erickson, and von Foerster's constructivism.

The central idea of the MRI approach is that ineffective attempts to solve problems result in maintaining the problem. The MRI research identified individual symptoms as a reflection of family dysfunction, maintained by the family system (Carr, 2000:76; Goldenberg & Goldenberg, 1996:211). Cybernetic concepts such as feedback loops and circular causality are basic to MRI thinking and therapy. The MRI team developed a series of brief, specific and symptom-focused interventions aimed at problem resolution. The approach is pragmatic, aimed at understanding the behaviour and finding solutions that change dysfunctional family rules, expose hidden agendas and modify paradoxical communication patterns (Goldenberg & Goldenberg, 1996:215).

An important concept introduced in the MRI approach is the level of change. **First-order change** does not change the structure of the system and change may be superficial and of short duration. **Second-order change** requires a fundamental alteration of the system's structure and function. The rules of the family system are altered, resulting in change to the system itself. According to Watzlawick (in Goldenberg & Goldenberg, 1996:215), therapy must accomplish second-order change, often achieved through the use of reframing of the therapeutic double bind.

The **therapeutic double bind** is a term for a variety of paradoxical techniques used to change persistent problematic family patterns. The client is told to change by remaining unchanged – he or she cannot fail to react to it but cannot react in the usual, symptomatic way. **Prescribing the symptom** is a way of urging the family to continue the practice of the symptoms, or even to exaggerate them in an effort to undermine resistance to change. This challenges the function of the symptom and assists the family to find new ways of interacting. **Relabeling** attempts to alter the meaning of a situation so that it is perceived differently by the family (Goldenberg & Goldenberg, 1996:218).

Assessment focuses on tracking problematic behaviour patterns and ineffective solutions, while intervention attempts to disrupt these problem-maintaining behaviour patterns through paradoxical suggestions to refrain from trying to solve them. According to Carr (2000:81), the MRI approach does not specify an articulate model of functional and dysfunctional families, but involves the view that a more flexible, adaptable family will avoid becoming trapped in ineffective cycles of problematic behaviour.

Interviews are conducted with the people who most want to change – there is no requirement for the whole family to attend therapy. However, the conceptual framework involves identifying others trapped in the repetitive cycle of interaction. The MRI model distinguishes between ‘customers’ who are committed to solving their problems and ‘window shoppers’ who are attending treatment to satisfy someone else. Historical, constitutional and contextual factors are of little significance in assessment, which typically involves a step-by-step description of how a problematic episode begins, progresses and concludes.

Treatment aims at achieving small but noticeable change that differs from the status quo, and is maintained and expanded through positive feedback (Carr, 2000:82). Restructuring family organisation or facilitating personal growth is not the focus of MRI therapy. Therapy sessions are the forum for developing and reviewing tasks carried out between sessions. Promoting change, rather than focusing on the process within the sessions, is the primary aim.

The role of the therapist is strategic, with a high level of control over the therapeutic process. The therapist may even strategically withhold information about the cybernetic and systemic rationale underpinning intervention (Carr, 2000:83). However, to encourage clients to work harder at resolving problems, the MRI therapist may take a one-down position, claiming uncertainty or helplessness in understanding the attempts of the family at various solutions. Use is made of **therapeutic restraint**, advising clients to ‘go slow’ to avoid making the situation worse through the use of impulsive,

inappropriate solutions until a firm foundation for change is laid. Therapeutic restraint typically has the paradoxical effect of accelerating change – increasingly cautious invitations to exercise restraint are met with increasing bold attempts to resolve a problem. An exploration of the dangers of quick resolutions, doubt about their permanence and predictions of relapse may further accelerate positive change. All change is credited to the family and not to the therapist. Termination may occur with an expression of puzzlement at the family's rapid progress rather than celebration. Requests for work on other issues may be met with the suggestion to allow for consolidation of change already made (Carr, 2000:84).

From the description of the type of intervention above, it seems to the researcher that the family therapist practicing MRI therapy would have to feel comfortable with a degree of duplicity and pretence, as well as a firm belief in the necessity of the therapeutic double bind as a technique to assist the family to achieve the desired second-order change. If this approach is to be used effectively, the family therapist needs to know if he/she can authentically put the techniques into practice, and if they are congruent with values and the self. From the researcher's perspective, inauthentic use of such techniques could be perceived as 'phoney' by the family, and thus prove ineffective or worse, damaging.

A related MRI strategy is to request clients to list the negative consequences of change in the early stages of therapy, and to explore these if intervention is met with resistance – again, the paradoxical effect of this may defuse resistance to change. Problems may be reframed in ways that the client can accept as plausible, and unique interventions are constructed in each case to disrupt problem-maintaining behaviour.

MRI therapy has been influential in casting human problems as interactional and maintained by the family system. Therapy aims to break the cycle of repetitive and destructive behaviour patterns and provide solutions to rapidly resolve problems in ways that change the family system.

#### 2.4.1.2 Strategic family therapy

The founder of strategic family therapy was Jay Haley, a member of Bateson's group and co-founder, with Cloe Madanes, of the Washington Family Therapy Institute. The central theme of strategic family therapy is that the family is ambivalent about change because the problem serves some function for family members – the problem is viewed as a strategy when other attempts at resolution have failed. The therapist must design specific interventions to undermine this ambivalence and help the family resolve the problem, while at the same time provide an opportunity to deal with the complex interpersonal issues the problem functions to serve (Carlson & Kjos, 2002:81; Carr, 2000:86; Thompson & Rudolph, 2000:325; Goldenberg & Goldenberg 1996:224).

Within strategic therapy it is assumed that healthy families have clear intergenerational boundaries, can adapt to the family life cycle stages with flexible rule and role changes, and have effective problem-solving skills. It is also assumed that within family relationships there are both complementary and symmetrical transactions, and that love is the central value of the family.

In contrast, the problematic family is characterised by an unclear boundary structure, a lack of flexibility in moving through the life cycle stages and relationships being exclusively either **complementary** or **symmetrical**. It is argued that differing hierarchical structures and coalitions may occur in families which may be denied and can lead to **pathological triangles** which may hinder progression through the life cycle stages. Relationships, particularly marital relationships, may be characterised by exclusively symmetrical transactions (e.g. persistent arguments) which have the potential to create unremitting conflict, or exclusively complementary transactions (e.g. caregiving) which inevitably become problematic over time (Carlson & Kjos, 2002:85; Carr, 2000:87).

Carr (2000:88) describes Madanes' conceptualisation of family difficulty as arising from attempts to control/to dominate; to be loved/to love and protect; to repent/to

forgive. Associated problems include aggression, delinquency and abuse; depression, anxiety, eating disorders, suicide and thought disorders; sexual and physical abuse.

In the first interview with a family, all members are expected to attend. Assessment in strategic therapy involves identifying the specific problem with which the family want help; clarifying the pattern of interaction around the problem; clarifying family hierarchy roles, life cycle ‘stuckness’ and reliance on symmetrical or complementary transactions. Family difficulties as described above are also addressed. The assessment interview has four sections – the first section consists of a **brief social stage**; understanding the perspective of each family member of the problem and its process; exploring previous attempted solutions and the effects of these. In the second stage or **problem stage** of the interview the therapist conveys the problem as one embedded in patterns of family interaction. During the third **interaction stage** the family are encouraged to explore the differing views they share concerning the problem, whilst the therapist observes any coalitions, power hierarchies and so on, and develops some hypotheses about future intervention. The final section of the initial interview is the **goal setting stage** whereby therapy goals are specified and defined in concrete ways that will be measurable over the course of the therapy (Carr, 2000:89; Thompson & Rudolph, 2000: 330; Goldenberg & Goldenberg, 1996:227).

Treatment in strategic family therapy consists of the therapeutic team formulating problems, reframing these for the family and providing **directives** that will disrupt the pattern of interaction which maintains the presenting problem. According to Madanes (in Goldenberg & Goldenberg, 1996:228), the directive is to strategic therapy what interpretation is to psychoanalysis – it is the “...basic tool of the approach”. A directive is an instruction from a family therapist for the family to behave differently (Gladding, 2002:223). Therapy sessions focus on reframing, giving directives and reviewing progress. Change is assumed to occur between sessions, as it is then that the problem maintaining patterns occur.

**Paradoxical directives** are designed to provoke defiance and may reveal the secondary gain inherent in the symptomatic behaviour. Haley (in Gladding, 2002:224; Goldenberg & Goldenberg, 1996:230) extensively taught the use of the therapeutic paradox to bring about change. Three stages are identified in designing a paradox, i.e. redefining, prescribing and restraining. Before the therapist can ‘prescribe the symptom’ the behaviour must be redefined as a loving gesture in the service of preserving family stability. The wording of the prescription must be concise, brief and unacceptable, the latter in order for the family to recoil from the instruction. The therapist must appear sincere in offering a convincing rationale for the prescription. When indications of change become evident, the therapist must restrain the family from accelerated change to preserve homeostatic balance (Hanna & Brown, 1999:221; Goldenberg & Goldenberg, 1996: 231).

A less confrontational intervention is **pretend techniques** (Madanes in Goldenberg & Goldenberg, 2000:241; Goldenberg & Goldenberg, 1996:231). These are paradoxical in nature but less likely to invite defiance, although still effective in overcoming family resistance. Based on humour, fantasy and metaphor, pretend techniques strategically help families abandon symptomatic metaphors and open up the possibility of attempting more adaptive ones.

Treatment encompasses several stages – building a relationship with the family, defining the problem, setting goals and making a concrete plan, issuing directives and observing the response. The role of the therapist in strategic family therapy is authoritative and active – the therapist is responsible for changing the family organisation and resolving the problem the family has brought to him/her through intervention that overcomes the family’s homeostatic tendencies (Gladding, 2002:225; Jurich & Johnson, 1999:202; Goldenberg & Goldenberg, 1996:226).

From the perspective of the researcher, the family therapist using strategic therapy would need to be comfortable with the responsibility of making decisions relating to what the family needs to do to change, as well as with giving directives. In particular,

the use of paradoxical directives requires a high level of self-awareness from the family therapist, as well as a firm conviction in the need for this form of intervention.

Criticism of strategic therapy relates to its manipulation and authoritarian aspects. The use of techniques such as paradox can be damaging if used by inexperienced practitioners, and as such requires considerable training (Gladding, 2002:227). In addition, strategic therapy is said to lack collaborative input from the family, emphasising expertise and therapist responsibility for change. Haley (in Goldenberg & Goldenberg, 1996:231) dismisses such criticism and believes that all therapies rely on therapist influence and expertise to resolve family problems, but that most fail to acknowledge their power.

In summary, typical characteristics of the strategic approach to family therapy are the use of paradoxical techniques aimed at changing family rules, disrupting dysfunctional patterns and promoting change through compliance or resistance.

#### 2.4.1.3 Structural family therapy

Structural family therapy was primarily the work of Salvador Minuchin and his colleagues, developed in response to a sense of disappointment with psychoanalytic therapy with working class clients. The central idea in structural family therapy is that problematic family organisation may compromise the ability to adapt to life cycle change, unpredictable family stressors or broader, external stressors (Aponte & DiCesare, 2002:2; Carr, 2000:91; Thompson & Rudolph, 2000:320; Jurich & Johnson, 1999:201). A family's **structure** is the set of 'rules' or functional demands that organise the way the family members interact with one another. Such a structure provides a framework for understanding the consistent and enduring patterns that maintain family stability, as well as adaptability to changing conditions (Gladding, 2002:201; Goldenberg & Goldenberg, 1996:191).

Within structural family therapy, healthy families are presumed to have a structure that is flexible in accommodating life cycle transitions. The **intergenerational boundaries** that exist between the family subsystems require definition and clarification, and according to Thompson and Rudolph (2000:320), families who understand the difference between healthy and unhealthy subsystem boundaries function more successfully. Such boundaries should be neither rigid nor diffuse, and functioning should be neither chaotic nor rigid. Subsystems function to organise the family according to criteria such as gender, generation, common interests, or task – many permutations may exist and each member belongs to several subgroups at the same time (Goldenberg & Goldenberg, 1996:193). The strength of the parental subsystem is significant in family stability and flexibility, and according to Jurich and Johnson (1999:196), many families do not have a balance of subsystems or even an executive (parental) subsystem, thus the potential for dysfunction escalates.

Emotional closeness requires a balance between **enmeshment** and **disengagement** (Carr, 2000:92; Worden, 1999:19; Goldenberg & Goldenberg, 1996:195). With enmeshment of family members, there is extreme proximity, intensity and over-involvement – separation and autonomy is viewed as betrayal. Subsystem boundaries are weak and poorly differentiated. At the other end of the continuum disengaged families are autonomous but have little sense of family loyalty or togetherness. Disengaged families struggle to provide support when needed, while enmeshed families find difficulty in permitting autonomy and are over-involved in one another's lives. Disengagement and enmeshment are strategies for avoiding conflict, either through preventing any discussion of change or denying any difference.

**Coalitions** refer to alliances between specific family members against a third member and can be an important determinant of family function or dysfunction. A strong parental coalition is often beneficial to effective child rearing, while a parent-child alliance may undermine family functioning. In some instances, conflict may be detoured through the child, a process referred to as **triangulation** - such triangulation may lead to psychosomatic responses. A weak parental subsystem may give rise to a

‘parental child’ or parentified child, who functions in a parental way, while a rigid hierarchy may fail to take childrens’ needs into account. A dysfunctional family cannot fulfil its function of facilitating the growth of its family members (Gladding, 2002:202; Carr, 2000:92; Goldenberg & Goldenberg, 1996:196).

**Clear boundaries** allow family members to enhance communication and relationships through dialogue and corrective feedback. According to Jurich and Johnson (1999:192) the family must define who it includes and excludes. In entering counselling, a family with **rigid boundaries** and a preconceived definition of their family create a closed, inflexible system that may prevent new information, options and resources from entering and challenging the family system. Overly **diffuse boundaries** encourage dependence and may result in family ‘members’ changing on a daily basis, with implications for counselling. Boundary problems may cause difficulties or families may become more extreme in their boundary styles either as a defence or coping technique (Gladding, 2002:203; Jurich & Johnson, 1999:194).

Assessment and treatment occur concurrently in structural family therapy. Members of the family and even people from the wider social system, if deemed significant, are invited to join the first session. Therapy begins with the **joining** of the therapist and clients to form a therapeutic alliance – Minuchin (in Goldenberg & Goldenberg, 1996:203) emphasised the importance of accommodating the style of the family and facilitating an atmosphere of safety in which to explore areas of pain and stress. **Tracking** refers to gaining an understanding of each member’s description of the problem, life themes, values and significant family events (Gladding, 2002:205; Hanna & Brown, 1999:180; Goldenberg & Goldenberg, 1996:203).

Gladding (2002:206) specifies **disequilibrium techniques** aimed at changing or perturbing the system so as to reduce ‘stuckness’. **Enactment** is a “...staged effort...” by the therapist to bring family conflict into the open in order to reveal the family structure, strengths and flexibility (Gladding, 2002:207; Goldenberg & Goldenberg, 1996:205). Through enactment the therapist encourages family members to jointly

attempt problem solving, perhaps even coaching family members to deal with difficult transactions or to try different solutions – the therapist actively avoids being inducted into problem maintaining interactional patterns which are part of the family dysfunction. **Unbalancing** is a procedure wherein the therapist allies with an individual or subsystem, thus forcing the family to relate differently to that person or subsystem. A focus on **process** is seen as more significant than on **content**, with the former needed to unbalance and restructure the family (Carr, 2000:93).

**Reframing** is a technique that is intended to change the original meaning of a family event or situation, and place it in the context of an equally plausible explanation – the aim is to provide a more constructive view, altering the way it is perceived. From a structuralist perspective, reframing relabels the problem as a function of the family structure (Gladding, 2002:206; Hanna & Brown, 1999:215; Goldenberg & Goldenberg, 1996:205). In the opinion of the researcher, this technique has a postmodern flavour, since it aims to alter the family member's belief about an event or problem. This suggests perhaps, that integration of modern and postmodern concepts is not out of the question.

The technique of **restructuring** is central to the structural approach – it involves changing the structure of the family by altering the existing hierarchy and interaction patterns so that problems are not maintained (Gladding, 2002:208). Structural interventions may increase stress on the family system and unbalance family homeostasis. However, they may open the way for transformation of the family structure through emphasis that the problem belongs to the family and not the individual 'symptom bearer'. In restructuring the family rules, members learn alternative ways to deal with one another and with conflict, increasing the growth potential of all the members.

From the perspective of the researcher, the nature of the structural approach to family therapy requires an enhanced understanding of family dynamics, not only those of the client family, but also those of the therapist's own family-of-origin. Knowledge of

one's role in one's family-of-origin, intergenerational boundaries and various systems and subsystems would be necessary, particularly if there are any similarities in the client family. Such similarities could result in the therapist being 'inducted' into the family system, thus compromising intervention if similar dynamics are replicated.

The structural family therapist is both observer and expert, using interventions to modify and change the underlying structure of the family and assist the family to unite in a healthy and productive way (Gladding, 2002:209). Criticism focuses on the approach being inadequate to address the complexity of family life; reinforcing sex role stereotypes such as executive roles for husbands and expressive roles for wives; focusing of the present and ignoring historical data; and disempowering for the family since the therapist initiates change.

In conclusion, structural family therapy focuses on family subsystems, boundaries and coalitions and the manner in which dysfunctional structures require renegotiation. Priority is given to insight into problem behaviour within the context of the family structure. Structural interventions are active, even manipulative on occasion, the aim being to change dysfunctional patterns and realign the family organisation.

#### 2.4.1.4 Cognitive-behavioural family therapy

Cognitive-behavioural family therapy evolved from the work of Gerry Patterson on behavioural parent training which used the principles of social learning theory to modify behavioural problems. Work on cognitive-behavioural marital therapy came from Richard Stuart's contingency contracting for conflicted couples, and intervention in both these domains has grown extensively over the years (Carr, 2000:94; Goldenberg & Goldenberg, 2000:265; Goldenberg & Goldenberg, 1996:253).

The central assumption of cognitive-behavioural family therapy is that problematic behaviour and cognitions are learned and maintained by repetitive patterns of interaction. **Imitation, classical conditioning** and **operant conditioning** are all factors

relevant to the acquisition of these patterns. The aim of therapy is to interrupt problem maintaining patterns through the coaching of skills that perpetuate healthy behaviour and challenge negative cognitions. Maladaptive behaviour can be ‘unlearned’ and replaced with new learned behaviours (Gladding, 2002:172; Goldenberg & Goldenberg, 2000:266; Hanna & Brown, 1999:29; Goldenberg & Goldenberg, 1996:257).

**Social learning** theory attempts to integrate the basic principles of learning with an understanding of the social context in which learning takes place. Vicarious learning occurs through observation of the behaviour of others, as well as the consequences of that behaviour. This offers a broader perspective than conditioning theories of learning and is seen as more appropriate to family behaviour. Through **modelling** the therapist or even a family member can provide an example of the behaviour to be imitated, which then becomes part of the client’s behavioural repertoire. Maladaptive behaviour, rather than the underlying causes, is seen as the target for change (Gladding, 2002:193; Goldenberg & Goldenberg, 1996:257).

Family therapy may or may not include all family members and will seldom involve extended family members – the focus is more on the individual with behavioural symptoms than on the family as system that is always active in symptom maintenance. The approach is more linear than circular with regard to causality, although some cognitive-behavioural family therapists do have a more systemic perspective in their view of family dynamics (Gladding, 2002:175; Goldenberg & Goldenberg, 1996:260). The role of the therapist is of expert and teacher who assist the family to modify or change cognitions and interactions. The role requires persistence, patience and energy (Gladding, 2002:187).

Research within the cognitive-behavioural school shows relationship differences between distressed and non-distressed families. In distressed relationships, family members engage in more negative interpersonal patterns of behaviour that are mutually reinforcing and which often maintain defiant and aggressive behaviour problems with children and between couples. In addition, **negative cognitive schemas** dominate the

thinking patterns of the family members – such schemas involve selective attention, attributions and assumptions based on negative thinking and behaviour patterns (Carr, 2000:95).

Assessment in cognitive-behavioural family therapy entails an analysis of problematic issues in the family, involving monitoring of duration, frequency and intensity of both negative and positive interactions as well as their antecedents, related cognitions and consequences. **Behavioural checklists** and psychometric questionnaires may be used to evaluate cognitions. Goals are aimed at increasing positive and reducing negative interactions, cognitions, feelings and behaviours (Carr, 2000:95; Goldenberg & Goldenberg, 1996:259).

**Cognitive restructuring** is an intervention technique aimed at modifying thoughts and perceptions, and is based on the idea that faulty cognition gives rise to dysfunctional behaviour (Goldenberg & Goldenberg, 1996:257). Cognitive restructuring is the principle intervention used to challenge negative cognitions – this involves a change in belief systems and is, according to this approach, the only way of effecting permanent change. The intervention involves monitoring situations that create certain cognitions, assessing the impact on behaviour and mood, and challenging them by finding ways to refute or support them – if no evidence supports the cognition, clients are challenged to find new cognitions to fit the evidence.

A large number of techniques are used in treatment in cognitive-behavioural family therapy. With children, these include reward systems to increase positive behaviour and time-out to reduce negative behaviour. **Contingency contracts** may be used with adolescents or between couples, and involve an agreement about the consequences of certain behaviour – contracts may be of a quid pro quo nature, where specific positive behaviours are linked with consequences for both parties. Alternatively, contracts may be based on good will or good faith, where positive behaviour is specified but not linked to consequences (Gladding, 2002:193; Carr, 2000:96; Jurich & Johnson, 1999:200). Other techniques include **problem-solving** wherein problems are defined

and broken down into smaller solvable parts, solutions evaluated and modified if necessary; **communication training** where clients are coached through modelling and role-play to communicate more effectively; **role-play** whereby family members are asked to “act as if” they are already the person they want to be; and **coaching** of families to engage in more appropriate responses and positive behaviours.

The researcher is of the view that this approach to family therapy requires an active and energetic therapist who is at ease with his/her role as expert and teacher. The focus on behaviour and cognition, and the discounting or minimising of emotional aspects implies a degree of intellectualising of problems which may feel more comfortable for some family therapists who may become overwhelmed by the complexity and intensity of family emotion. Again however, a high level of self-awareness is called for, knowing what fits for the self to facilitate authentic practice.

Gladding (2002:189) states that cognitive-behavioural family therapy is less systemic than many other approaches – learning is focused on individual or subsystem behaviour and thus may hinder complete family change. Feelings are not the focus of therapy and although family members may change behaviour, they may not feel or think differently. The approach favours family action over family insight and does not explore family dynamics sufficiently. In addition the approach is criticised for being rigid in application, which may result in losing rapport with the family. There is little emphasis on building and maintaining a therapeutic alliance, nor on process over problem identification and solving.

Cognitive-behavioural family therapy is an attempt to bring a scientific method to intervention with families experiencing problems, through monitored procedures based on social learning and the influence of cognition on family interactions.

#### 2.4.1.5 Functional family therapy

Functional family therapy is an attempt to combine behavioural family therapy with aspects of strategic and structural family therapy, based on the observation that families often find cooperation in cognitive-behavioural family therapy difficult (Carr, 2000:97; Goldenberg & Goldenberg, 1996:276). The belief is that families firstly need to understand the function of the behaviour in their interactions. Therapy is aimed at replacing problematic behaviours with non-problematic behaviours that fulfil the same function in relationships.

For the functional family therapist, all behaviour is adaptive, serving a function in an effort to create a specific outcome in interpersonal relationships. Goldenberg & Goldenberg (2000:289; 1996:276) differentiate between three interpersonal states that family members strive to achieve: contact and closeness (**merging**); distance and independence (**separating**); and a combination of the two (**midpointing**). By understanding the interpersonal functions served by the problem behaviour, the therapist can help the family find alternative ways to achieve the same result.

Functional family therapists use some systemic and behavioural principles in intervention. **Relabeling** is used to provide new meaning to causes of behaviour that will lead to changed perceptions and thus behavioural change. Education is deemed necessary in order to provide the context for learning skills needed to maintain positive change. To achieve change, the functional family therapist uses a variety of cognitive-behavioural techniques, such as contingency contracts, modelling, and communication training to enhance family functioning (Carr, 2000:98; Goldenberg & Goldenberg, 1996:278).

Functional family therapy aims to integrate systems, behavioural and cognitive theories in working with families. The view that all behaviour serves an interpersonal function for the family implies that change is required of the behaviour that maintains these

functions. The eclectic feel of this approach may appeal to the family therapist who is confident in working with an integrated approach.

The five theories of family intervention described above focus on identifying problem maintaining behaviour patterns and attempts to disrupt them. Strategic and structural models emphasise the importance of the organisational structure of the family in contributing to family dysfunction, while all of the approaches, with the exception of structural, focus on problem resolution as the primary goal. Personal growth is not of major concern with these approaches, and treatment tends to be brief.

In the following section, the approaches emphasise the role of belief systems in patterns of family interaction.

#### 2.4.2 Theories that focus on Belief Systems

In the section that follows the focus is on theories that emphasise belief systems serving patterns of family interaction. These are: constructivism; the Milan School; social constructionism; solution-focused family therapy; and, narrative family therapy (Carr, 2000:110). Controversy exists however, about the place of the Milan approach, with some authors seeing it as more strategic in nature, while others question its apparent similarities, believing them to mask deeper differences (McKinnon, 1983:425). According to Goldenberg and Goldenberg (2000:300), the developments of the Milan approach has moved it towards a second-order cybernetic viewpoint – a post-Milan position. This collaborative position provides a link to postmodernism, and the theory focuses on enabling the family to give meaning to how their lives and family organisation are defined.

The approaches described below share a rejection of positivism and a commitment to an alternative epistemology (Carr, 2000:110). In order to grasp more adequately the epistemological shift that connects these theories, a brief exploration of this shift will be

undertaken, before moving on to a discussion on the theories of family therapy that focus on belief systems.

#### 2.4.2.1 Epistemology: positivism, constructivism, social constructionism, modernism and postmodernism

Although defined in Chapter 1, the above concepts will be examined in relation to the family therapy theoretical arena.

- **Epistemology:**

Epistemology is the study of knowledge. However, Bateson used the term more loosely to refer to an idea that the universe, both material and non-material, is a single ecological system made up of an infinite number of subsystems. Following the more informal use of the term epistemology within the family therapy field, Carr (2000:111) describes it to mean a specific theory of knowledge or worldview. According to Rorty (1980:316), to construct an epistemology is to seek common ground, assuming that such common ground exists. The claim to an epistemology can be fiercely debated in an academic context and is beyond the scope of this thesis.

Distinction is made between three epistemologies, namely, positivism, constructivism and social constructionism.

- **Positivism:**

Positivists argue that our perceptions of the world truly reflect how it is – a single reality may be directly perceived. Family therapy from a positivist position assumes that there is a single ‘real’ definition of the problem which may be discovered through assessment and resolved through the use of scientifically proven techniques. The therapist is the ‘expert’ on the true nature of the problem. The usefulness of positivism in family therapy lies in the development of assessment and intervention that has been scientifically tested. However, according to Carr (2000:115), the outcome of these

studies is useful to social constructions rather than to objective truth. In other words, they represent our shared constructions of events, and not necessarily reality.

Positivism is associated with a number of related positions, namely: empiricism – true knowledge is gained through the senses; representationalism – perceptions are accurate representations of the world rather than personal or social constructions; essentialism – objects and/or events have an essential nature that may be discovered as opposed to multiple meanings that may be given to objects and/or events; realism – belief that there is one real world rather than multiple personal or social constructions (Carr, 2000:115).

- **Constructivism:**

The constructivist argument is that individuals construct their own representations of the world through their senses, information-processing capabilities and belief systems. This personal construction of the world is influenced by characteristics of the individual and the environment (Mills & Sprenkle, 1995:369). Radical constructivists (such as Maturana and Von Glaserfeld) accord priority of perception to individual characteristics while constructive alternativism, advocated by Kelly, emphasises both environmental and personal contributions to perception (Carr, 2000:116). Carr goes on to suggest that radical constructivism poses a problem for family therapy, rendering communication and cooperation within the family meaningless in the face of such predominantly individualistic perception. Kelly's view on the other hand suggests similar, shared worldviews within the family as influenced by a common environment but with an individual, unique interpretation of events.

Within the field of family therapy radical constructivism has influenced the MRI approach (Von Glaserfeld and von Foerster), while the Milan systemic school has been influenced by Maturana who argued that families will only adapt their problematic situations in ways consistent with their physiological and psychological structure – the therapist can only 'perturb the system' but not direct it to change in any predictable manner (Carr, 2000:116; Mills & Sprenkle, 1995:369).

Kelly's personal construct theory, constructivist family therapy and aspects of the cognitive-behavioural tradition are grounded in constructive alternativism. This epistemological stance affects therapeutic practice in a significant way – each family member's view of the problem is unique and valid, although some constructions lend themselves to more effective problem-solving. Self-defeating attributions may be replaced with more empowering beliefs. Of value to the self-reflective process of the therapist is the degree to which we hold beliefs about a family from their behaviour, or from our own theories and professional 'prejudices' (Carr, 2000:117).

Minuchin (1991:48-49) writes on the “...seductions of constructivism” and claims that in denying the legitimacy of expertise and developing interventions aimed at avoiding ‘control’, constructivists are proclaiming themselves as the “...new crew of experts”. He believes that the theoretical concepts of constructivist therapy, i.e. a neutral, curious, and non-directive stance, the idea that objectivity is impossible, that language creates reality rather than merely reflects it, and that all truths are reached through social consensus, have produced little in the way of how to put theory into practice when intervening with real families with real problems. A further criticism is the inclination of constructivist therapists to focus exclusively on the idiosyncratic story and ignore the social context that impacts on life, e.g. socio-economic conditions, the realities of age, illness, gender, race and class.

- **Social constructionism:**

The social constructionist position, popularised by Gergen, argues that individual knowledge of the world is socially constructed through language, family and culture. An evolving set of meanings emerge from social interactions and form part of a constantly changing narrative (Atwood, 1995:10). As with constructivists, the social constructionist accepts that individual perception is determined in part by the objects/events themselves, and in part by the person's physiology and psychology – however there is emphasis on the influence of social interaction within the person's community which occurs through the medium of language. The truth is constructed

rather than discovered, by communities in conversation – constructions that do not prove useful are discarded (Carr, 2000:117; Mills & Sprenkle, 1995:369).

Golann (1987:334) states that a large and relatively unexplored area exists between the recognition of constructed realities and the appreciation that all realities are not equal with regard to degree of consensus. He argues that some events can be interpreted more reliably, or with higher consensus than others, and that all subjective descriptions are not equally valid when moving from the individual to the group level. There is a range of consensus in the way events and the environment is described, and reality should not be dismissed as an illusion. Critics of social constructionism argue that the philosophy is inherently negative and that if human behaviour is constrained by social interactions, language and behaviour, then there is no possibility of alternatives and hence, change (Rivett & Street, 2003:35).

Social constructionism is endorsed by Milan systemic therapists, including Cecchin and Boscolo, Lynn Hoffman, Tom Anderson's reflecting team approach, Anderson and Goolishian; by solution-focused therapists such as deShazer; and by narrative therapists such as White and Epston (Carr, 2000:118).

In relation to family therapy, social constructionists co-construct with clients more useful ways to describe the problem that opens up the possibility of alternative solutions. The therapist's stance is one of uncertainty, and questions are used as interventions, allowing for the possibility of alternative non-problem definitions (Atwood, 1995:15). Carr (2000:118) believes that this is the "...most coherent epistemology" for family therapy and family therapy research since the results are not objectively true, rather they are useful social constructions developed through conversation. Hoffman (in Reimers & Treacher, 1995:189) summarises the main points of second-order, social constructivist thinking: an observing system position and inclusion of the therapist's own context; collaborative rather than hierarchical; goals that emphasise a context for change without specifying change; a circular view of the problem; a non-judgmental view.

Central to the social constructivist paradigm is the “...relational, dialogical and generative nature of knowledge and language” (Anderson, 1999:3). This view influences the notion of transformative or dialogic conversations, which is active, collaborative and allows clients both to be heard and to contribute.

- **Modernism and postmodernism:**

The positivist theory of knowledge is an integral part of the modernist movement, whereas postmodernism, associated with constructivism and social constructionism, arose in response to the perceived failure of modernism that had promised freedom from superstition through science and reason. Modernism assumes the existence of universal laws discovered through systematic, empirical investigation. Knowledge would be value-free, rational and scientifically progressive (Carr, 2000:119; Polkinghorne, 1992:147).

The postmodern transformation began in response to scepticism regarding modernist assumptions, questioning the belief in value-free objectivity, and deconstructing modernist discourse as no more than “...ungrounded, historically-situated rhetoric” (Carr, 2000:119). The notion of a single objective and rational account of the world is rejected – the world is socially constructed by communities of people. In Bertrando (2000:88) the postmodern therapist views the cybernetic position as mechanistic, failing to do justice to the “...humanity of ‘human systems’”. However, Bertrando (2000:89) goes on to state that analogies to computer science were not the intention of Bateson – the cybernetic metaphor is not a metaphor but is descriptive language used to distinguish their approach and free themselves from humanistic psychoanalytic language. A misuse of cybernetic models may result in a reification of computer metaphors that were never the intention of the originators.

Postmodernism challenges taken-for-granted assumptions (deconstruction) and meta-narratives, and reconstructs people’s stories in more empowering ways (Goldenberg & Goldenberg, 1996:306). A meta-narrative is defined by Sim (1998:315-316) as any theory claiming to provide universal explanations and to be universally valid.

Collaboration between therapist and family members is participatory, assisting the family to co-construct alternative stories or new outcomes (Goldenberg & Goldenberg, 2000:299).

Postmodernism has implications for family therapy. Gergen (in Carr, 2000:119) states that no single true model of family therapy may be constructed. Rather, certain problems and contexts lend themselves to particular models, while empirical research results are not reflections of the truth but are socially constructed statements by researchers in conversation that may prove the use of particular therapies with specific problems in certain contexts. In addition, contextual variables such as gender, patriarchy, culture, class and ethnicity must be incorporated into useful models of family therapy because there are no universal principles for good practice (Goldenberg & Goldenberg, 1996:303).

According to Kvale (1992:6-7), discussions on postmodernism become entangled with modernist "...polarities of thought...". Postmodern is a descriptive term, depicting what comes after modernism. The term is not anti-modern, implying an undermining of modernism - rather it re-uses concepts and recycles them in new contexts. A postmodern discourse leads to re-conceptualisation of subject matter, thus opening new avenues for social sciences. Kvale (1992:200) sees contradiction in the implied anti-modernist stance of the postmodernist, and goes on to state that it is impossible to delineate clearly between modern and postmodern. However, this issue is fraught and complex and is not within the domain of the current argument. For the purposes of this thesis the trend in postmodern psychology of questioning, reframing and allowing numerous possibilities is helpful in the formulation of a family therapy framework within a multicultural South African society.

Bertrando (2000:92) suggests that the postmodern approach has "...its own internal inconsistencies" which create difficulties and paradoxes. To accept all narratives as equally valid and therefore equally true, is to take a position of being obliged to **not** take a position, i.e. to disregard theory. Bertrando (2000:93) goes on to state that

postmodern thinkers such as Derrida and Lyotard did not deny the existence of some sort of reality, but rather encouraged systematic doubt regarding one's premises and theories (metanarratives). Postmodern therapists run the risk of turning doubt into a certainty, thus being modernist. For the researcher, the issue is perhaps one of openness to shifts in thinking, and a questioning of our own position of certainty with regard to knowledge and its meaning for the families we encounter.

According to Held (1995:4-5), the single position that unites the many manifestations of postmodern thought is a rejection of realist epistemology in favour of an anti-realist stance. Realism suggests that knowledge can be attained objectively and independently – it is not merely a cognitive, linguistic or theoretical construction on the part of the knower. The anti-realist principles that form the core of linguistic philosophy, and thus postmodern theory, radically alter what is commonly accepted to be the nature of truth. Truth is a construction in language situated in particular discursive contexts (Held, 1995:8-9). Held (1995:9) makes the point that anti-realism, as with realism, contains more than one formulation – for extreme anti-realists there exists no independent reality other than our own mental constructions. According to Rivett and Street (2003:46), Held is the most consistent critic of the postmodernist anti-realism perspective. These authors discuss an article by Held (2000) which suggests that anti-realism leads to a stance of being anti-theoretical – this position is defended as the individualisation of therapy. According to Held (in Rivett & Street, 2003:46-47), the two positions have no connection – anti-realism can only support individualised practice if the client's perspective is one of realism. Furthermore, the anti-realist stance prevents family therapists from being involved in research which will help them to understand how best to help the client family. Held (in Rivett & Street, 2003:47) believes that it is only through empirical observation that the family therapist can determine what is or is not evidence of successful treatment.

The modern position adheres to the realist doctrine which is characterised by general laws and truths obtained by way of reason, science and technology, the determinacy of meaning and the subject having a real existence (Held, 1995:9). The postmodern view

which is fundamentally anti-realist is, in contrast, characterised by a rejection of general laws and truths, an espousal of plurality of meaning and a denial of the real existence of the subject (Held, 1995:10). Cognitive representations of the world are historically and linguistically mediated, therefore truth is local, specific and transitory. In her critique of postmodernism, it is the belief of Held (1995:14) that the postmodern movement diminishes the complexity of theories of therapy and has failed to generate knowledge concerning what causes problems and what creates solutions. The practitioner is ‘free’ to focus on the unique circumstances of each client, without the burden of having to know and apply a vast amount of theory and research. From the perspective of the researcher, the family therapy practitioner is required to have knowledge of theory – however the way in which interventions are implemented is the issue. Do they come from a position of certainty, or are they possibilities that may or may not have meaning and create change for the family?

Implications for practice from a postmodern perspective include a rejection of the idea of a true ‘diagnosis’; a single definition of the problem or solution; the view that the therapist’s view should be privileged over the client’s. The therapist is no longer the outside ‘expert’ on the family’s problem, prepared to manipulate or instruct the family to behave in certain ways. Multiple perspectives and solutions are sought, aimed at finding useful outcomes that are provisional and tentative, with collaboration between family and therapist. Language is the medium or “...therapeutic vehicle” for creating meaning and co-constructing more empowering stories to create new ways of coping in the family (Goldenberg & Goldenberg, 1996:305).

In the opinion of the researcher this has clear implications for the practice of family therapy in South Africa, where multi-cultural and cross-cultural contexts are evident.

Family therapy approaches that explore constructivist, social constructionist and postmodern ideas as a basis for practice will be considered in the section that follows.

#### 2.4.2.2 Constructivist family therapy

Carr (2000:120) positions constructivist family therapy within the personal construct theory of George Kelly. The core assumption of this theory is that people develop constructs or beliefs to enable them to anticipate events – a personal construct system may change as experience suggests modifications that may lead to more accurate predictions. The constructive therapist acknowledges that we are looking at events through “...lenses...” and that how we look determines what we see and do (Hoyt, 1998:2).

Change in construct systems occurs where new experiences make new aspects relevant, and according to Kelly (in Carr, 2000:121), peripheral and permeable constructs are more accessible to change than are core constructs that define a person’s identity and which change more slowly.

Of relevance to family therapy is the view that people choose marital partners who they believe will help them to elaborate on their construct systems so that their world becomes more predictable and understandable. Families develop shared construct systems which are validated or invalidated by the collective behaviour, interactions and dialogues within the family. These shared belief systems play a role in organising patterns of family interaction, and are originally negotiated by the marital couple with the influence of their own family-of-origin constructs and idiosyncratic interpretations of the dominant cultural construct system (Carr, 2000:121). Where family construct systems are too tight (e.g. rigid, enmeshed families) or too loose (e.g. chaotic families) or where life cycle transitions invalidate the family construct systems, symptoms may occur. Fixed belief systems influence not only what people perceive, but also how they analyse, interpret and give meaning to their perceptions (Goldenberg & Goldenberg, 1996:307).

In constructivist family therapy the position of the therapist is both collaborative and expert. Clients and therapist collaborate on the articulation of the family’s personal

construct systems and test the accuracy of the predictions that form the bases of their constructs – clients are the experts on the content of their constructs. The therapist is the expert on the process of facilitating exploration of the constructs and in designing useful ways of testing and revising them (Carr, 2000:122; Goldenberg & Goldenberg, 1996:304).

Assessment and intervention phases are not clearly defined in constructivist family therapy. However some techniques that are more assessing in nature are: **laddering**, a method of discovering hierarchical constructs that define the family identity; **circular questions**, as typified by the Milan school; the **Repertory Grid Test (REP)** is a paper and pencil or computerised method used to elicit constructs using triadic questioning, and useful as a basis for therapeutic conversations regarding the revision of construct systems; **self-characterisation** as a method of identifying core constructs; **autobiographical sketches** of the relationships, transitions, and so on, which may reveal differences and similarities in the constructs; the use of **metaphor** to best fit the family or presenting problem (Carr, 2000:124).

The role of the therapist is aimed at facilitating constructive revision so as to help client families to develop constructs that lead to more accurate predictions. Intervention may be directed at reviewing role and inaccurate constructs that may impact on predictions and thus on behaviour. According to Carr (2000:125), resistance is viewed as the product of inaccurate therapeutic constructs which entail the belief that clients should exhibit cooperative behaviour under certain conditions. From the perspective of the researcher, this approach seems to require a flexibility with regard to the personal constructs of the family therapist. In other words, an awareness of one's own constructs and the predictions which ensue is necessary, both to avoid 'knowing' what the family's issues are, and to facilitate a process of change.

Thus, the constructivist approach focuses on personal and family constructs that may contribute to problem-development and -maintenance.

### 2.4.2.3 Milan systemic family therapy

One of the unique features of the Milan approach is a concern with systemic or circular understanding of the family and the problem (Gladding, 2002:229; Goldenberg & Goldenberg, 1996:304). The Milan theoretical perspective, with its second-order cybernetic implications that the therapist is part of the system being observed, has strongly influenced postmodern family therapy. Carr (2000:126) as well as Reimers and Treacher (1995:182) describe the Milan school as split into at least two sub-traditions – one with its commitment to the original strategic approach (Selvini-Palazzoli and Prata), the other committed to a more collaborative social-constructionist approach (Boscolo and Cecchin). The latter has been most influential in the USA.

In practice, the original Milan family therapy team meet before the initial session to hypothesise on the basis of information gained telephonically. **Hypotheses** are formulated around the presenting problem, problem-maintaining interaction patterns and family belief systems. During the interview these hypotheses are tested by eliciting the perspective of each family member and observing interaction patterns. Cecchin (1987:412) sees hypothesising as “...suspending the search for one explanation” and challenging our own beliefs and descriptions.

**Circular questioning** aims at constructing new information about the situation that challenges prevailing belief systems that maintain problematic interactions. Circular questions focus attention on family connections through framing differences in perception by family members concerning events or relationships. A position of neutrality is taken by the therapist, in contrast to structural family therapy which aims to unbalance the family and restructure it (Gladding, 2002:230; Carr, 2000:127). According to Cecchin (1987:412), circular questions are “...nurtured by curiosity” and provide the possibility of undermining the belief system of the family that is based on accepted ‘truths’. Reimers and Treacher (1995:191) support the view of questioning as facilitative, but suggest that all forms of questioning, including circular, may be construed by the family as judgemental and experienced as distancing, unempathic and

even punitive. The power of the therapist is evident in his/her ability to dominate the session through questioning – thus an egalitarian therapeutic relationship cannot be built on the basis of questioning.

A team using the Milan approach will meet again mid-session, to discuss the relevance of the hypotheses and synthesise information into a systemic hypothesis regarding symptom-maintenance, recursive patterns and underlying beliefs within the family. **Positive connotations** are attributed to the behaviour of all family members – behaviour is labelled as benevolent and motivated by good intentions (Gladding, 2002:230). Tasks may be assigned by the team and given to the family by way of a message. Finally, the team has a post-interview discussion. Family resistance to therapy may be handled through the expression of “...therapeutic impotence...” on the part of the team, suggesting that the family problems are too complex and intervention too risky to consider (Carr, 2000:128).

In this original model of family therapy, the process described above is typical. Around the 1980s a split occurred, with the original approach developing strategic aspects to the model and developing the concept of ‘family games’, i.e. problem-maintaining interaction patterns whereby family members stabilise around disturbed behaviours in an attempt to benefit from them. According to Reimers and Treacher (1995:183), the crucial difference between the two groups hinges around the issue of ‘neutrality’ which these authors believe Palazolli to have abandoned. The family games are often described as ‘dirty’ with family members displaying ‘subtle cunning’, ‘manipulation’, ‘treachery’ and ‘relentless revenge’. While this may be seen as dehumanising, Reimers and Treacher (1995:183) explore an explanation by Selvini and Palazolli which claims their approach guards against the therapist supporting or even reinforcing a pathogenic family process. The **invariant prescription** is a standardised directive, aimed at breaking the power struggle between generations. Failure by the family to comply with this prescription may result in termination of therapy (Gladding, 2002:231; Carr, 2000:129).

The assignment of **rituals** is an attempt to break up dysfunctional rules in the family. They are a type of prescription that directs family members to change their behaviour under certain circumstances, and thus change the meaning of the behaviour (Gladding, 2002:231).

In Milan systemic therapy, the therapist is both an expert and co-creator of an “...evolving family system”. Overt challenge is avoided, with the therapist rather taking a paradoxical position of “...change agent who argues against change” (Simon in Gladding, 2002:232). As the family evolves, the ‘old epistemology’ is discarded and more productive behaviours emerge.

Criticism of the approach focuses on the neglect of historical patterns of family interaction, change that focuses on behaviour in favour of insight, and the use of teams which adds to cost in terms of human resources (Gladding, 2002:237). The researcher experiences a sense of discomfort at some of the aspects of the Milan systemic approach, specifically the reference to ‘family games’ which hint at judgment and criticism of the family’s attempts to cope with life. However, it is clear that becoming involved in a perpetuating cycle of problematic beliefs is of little or no benefit to either the client family or the process of change. Again, self-awareness and reflexivity are essential to both chosen approach and practice.

In conclusion, Milan systemic family therapy uses a team approach to help families solve problems, using innovative techniques designed to change behaviour and thinking.

#### 2.4.2.4 Social constructionist developments

In contrast to the directive strategic aspects within the original Milan approach, Cecchin and Boscolo developed a style based on social constructionist premises. From this perspective the stories of the individuals within the families are not necessarily owned by the individual – they may be family stories or cultural stories.

The use of **circular questioning** allows the therapist and family to co-construct multiple perspectives relating to the problem – within these perspectives are possibilities for problem resolution. As originally devised, circular questioning was a powerful tool for the therapist, but as previously stated, Reimers and Treacher (1995:186) suggest that this form of questioning may be controlling, distant and uninvolved. Boscolo evolved the system of circular questioning to a more future focused exploration of new belief systems about problems and solutions and the idea of creating new realities. Emphasis has shifted with regard to the position of the therapist and approaches to circular questioning (Carr, 2000:129).

Cecchin expanded the concept of **neutrality** to include **curiosity**, i.e. multiple explanations of a problem, and **irreverence** toward the therapist's frame of reference, 'pet' theories and biases. Neutrality is seen as the creation of a position of curiosity in the mind of the therapist, leading to the exploration of alternative views. Curiosity opens up new ways of viewing a problem and is a stance not only for the therapist but for the family. It involves not being too attached to any one hypothesis or explanation, but to engaging in conversation that opens up the possibility of new perceptions (Carr, 2000:129; Reimers & Treacher, 1995:186; Cecchin, 1987:405-406).

Other significant developments within the social constructionist movement include the work of Karl Tomm's interventive interviewing, Tom Andersen's reflecting team approach and Harlene Anderson's collaborative language approach (Carr, 2000:130). These developments will be considered briefly:

- **Interventive interviewing:**

Tomm developed new ways of conceptualising the position of the therapist and the therapeutic use of questioning. Interventive interviewing refers to circular questioning guided by strategies, which in turn refers to clarifying the intention of asking particular questions. Four main types of intent are identified: **investigative** (to gain information); **exploratory** (to uncover patterns); **corrective** (to direct clients to behave in various ways); **facilitative** (to open up new possibilities).

Also distinguished are four types of question which correspond to the four intentions: **lineal** (inquire about problem definitions and explanations); **circular** (inquire about patterns of interaction); **strategic** (direct and confrontative); **reflexive** (suggest new possibilities) (Carr, 2000:131; Worden, 1999:82-84).

- **Reflecting team:**

The reflecting team approach will be explored in depth in Chapter 3 of this thesis. However, for the sake of continuity, its position in social constructionist theory will be touched on.

According to Carr (2000:131), Andersen, using conversation and collaboration, developed new ways of giving the family a message from the team during the session. The family are given the opportunity to observe the team members explore the family interview, listening to reflections that focus on family strengths and ideas that open up possibilities of problem resolution. The family and primary therapist resume the session, discussing useful ideas and observations gained from the reflecting team. This cooperative, egalitarian approach contrasts with the original Milan team which was more secretive, strategic and allowed no possibility for clarification or discussion. The attitude of the reflecting team is tentative, respectful, positive, accepting and non-judgmental.

Reflections may explore the problem situation, possible solutions or hypothetical future scenarios, constructs of family members, and non-verbal processes that may be outside the awareness of the family (Carr, 2000:131; Goldenberg & Goldenberg, 1996:319; Mills & Sprenkle, 1995:373). According to Dallos and Urry (1999:177) the discussions in front of the family offer not only some new stories, but also an opportunity to hear different ways of talking about their situation.

- **Collaborative language systems:**

Anderson and Goolishian developed a unique social constructionist approach to family therapy, abandoning systemic and cybernetic frameworks and replacing these with the

notion of collaborative language systems. People converse about problems and either co-construct them or ‘dissolve’ them through language (Carr, 2000:132, Mills & Sprenkle, 1995:370). Therapy is seen as an opportunity to change the family system through dialogue that opens up the possibility of new interpretations. Anderson (1999:4) refers to this as a dialogic conversation that involves talking, thinking and listening – listening is active, reflective and participatory. Change is the evolution of new meaning through dialogue (Anderson & Goolishian, in Hoyt, 1998:5).

Minuchin’s critique of language systems suggests that the privileging of language over experience is limiting, and that an understanding of people includes emotions such as anger, anxiety, pleasure, fear, and many more which tend to silence or obscure language (Minuchin, 1999:13). Held (1995:1-2) states that the linguistic paradigm is part of a broad, intellectual movement in the humanities and social sciences, based on a sense of inadequacy with modern scientific approaches. This author believes however, that the theoretical and applied implications of postmodernist theories have not received serious and comprehensive scrutiny or critical evaluation.

Returning to the discussion on social constructionist developments, the approach distinguishes between **problem-determined systems** and **problem-dissolving systems**. The former refers to people who agree that a problem exists and whose belief maintains the problem – this may include family members as well as others in the social network, such as teachers, health care professionals and so on. The latter in contrast, refers to the therapist in collaboration with the problem-determined system who believe there is a problem and who dissolve the problem through the ‘therapeutic conversation’. The role of the therapist is non-expert, non-hierarchical and collaborative – the client’s view is privileged as much as the therapist’s. Respectful listening that does not consciously hypothesise or strategise is used to generate dialogue and explore multiple constructions of the problem and solution to create new meanings. Conversations and co-constructions are conducted in the client’s language rather than using jargon and technical terms (Carr, 2000:132; Goldenberg & Goldenberg, 1996:315; Mills & Sprenkle, 1995:370).

Considering the issue of expertise, Anderson (1999:5) believes that there is space for therapist expertise, but that this is not an observing, judging or instructing expertise that is an agent of change or that rescues ‘victims’ from dominant discourses. Instead, the therapist’s expertise involves creating a space for dialogue and participation in a dialogical process - expertise and wisdom are co-created in this space, responsibility is shared, and the therapeutic relationship is less hierarchical, and more collaborative. Taking a ‘not-knowing’ position refers to how a therapist positions him/herself in relation to the clients and how he/she responds and interacts with them. What we think we know is held in doubt, offered as one possibility amongst many, and without the need to be right. Not-knowing does not mean that we have no opinions, views or information – it is being open and honest about our thoughts, while providing a place for the uniqueness of people’s experience. Anderson (1999:6) believes that the imposition of theoretically determined bias limits or closes dialogical conversation.

In contrast, Minuchin (1999:13) believes there is room for “...benign expertise...” which is not used to silence clients’ voices, nor does it represent an abuse of power. Bertrando (2000:92) also criticises the not-knowing position, stating that it is impossible to adopt a true not-knowing position, because the therapist cannot avoid knowing her own experience, and when faced with any new situation, will inevitably remember a theoretical position or hypothesis based on similar situations. It is a “...simulation...” of not knowing, pretending not to have a viewpoint. The researcher is of the opinion that Anderson does not refute expertise, but rather holds knowledge as a possibility, rather than a certainty. This implies being open to alternative interpretations by family members, and respecting their position on an issue. In keeping with postmodern family therapy, this would thus allow for a multiplicity of meanings, realities and solutions, rather than maintaining the therapist’s knowledge as a metanarrative.

Tomm elaborated on the Milan school’s interviewing techniques, while Andersen developed new ways of giving families a message mid-session. Anderson and

Goolishian focused on the position of the therapist in relation to the clients and on language and conversation to develop new possibilities and solutions.

More well-developed are the solution-focused and narrative approaches to family therapy, also based on a social constructionist world view, to be considered next.

#### 2.4.2.5 Solution-focused therapy

Solution-focused therapy developed as an approach to work with a wide range of client populations. The emphasis is on strengths and positives using culturally based resources, and is respectful of cultural and social differences. Intervention is seen as an empowering, collaborative enterprise. Developed by de Shazer and his associates, solution-focused therapy is concerned with change rather than the historical antecedents of family problems. Led by the therapist but directed by the client's goals, dialogue focuses on solutions to be constructed together to reach these goals. The approach capitalises on the concept of "...news of a difference" and its purpose is to engage in a therapeutic conversation with the family that is conducive to solution-building (Lee, 2003:390; Carr, 2000:133; Mills & Sprenkle, 1995: 371).

Dysfunction in a family arises from faulty attempts at problem resolution. Within the therapeutic encounter, attention is given to circumstances where the problem does not occur, and the assumption is that clients know how to solve their problems. The role of the therapist is to help them construct a new use for the knowledge they already have but are not using. De Shazer and Berg (1992:80) describe how meanings are negotiated in the face-to-face encounter with the family, and how in the understanding of these meanings, new solutions are developed. They warn however, that this activity is not a technique – rather it is spontaneous and natural, requiring of the therapist an awareness of the possibilities for change so that a shift in meanings can lead to the development of useful interventions that fit the family and are pragmatically aimed at the family's goal for therapy.

The line between assessment and therapy is not clearly drawn in solution-focused therapy. Assessment, such as it is, may begin with inquiries about the problem, the position of clients with regard to the problem, and view of the role of the therapist with regard to problem resolution. A distinction is made between ‘visitors’ (clients who are sent to therapy at someone else’s request), ‘complainants’ (clients who accept they have a problem but are unwilling to participate), and ‘customers’ (clients who accept they have a problem and want to change). These positions are not fixed and clients may move from one to another over the course of the therapy (Gladding, 2002:247; Carr, 2000:134).

The idea of resistance is based on the view that people have unique ways of cooperating, not all of which conform to the therapist’s expectations. To promote cooperation, tasks must be selected to fit clients’ readiness to change – these may be complimentary (empathic statements), observational (observing exceptions or occurrences of successful coping) or behavioural (doing more of what works or doing something different) (Gladding, 2002:244; Goldenberg & Goldenberg, 1996:313).

Assessment is also relevant regarding **exceptions**, i.e. where/when the problem did not occur, or was less intense, and in articulating goals for problem resolution. **Outcome questions** help clients to envisage life without the presenting problem or with acceptable improvements. The ‘**miracle question**’ is a typical outcome question used to assist clients to visualise a better outcome to their problem. **Scaling questions** can be useful to measure more abstract change, such as feelings and mood. **Relationship questions** ask clients to imagine how significant others in their environment may react to solutions and changes to be made. The use of **skeleton keys** helps families to ‘unlock’ a variety of problems by using strategies that have worked in the past and have universal application. The brevity of the model (usually five to ten sessions) creates the expectation of change – small changes, once initiated, may lead to changes in the system (Lee, 2003:390; Gladding, 2002:245-246; Carr, 2000:133-135; Thompson & Rudolph, 2000:119-126; Goldenberg & Goldenberg, 1996:310-312).

A positive, optimistic and hopeful perspective regarding problem resolution, respect for the client's problem-solving resources and simple therapeutic techniques form the basis of solution-focused therapy. It encourages, challenges and sets up an expectation of change (Gladding, 2002:248). Criticism of the approach centres on it being too simple, too brief and reliant on suggestibility with long-term change being unlikely. Some recent developments indicate a more affective and relational aspect becoming part of solution-focused intervention. Further criticisms include the absence of historical information about the family and an exclusively present focus of concern.

From the perspective of the researcher, this approach lends itself to work with families who may have an alternative worldview to that of the therapist, hence its applicability to postmodern, multicultural intervention. It requires too however, a degree of comfort with the unknown, and with taking a 'bottom up' approach to the development of solutions that suit a particular family, thus making the expert position redundant.

Solution-focused family therapy aims to help the family seek solutions to problems and tap into unused resources and potential. Change involves constructing a different perspective in collaboration with the client family through the use of questions that reinforce small, but specific gains in problem resolution.

#### 2.4.2.6 Narrative therapy

Michael White and David Epston are the originators of the narrative approach to family therapy, influenced by the postmodern movement within anthropology, philosophy, psychology and feminist theory. Narrative counselling uses the story metaphor to understand the meanings people construct about themselves on the basis of their lived experience in the world (Gladding, 2002:252; West & Bubenzer, 2002:355; Monk, Winslade, Crocket & Epston, 1997:85).

Discourse theory is part of the postmodern approach to knowledge whereby 'master' or metanarratives and universalising themes are perceived as constricting. Dominant

discourses are produced through social interaction, language and the socio-economic context (Hare-Mustin, 1994:20). They are familiar, taken for granted and reinforced through assumption of their validity. Subordinate discourses on the other hand, are marginalised and subjugated. Hare-Mustin (1994:21) draws attention to the work of White, which emphasises how power is often invisible to those who experience it and to how people are led to “...embrace their own subjugation through the influence of presumed truths”. This quote and the views of White which follow, have immense resonance for the researcher within the context of family therapy practiced at Family Life Centre. Families are often referred from other organisations and have been ‘labelled’ or diagnosed in various ways, labels which often seem to be accepted by the family without question. People seem to accept ‘expert’ discourses which have the power to create ‘problem’ individual and family identities.

White (in Carr, 2000:137) rejects the traditional concept of individually based problems and the use of the systemic framework which has characterised almost all forms of family therapy. Using the work of Foucault as a frame, White refers to the process of diagnosing clients and the resultant labels which come to constitute their identity as ‘totalizing techniques’. In addition, the keeping of files written in the context of pathological and deficit discourses promote the construction of **global** knowledge which undermines **local** knowledge. Scientific knowledge typically entails the exertion of power or social control over clients, and White questions the ethics of practices that privilege global knowledge and totalizing techniques, resulting in the development of **problem-saturated** identities (Carr, 2000:137). Bertrando (2000:90) states that the discourse of Foucault on power, two decades before the rise of narrative therapy, is completely different from narrative thinking linked to political criticism and power relations, and that one does not have to be a narrative therapist to be concerned with issues of power. If, as Foucault may have put it, power is a network of connecting relationships, rather than the intention of an individual, the very fact of being a therapist and asking questions puts one in a position of power (Bertrando, 2000:91). The researcher would, however, argue that from a dialogical point of view, questions arising

from the therapist are part of the dialogue, and not necessarily a misuse of power in the therapeutic encounter.

Lyddon (2001:581) emphasises the narrative or story as the central organising principle for human understanding from a narrative perspective. Humans create order and meaning through the stories they tell one another. However, many of the narratives people accept are socially determined (dominant) and thus, may constrain individual freedom and self-expression. Morgan (2000:13) believes that certain discourses may give rise to thin conclusions (elucidated below) which may negatively affect peoples' lives. People (and families) become disempowered, and may be labelled dysfunctional or inadequate.

According to White (in Carr, 2000:137), when families are conceptualised as systems with interpersonal problems viewed as serving a particular function (family homeostasis), the goal of therapy is to discern the function of that problem and replace it with a less destructive routine that fulfils the same function. This system analogy entails the view that some families are dysfunctional and require the problem to remain intact for homeostasis. It implies also, that their behaviour is a requirement rather than a personal choice. In contrast, narrative therapy privileges the ability of the individual to choose his or her personal narrative.

When the 'game' analogy is used to understand problematic family interaction, members are seen as using moves and countermoves to win the 'game'. Strategies are used to end the game, with the therapist using deception in the form of paradoxical intervention to bring about this result. Narrative therapy uses an open, collaborative partnership with clients, avoiding the use of deception and power practices (Carr, 2000:138). However, as has been pointed out, power is an inescapable fact of life and efforts to avoid it may serve to drive it underground, where its impact may be more dangerous through being unacknowledged.

Morgan (2000:2) describes narrative therapy as a respectful, non-blaming approach which focuses on people as the experts on their own lives. Narrative therapy does not distinguish between problem and non-problem family development, rather its focus is on problem development. In narrative therapy the person is not the problem, the problem is the problem (Morgan, 2000:2; Monk, *et al.* 1997:26). The technique of externalisation (defined below) to dysfunction in the narrative approach may thus diffuse the argument above that power is an inescapable fact of life. Rather than ignoring the power relations inherent in therapy, narrative therapy rather empowers the therapist and the client over the problem, by labelling the problem as the problem, rather than the client as dysfunctional and thus powerless.

Human problems, from a narrative perspective, arise from and are maintained by oppressive stories which dominate people's lives. These are referred to as **thin descriptions**, which according to Morgan (2000:12) limit complexity and contradiction in life and obscure other possible meanings. To be freed from the influence of limiting discourses it is not enough to re-author an alternative story. The narrative therapist is interested in finding ways in which these stories can be "...richly described..." giving rise to **thick descriptions** (Morgan, 2000:15).

Narrative therapists are interested in discovering, acknowledging and taking apart the beliefs, ideas and practices of the broader social system that may serve to assist the problem story. **Deconstruction** is the crux of narrative family therapy – clients are helped to explore and create different interpretations of their story, and challenge accepted and dominant texts that subjugate their lives (Rivett & Street, 2003:37; Morgan, 2000: 45; Mills & Sprenkle, 1995:371; White, 1991:121).

A central goal of narrative therapy is to help people **re-author** their lives so as to define themselves in non-pathologising and non-problem-saturated ways. This is a collaborative practice, requiring of the therapist a consultative position. **Externalisation** is a technique used to help clients separate themselves from the

problem, viewing it without a sense of blame and failure. The objectification of the problem engages people in externalising conversations, which provide an account of the effect of the problem on their lives. **Unique outcomes** are sought in a search for exceptions to the problem, anything that does not fit with the dominant story.

Contradictions to the problem-saturated story are ever present, varied and many. Sometimes known as **sparkling events**, these exceptions shine or stand out in contrast to the problem story – they are elaborated upon using **landscape-of-action** and **landscape-of-consciousness** questions. The former type's of question address sequences of events, whereas the latter are concerned with the meaning of events. **Landscape-of-identity** questions involve preferences, values, personal qualities, skills and abilities, plans, motives and beliefs. **Experience-of-experience** questions facilitate the re-authoring of lives and relationships – they generate reflection on a person's life and of how another person may experience them (West & Bubbenzer, 2002:366-369; Morgan, 2000:52-60; Carr, 2000:138; Monk, *et al.* 1997:301-306; White, 1991:126-132).

Therapeutic solutions to problems are developed through the authoring of alternative stories, previously marginalised by the dominant narratives, and which fit the client's lived experience and open up possibilities for controlling their own lives. A therapeutic conversation or narrative interaction allows for a description of therapeutic change that transcends dominant themes, and comes to include new experiences, meanings and interactions that loosen the hold of the dominant discourse. Many possible directions can be explored in such a conversation, with none being more 'correct' (Carr, 2000:136; Morgan, 2000:3; Sluzki, 1992:219).

According to Monk *et al.* (1997:24), narrative counselling is not a formula or a recipe. It is a co-creative practice which views the client as having local, expert knowledge. Curiosity safeguards against counsellor 'expertise', opening space for new possibilities and directions. The narrative therapist uses basic relationship skills to enable the family

to tell their story. However, it is not assumed that symptoms serve a function for the family – rather problems are seen as oppressive (Gladding, 2002:255).

Sluzki (1992:220-221) sees each therapeutic encounter as idiosyncratic because the elements of process and content become interwoven with the contributions of all the participants. However, some common themes seem to emerge in narrative consultations - these are as follows: framing the encounter – often implicit and involving seating, opening exchanges and questions by the family and therapist; eliciting the dominant story; favouring alternative stories – exceptions that challenge the dominant story; enhancing the new story and validating it; anchoring the new stories through the use of rituals or tasks designed to confirm the new themes. Sluzki (1992:221) warns however, that this is not a design or blueprint for narrative consultation.

Sluzki (1992:218) poses a number of pertinent questions relating to how clients and therapists generate a number of plausible stories to account for a problem and its cause, and how change may be generated through so many different “...conversational avenues”. He believes the answer lies in one common aspect – an alternative story is co-constructed by the therapist and family around the available cultural themes, thus the problem story loses its dominant hold and is redefined.

Narrative therapists link unique events to the past and extend the narrative into the future to form an alternative and preferred narrative that fits with the self. The use of outsider witnesses (significant members of the client’s social network, others therapists, or even people unknown to the family) aims to consolidate change and witness the new narrative. White uses a reflecting team as a particular type of outsider witness group – the reflecting team is to be explored in Chapter 3. Hoffman (1995:xiii) distinguishes between the narrative approach to reflecting teams and that of Tom Andersen and Anderson and Goolishian. She states that the former is strongly therapist-driven and has an “...activist social frame”. The latter is characterised by a “...purposeful

planlessness...” and is far less intentional. Hoffman believes that this divergence of philosophical background gives the two therapies a totally different feel.

New self-narratives may be documented using literary media, such as letters, certificates and declarations. Finally, clients are encouraged to give back to others suffering from similar oppressive narratives, through the sharing of their new narratives. All of these interventions serve to gain an alternative view of the client’s life history and empower them to engage in behaviour consistent with their new narrative (Morgan, 2000:121; Goldenberg & Goldenberg, 1996:318).

Working with families from a narrative framework would appear to be sensitive to cultural differences, especially in the South African context where dominant discourses have tended to be Western-based, particularly concerning issues around family functioning and mental health. As with other postmodern approaches, comfort with a non-expert role would be a requirement for this type of intervention to feel authentic to the family therapist. However, as previously mentioned, power is implicit in all aspects of life, including human relationships, and hence, therapeutic relationships. It may be that the therapist him/herself is unaware of the insidiousness of dominant discourses that influence his/her beliefs and views relating to certain families or groups of people. In an article critical of the postmodern ‘fashion’, Minuchin (1999:10) states that while he agrees with the importance of listening to and witnessing family narratives, he fails to see how this is sufficient or more significant than other forms of therapeutic intervention. Bertrando (2000:97-98) suggests that while stories are useful in understanding the experiences of the individual, the context of the family interaction is on a separate level – each family member’s story is their personal experience. Narrative and postmodern thinking points to the political macro-context, but overlooks the micro-context in which the family is embedded.

Narrative therapy is social constructionist in its premises, using literary metaphors of stories and writing. The emphasis is on a collaborative relationship with families, used to co-create new narratives and thus, new realities.

Although not included in the above classification of family therapy approaches, the researcher feels compelled to include a discussion on postmodern feminist theory in order to enhance awareness of how dominant ideologies may influence the therapy session. Included too, is an overview of existential family therapy using the concepts of Viktor Frankl. This family therapy approach is directed toward facilitation of a family search for meaning. Without wishing to ‘tamper’ with the classification system of Carr (2000) used to structure the presentation of the theories discussed in this thesis, the researcher believes that the addition of these two approaches may enrich the exploration of family therapy theory based on belief systems.

#### 2.4.2.7 A postmodern feminist approach

Feminist family therapy emerged from the growth of the women’s movement and the growing belief that the subordinate role of women in patriarchal societies is perpetuated in traditional family therapy contexts, which normalise roles and behaviour according to beliefs about gender (Goldenberg & Goldenberg, 2000:46; 1996: 322).

According to Hare-Mustin (1994:21), postmodern feminists have focused on the way dominant discourses produce and sustain power against subordinate discourses of marginalised sectors of society, such as women, minorities, old and poor people. Discourse about women’s participation in public and political life is systematically trivialised, subsumed or ignored. However, feminist efforts have brought some marginalised issues into public awareness, for example, the abuse of women and children. Hare-Mustin (1994:21) believes one way to assess the relative dominance or subordination of a discourse is to question what institutions and ways of being are supported by the discourse. She believes too, that both men and women participate in perpetuating dominant discourses, including those on gender. Through recurring, day-to-day practices and meanings, the discourses of gender differences and patriarchy are maintained and perpetuated in society.

Hare-Mustin (1994:24) goes on to describe how many discourses converge and interact to create familiar narratives, and that they co-exist to define what is expected of men and women by each other, and produce male/female identities. These identities become part of the individual's 'nature' and may constrict and compel their choices and behaviour. According to Goldenberg and Goldenberg (1996:320) and Kjos (2002:161), feminists view traditional approaches to family therapy as patriarchal and sexist, reflecting the context and times of their origins, but at the same time endorsing 'male' characteristics (e.g. logic, rationality, independence) while denigrating 'female' characteristics (e.g. nurturing, interdependence). These assumptions influence beliefs about desired family functioning and family roles. Feminism has challenged family therapy to address issues of power, patriarchy and inequality. While the researcher concurs with this challenge, awareness of one's own position regarding family roles and functioning is essential – the imposition of one's own values and beliefs upon a client family is both inappropriate and unethical. However, enabling the family to explore their own beliefs and the antecedents of these may give rise to new perspectives in keeping with the values of the client family.

Goldner and Luepnitz (in Goldenberg & Goldenberg, 1996:320) explore the unacknowledged "...sexual politics..." inherent in family therapy theory and practice, as well as the systemic view of participants in a system, which implies an equality of power that fails to take into account the larger socio-economic, political and cultural context of unequal status. Hare-Mustin (in Reimers & Treacher, 1995:192) articulates some differences between the "...alpha prejudice..." of some psychotherapies such as psychoanalysis which makes rigid distinctions between men and women, and the "...beta-prejudice..." of systemic theories which overlook gender differences and view all members of a system as similar and equal, and ignore the disadvantaged position of women and children.

According to Hare-Mustin (in Goldenberg & Goldenberg, 1996:320), ignoring differences between men and women in gender-role socialisation and in the power differential serves to reinforce the status quo and perpetuate the subjugation of women.

In the context of family therapy, if the therapist and family are unaware of subordinate discourses these will remain outside the room, and hence be unacknowledged and unexplored. If therapists see meaning as created in the therapeutic conversation but disregard the meanings associated with the social context of the individual's life, people come to be viewed as equal despite their position in the social hierarchy. Participants in therapy have differing authority in the family – inequalities influence the therapeutic conversation, i.e. who is allowed to speak, when and about what. Obviously this applies to the therapist too, if he/she is accorded greater authority.

The conversation in the session comes from the prevailing ideologies in the language community – it is this construction of reality that determines the therapeutic conversation. Conversation can be oppressive in what it excludes, and the therapeutic conversation can replicate limiting views of gender, race, age, etc. (Kjos, 2002:162; Hare-Mustin, 1994:23-33). When therapists are unaware of the pervasiveness of their views it is unlikely that they will open up alternatives for the family to consider. The development of self-reflexivity is a significant way to escape the subconscious ideologies that permeate our thinking and influence what we 'know'. Madigan (in Goldenberg & Goldenberg, 1996:321) states that it is essential that therapists be aware not only of their own values and beliefs, but remain sensitive to what values their actions reinforce in others.

Reimers and Treacher (1995:194) cite Walters, Carter, Papp and Silverstein who presented a number of guidelines to help feminist family therapists keep track of the issues that require exploration in therapy. These are:

- Identification of the gender message and social constructs that govern behaviour and sex roles.
- Recognition of the real limitations of female access to social and economic resources.
- An awareness of sexist thinking that constricts the choices of women to direct their own lives.

- Acknowledgement that women have been socialised to assume primary responsibility for family relationships.
- Recognition of the dilemmas and conflicts of childbearing and childrearing in society.
- Awareness of patterns that split the women in families as they seek to acquire power through relationships with men.
- Affirmation of values and behaviours characteristic of women, such as nurturing, connectedness, and emotionality.
- Recognition and support for possibilities for women outside of marriage and family.
- Recognition of the basic principle that no intervention is gender free and that every intervention will have a different meaning for each person.

Reimers and Treacher (1995:195) explore the work of Perelberg and Miller which contains examples of how gender issues can be used in therapy without clients feeling that issues crucial to the therapist are marginal to themselves. Reimers and Treacher (1995:195) further suggest that there is often a clash of perspectives between clients and therapists, which can undermine the success of therapy, but that there is also often a clash between male and female clients themselves. Expanding the therapeutic conversation to include wider gender issues may resolve such a difficulty. Again, self-awareness on the part of the therapist is essential – consideration of the need to push one’s own views and agenda onto clients who may have a far narrower focus of concern is a dilemma which may need to be shared with the family. The researcher has witnessed a number of times, the seeming meaninglessness of gender issues for families, issues which the primary therapist or reflecting team raised at some point. Perhaps this illustrates the pervasiveness of patriarchal discourse.

According to Dallos and Urry (1999:177), feminist practitioners have contributed a major form of therapy which focuses on the individual, the relationship and the wider social context. These authors describe three central principles in the growth and development of feminist practice: a commitment to equality within therapy; a commitment to bringing the social context into therapy; a commitment to power

redistribution within society and equality between the sexes. To the researcher these principles are an important consideration regardless of whether one is practicing from a feminist perspective or any other.

Feminist family therapy forms the basis of gender-sensitive therapy, which emphasises egalitarian relationships with clients that promotes respect and collaboration, and a role that eschews manipulation and objective expertise. According to Goldenberg and Goldenberg (1996:319), feminist approaches differ from postmodernism in their belief that cultural and gender stereotypes dominate the belief systems of the family. Feminist and gender-sensitive therapies are distinguished in that the latter emphasise depth of understanding of both males and females, integrating gender-role stereotypical issues in the therapeutic encounter.

Postmodern thinking regards knowledge as partial and challenges the dominant discourses that marginalise alternative ways of thinking and behaving. A postmodern orientation proposes that all realities are constructions, some more influential than others. Feminist family therapy offers a viewpoint that encompasses recognition of women's subordination, the forces that maintain it, and a commitment to change that values equality between the sexes (Goldenberg & Goldenberg, 1996:321; Hoffman, 1990:7).

#### 2.4.2.8 Existential family therapy

The work of Viktor Frankl, referred to as logotherapy, is directed toward helping people find meaning in their existence as human beings (Lantz, 1993:3). Based on his experiences as a prisoner in various concentration camps during World War II, Frankl developed his ideas about human behaviour which received wide acceptance. However, according to Lantz (1993:4) little has been published about family application of his ideas and concepts.

The basis of **logotherapy** is that meaning exists in all circumstances, life is unconditionally meaningful, and that the desire to find meaning in human existence is the primary motivation for most human and family behaviour. Life never loses its meaning, although meaning may be lost and regained (Durston, 2005a; Lantz, 1993:4). Failure to find meaning results in an **existential vacuum** which is filled in one of two ways – either by developing a sense of meaning, or by psychological or existential symptoms of depression, anxiety, despair, confusion and the experience of anomie (meaninglessness). The primary goal of logotherapy is to assist the client to find meaning in life, which fills the existential vacuum and limits the opportunity for the development of symptoms (Frankl in Lantz, 1993:4). According to Durston (2005a), logotherapy is not only a therapy but a lifestyle, in that it has a dual value, both for the period of crisis, and to serve as a strategy for a meaning filled life. It stems from a position of optimism, as we begin to understand that a life entire brings many unique opportunities.

Frankl (in Lantz, 1993:5; Durston, 2005a) discusses three aspects to meaning: the meaning of life; the will to meaning; and the freedom to will. The view that life has meaning differs from that of other existential thinkers who believe that life itself does not have meaning, but that human beings can decide to behave as if it does. Frankl on the other hand, argues that life itself has meaning, which is discovered in many ways that are unique to each individual. The spiritual part of the self can transcend biology, environment and the influence of past experiences.

Human beings face three existential problems, referred to as the **tragic triad**. These universal issues are: death, suffering, and guilt (Durston, 2005a; Lantz, 1993:5). The elements of the triad are catalysts that have the potential to evoke a meaningful response and reaction. According to Durston (2005a), society seldom allows people to find meaning in existential problems, inclining more towards pity, helplessness and “...disabling compassion...”. Frankl (in Durston, 2005a) believed that the only way to find meaning in response to the existential problems is to act as if each day is our last,

and to view the transitory nature of life as something to be treasured, rather than something to be lost.

Logotherapy does not attempt to promise a life of pleasure and happiness, but rather is a lens to look at life in a new way (Durston, 2005a). Meaning in pain and loss is found by seeing that it requires a new attitude to living – one's attitude to life determines the meaning we invest in it. In the opinion of the researcher, this view resonates with a constructivist paradigm, whereby beliefs are constructed in the mind of the person and thus meaning is made.

According to Frankl (in Lantz, 1995:5-6; Durston, 2005a), there are three categories of values that can help people find meaning in life and to the existential problems in life. These are: creative values, experiential values, and attitudinal values. Creative values involve meaning in what we create through our work, commitment to a cause, and so on, and according to Durston (2005a) are aligned to the spiritual dimension of human beings. Experiential values are meanings found in our experience of nature, art and relationships. Attitudinal values develop in response to the meaning we find in tragic situations. Durston (2005a) speaks of a distinction between finding meaning **in** suffering, as opposed to insight derived from the wisdom of hindsight. The latter, he believes does not involve spiritual transcendence while in the midst of suffering.

Frankl (in Lantz, 1993:6) distinguishes between three dimensions of human existence: the physical, the psychosocial, and the spiritual. All three dimensions are relevant in understanding human beings, but the spiritual aspect frees us to think about the self and make changes to that self and to the environment. Tension is part of human existence and according to Frankl (in Lantz, 1993:7) equilibrium does not result in mental health but in a loss of meaning. Happiness is a by-product of a meaningful life, and to achieve happiness it is necessary to replace a search for this elusive state with a search for meaning. In other words, the search or goal is for the discovery of meaning rather than happiness, but happiness may be achieved through finding meaning in suffering and in life.

Lantz (1993:22) states that meaning and family interaction have a close and reciprocal relationship. The search for meaning can stimulate family interaction, which in turn stimulates increased awareness of meaning within the family. A lack of awareness of meaning or failure to discover, recognise and accept meaning, may result in dysfunctional interaction which further obscures awareness of family meanings.

Intervention with families is directed at the facilitation of the family's search for meaning. In direct form, intervention focuses on the family's ability to discover meaning in their shared history and family existence. This involves taking a **family life chronology** with emphasis on the meaning connections that family members may make about their unique history. Visual methods such as the family photo album may be helpful for family members to make connections. The **Socratic dialogue** involves facilitating communication in a way that helps the family to become more aware of their spiritual dimension, their strengths, values, hopes and achievements – it is the search for meaning in the ordinary events of life (Durstun, 2005; Lantz, 1993:27). According to Lantz (1993:15), the Socratic dialogue is a technique used in both the Milan school and Franklian family intervention. The similarity lies in the use of questions designed to introduce new information into the family system – the difference with the Franklian approach is a focus on helping family members make meaning connections that stimulate awareness of the unconscious.

The indirect approach is used to help the family change dysfunctional interactional patterns that obscure the awareness of meaning. Compatible with the methods of Satir's communication methods and Minuchin's structural methods, Franklian family intervention involves reflection upon family patterns, reflection upon one's internal response to family patterns, and techniques such as de-reflection, paradoxical intention and provocative comments (Lantz, 1993:28-29; Durstun, 2005b). Direct and open reflection by the family therapist about family patterns may develop awareness and insight into how family members inhibit the family's search for meaning. With regard to therapist reflection on internal responses to family patterns, Lantz (1993:33) cites Yalom who refers to "...existential countertransference..." which can be used to help

both therapist and family discover meaning. This form of reflection allows for the occurrence of involvement and meaning in the emotional life of the family, enabling the internal state of the therapist to become relevant in the therapeutic relationship, and facilitating the quest for growth of both the therapist and the family.

**De-reflection** entails the therapist helping the family to turn their attention to subjects other than the problem area. It challenges family patterns that are a reaction to hyper-reflection which inhibits the search for meaning (Lantz, 1993:35; Durston, 2005b). Hyper-reflection refers to excessive attention given to fears, symptoms or behaviour, which inhibits functioning. De-reflection redirects the family to other meaningful aspects of life. **Paradoxical intention** is designed to break vicious cycles that have developed in response to anxiety. In logotherapy, this technique is not used in a strategic or indirect way, but openly, to facilitate insight into cycles of anticipatory anxiety. According to Lantz (1993:35), used openly, paradoxical intention challenges reductionism and engages the family in accepting responsibility for change. **Provocative comments** may be useful to stimulate change in family interaction that helps the family to discover unique meanings as they occur in their interaction (Lantz, 1993:36). Such comments are only useful when they stem from a position of care, concern and respect, and can be destructive when used to express the therapist's hostility or to manipulate the family. In the opinion of the researcher, the use of such a technique requires considerable self-awareness and reflexivity on the part of the therapist.

Durston (2005b) stresses that meaning may not emerge immediately for the family, requiring a position of faith and acceptance of the process by the therapist. Meaning can at best be facilitated and described, but must "...unfold and be embraced by the conscience of the recipient". It is not the responsibility of the therapist to prescribe meaning.

Logotherapy in a family therapy context is an approach to helping the family in the search for meaning, based on the belief that this represents the most important human

activity. The researcher is of the opinion that this form of family therapy is one that would be very personal, requiring authenticity and meaningfulness on the part of the family therapist, and is more a way of being than an approach to be used to facilitate family change.

The strength of the approaches described above lies in the importance placed on a multitude of perspectives, with many creative techniques used to explore possibilities for change. A criticism of these views is the paradoxical view that the fundamental truth is that there is no truth, and the abandonment of systemic and cybernetic theory leaves little in the way of a framework for practice. Eron and Lund (1993:292) state that postmodern approaches have come under scrutiny for being “...soft on therapeutic direction and therapist responsibility” and vague with regard to what works to bring therapeutic change. Empirical evidence of effectiveness is still to be sought. As mentioned by many authors in chapter 1, as well as an opinion held by the researcher, an integration of the insights and practices from the various approaches may prove valuable, as no one approach has all the answers to therapeutic change.

The approaches to family therapy described in this section all focus predominantly on belief systems that form the bases of problematic interaction patterns. Constructivist, social constructionist, solution-focused and narrative theories all involve gaining new insight into problems in order to resolve them. They share common ground with cognitive-behavioural approaches to therapy insofar as they explore problem-maintaining belief systems. The original Milan school also aims at disrupting problem-maintaining interaction patterns and belief systems. Solution-focused and narrative approaches privilege the importance of exploring exceptions to problems, and of solutions over and above problems. Treatment tends to be brief, and personal growth is not a major focus. Feminist and gender-sensitive family therapy attempt to transcend the sex-role stereotypes that constrict peoples’ functioning and impact on family relationships. Logotherapy is directed towards the facilitation of a family search for meaning.

In the next section, approaches that focus on historical, contextual and constitutional factors that predispose family members to the development of problems and maintain problem behaviour will be explored.

### 2.4.3 Theories that focus on Context

The previous sections focused on theories that are categorised in terms of their focus on behaviour patterns and belief systems. In this section the theories to be explored highlight the role of historical, contextual and constitutional factors in family dynamics. Approaches that fall into this category are: transgenerational family therapy; psychoanalytic family therapy; attachment based theories; experiential family therapy; and, psychoeducational family therapy.

#### 2.4.3.1 Transgenerational family therapy

The basic premise of transgenerational family therapy is that the family-of-origin influences relationships and predisposes family members to develop current life problems in the family-of-procreation. Bowen and Boszormenyi-Nagy are key figures in the development of this approach, which is based on the belief that family problems are multigenerational phenomena resulting from patterns being replicated from one generation to the next (Carr, 2000:159; Hanna & Brown, 1999:15; Goldenberg & Goldenberg, 1996:165).

Bowen's theoretical contributions can be viewed as a bridge between psychodynamically orientated views that focus on self development, the significance of the past and intergenerational issues, and systems approaches that focus on current interaction patterns. The emphasis is on family anxiety and family emotional systems, extending over several generations. Family anxiety occurs under perceived threat, and families engage in recursive, emotionally problematic patterns of interaction. The degree of anxiety in the family determines the degree to which family members become differentiated (Geurin & Geurin, 2002:130; Carr, 2000:159).

According to Bowen, eight forces shape family functioning: differentiation of self; triangles; nuclear family emotional system; family projection process; emotional cutoff; multigenerational transmission process; sibling position; and societal regression (Gladding, 2002:128; Goldenberg & Goldenberg, 1996:169).

Highly anxious families are characterised by an **undifferentiated ego mass** – they are enmeshed or fused with extremely emotionally close relationships. In contrast, families with lower anxiety evidence a higher degree of differentiation and autonomy. Undifferentiated people deal with their families in one of two extremes: **cut-off**, whereby there is an attempt to keep distant and deal with family tension through having as little contact as possible; and **fusion or enmeshment**, which prevents a differentiated self from emerging. The degree to which differentiation of the self occurs reflects the extent to which each person is able to distinguish between the intellectual process and the feeling process being experienced. Thus a **differentiated self** can avoid his or her behaviour being unconsciously driven by emotion through a balance of feeling and cognition (Gladding, 2002:128; Goldenberg & Goldenberg, 1996:169-170).

Bowen sees the basic building block of the family's emotional system as the **triangle** (Gladding, 2002:130; Goldenberg & Goldenberg, 1996:173). When a certain level of anxiety is reached, a dyad (two person system) will involve a third person to dilute the anxiety – the triangle has a higher tolerance for dealing with stress. Generally the greater the degree of family fusion, the more intense are efforts to triangulate, with the least well differentiated person in the family particularly vulnerable to being drawn in to reduce the tension. However, triangulation does not always diffuse tension, and anxiety may even be heightened.

Transgenerational theory posits that people choose a partner with equivalent levels of differentiation to their own (Gladding, 2002:129; Goldenberg & Goldenberg, 1996:174). Two relatively undifferentiated partners i.e. a marital dyad, will probably recreate a family with the same characteristics and dynamics – the resultant **nuclear family emotional system** will be unstable and seek various ways to reduce anxiety.

Three possible symptomatic patterns may be the outcome of intense fusion between partners: physical or emotional dysfunction in a spouse, possibly becoming chronic, as an alternative to dealing with family conflict; overt, chronic marital discord with cycles of emotional distance and closeness of equal intensity, with anxiety being absorbed by the spouses; psychological impairment of a child who becomes the focal point of the family problem, and who absorbs family anxiety, becoming vulnerable to dysfunction. In addition, dysfunction in one spouse may take the form of **over-adequate** or **under-adequate reciprocity**, wherein one partner takes on most or all family responsibility while the other increasingly underfunctions (Goldenberg & Goldenberg, 1996:175).

The nuclear family emotional system is multigenerational with styles of relating learned in the family-of-origin and being passed along to offspring. According to Bowen (in Goldenberg & Goldenberg, 1996:175), the resolution to current problems lies in change in the individual's interactions with the families of origin, resulting in higher differentiation and less reactivity to emotional processes in the family.

The **family projection process** operates when parents, in their differential behaviour towards each child, focus on the most 'infantile' child (regardless of birth order) to project their own low level of differentiation onto. The child becomes triangulated into the parental relationship. The greater the level of parental undifferentiation the more likely they are to rely on the projection process to stabilise the system (Goldenberg & Goldenberg, 1996:176).

Children less involved in the projection process may have a greater ability to withstand fusion, to separate thinking and feeling – those more involved may try various strategies to insulate themselves from the family, either through geographical separation, the use of psychological barriers, or through **emotional cutoff**. This is viewed as a 'flight' from emotional ties rather than true 'emancipation'. Cutoffs tend to occur where there is a high level of emotional dependence and anxiety, with some members seeking distance in an act of self-preservation. According to Bowen (in Goldenberg & Goldenberg, 1996:178), it is imperative that therapists resolve their own

issues of differentiation to avoid being triangulated into conflicts with client families, and to ensure that their own unresolved issues are not played out in the family therapy arena.

Transgenerational family therapy views all generations as part of a continuous natural process. The concept of **multigenerational transmission process** is viewed as the outcome of the family's emotional system over several generations. The two concepts of selection of spouse with a similar level of differentiation and family projection process are relevant here.

**Sibling position** is viewed as significant by Bowen, who hypothesises that the more closely a marriage duplicates one's sibling position, the better will be its chance of success. Birth order frequently predicts certain roles and functions within the family emotional system, although often a person's functional position in the family system determines behaviour and expectations (Goldenberg & Goldenberg, 1996:178).

The final concept of Bowen's theory is **societal regression**, wherein society's emotional functioning mirrors the family with opposing forces of undifferentiation and individuation. An anxious social climate pushes society closer with concomitant erosion of differentiation and hence difficulty in the balance between emotion and intellect (Gladding, 2002:130; Goldenberg & Goldenberg, 1996:179).

Transgenerational family therapy occurs in stages with an initial assessment of the family's emotional system, past and present. The therapist must remain separate from the family's emotional system, not fusing with it or being triangulated into their conflict. Objectivity and neutrality, rather than emotional reactivity is the role to strive for. Family therapy is seen as a way of conceptualising a problem rather than a process requiring a certain number of family members to be present. Work with an individual family member towards a higher level of differentiation is not uncommon, based on the premise that if one person can increase their level of differentiation the functioning of the whole family may improve.

Evaluation begins with a history of the problem, emotional functioning, anxiety levels at different stages of the life cycle, and degree of stress. The genogram is a graphic portrayal of multigenerational family patterns and is a crucial technique in transgenerational family therapy, often providing families with their first inkling of intergenerational family patterns. Two goals are the focus of therapy: a reduction of anxiety and relief from symptoms; and an increase in each participant's level of differentiation. Bowen himself often worked with the parents, even when the identified patient was the child, based on the premise that the problem lies with them and their level of differentiation. Family members talk to the therapist rather than directly to one another – confrontation is avoided to reduce the emotional reactivity between them. The paradox of this form of family therapy is that by **not** focusing on relationships but on autonomy and differentiation, family relationships are enhanced (Carr, 2000:159-161; Thompson & Rudolph, 2000:314-319; Worden, 1999:17-18; Goldenberg & Goldenberg, 1996:168-184).

According to Gladding (2002:133), the differentiation of the therapist from his/her own family-of-origin is crucial in transgenerational family therapy. Objectivity and neutrality are seen as significant characteristics for the therapist to display - the therapeutic focus is systemic and the practice cognitive in nature. From the experience of the researcher, objectivity and neutrality are a challenge in the complex arena that is family therapy. Family therapy seems to evoke a multitude of opinions, beliefs, ideas and resonances for practitioners. Perhaps if one is working with an individual member rather than the whole family such neutrality and objectivity may be more achievable. In addition, the researcher wonders whether objectivity and neutrality can coincide with authenticity, echoing Bowen's own sentiments that this would require a high degree of self-differentiation from the therapist.

Criticism of the approach centres on it being focused on the past rather than on the present circumstances of the family; promoting insight before action; and the view that the number of people who can benefit from this approach may be limited (Gladding, 2002:135).

In conclusion, transgenerational family therapy is based on the assumption that relationships and events from the family-of-origin predispose people to developing problems in their current lives. Family problems are viewed as multigenerational phenomena where patterns of interaction are repeated from one generation to the next.

#### 2.4.3.2 Psychoanalytic family therapy

According to Goldenberg and Goldenberg (1996:110), psychoanalytic theory, despite its seeming emphasis on the individual, is grounded in the interaction within the family. Many of the pioneers of family therapy, such as Ackerman, Bowen, Minuchin and Boszormenyi-Nagy were psychoanalytically trained, and a focus on systemic thinking has not necessarily replaced the idea of individual pathology being linked to childhood developmental conflict. The classical psychoanalytic view of Freud has been succeeded by a briefer, more flexible procedure and methodology. A more balanced view that recognises the family as a system, as well as the unique experiences of the individual, has resulted in frameworks that attempt to integrate systemic and psychoanalytic concepts. One such framework is object-relations theory, developed from Ronald Fairburn's theory and the work of Klein, Winnicott, Dicks and later, Scharff (Gladding, 2002:119; Carr, 2000:163; Goldenberg & Goldenberg, 1996:111).

Object-relations theory evolved from the study of early mother-child relationships with attention drawn to the persistent impact of those experiences on later adult functioning. This is in contrast to Freud's intra-psychic, drive-orientated theory which suggests that the infant's struggle is to resolve sexual and aggressive impulses aimed at acquiring gratification from a parent (Scharff & Scharff, 2002:253; Goldenberg & Goldenberg, 1996:118). The focus of object-relations theory is on internalised 'objects' that are mental images of other people built up from experiences and expectations. The belief is that we relate to people based on the expectations formed by early experiences, and which unconsciously influence our lives in powerful ways. The infant uses the defence mechanism of **splitting** - this involves viewing the mother as two separate people, the good object who satisfies their needs, and the bad object who frustrates them. Splitting

allows the child to protect the good object from the threat of annihilation by directing anger at the bad object.

According to object-relations marital and family theory, romantic partners use **projective identification** to project onto each other an image of what they unconsciously cannot accept in themselves, rather than responding to the reality of who their partner is – the partner is manipulated to behave in accordance with this projection. As the relationship matures and exceptions to these projections become apparent, the projection process is gradually replaced with more accurate perceptions. In problematic relationships partners either conform completely to the demands of their partner's projections, or do not conform sufficiently. Either option leads to disappointment and conflict but the couple remain bound together because the projection process allows them to view the 'self' as all good and the partner as all bad.

Symptomatic behaviour in a child may be a means of deflecting attention from marital conflict (Goldenberg & Goldenberg, 1996:122). Identification of this role as 'patient' detriangulates the child from the marital dyad and the therapist may continue to work with the couple to maintain the integrity of the marital unit. Framo (in Goldenberg & Goldenberg, 2000:129; 1996:123) argues that intrapsychic conflicts stemming from the family-of-origin are repeated, defended against, lived or mastered in relationship to one's partner, children and other significant people. This view is reiterated in Carr (2000:164) wherein it is stated that unconscious intrapsychic problems impact on the marital relationship, as well as being passed along to children who will perpetuate similar problems in their own marriage. Family-of-origin therapy consists of involving each partner, individually in sessions with the family-of-origin in order to work out past or current problems with a therapist. The goal is to explore issues impacting on the current family and to provide a corrective experience with parents and siblings. It may serve to have a restorative function, reconnecting family members and healing rifts.

According to Goldenberg and Goldenberg (2000:132; 1996:125), the family therapy approach most faithful to object-relations theory comes from the collaboration of David

Scharff and Jill Scharff. Unlike individual psychoanalysis, the focus is on the family as a system of relationships that function to support or obstruct the progress of the family and its separate members, through the stages of the life cycle. The family is viewed as an interpersonal, cybernetic system that has difficulty negotiating a developmental transition, and family problems represent manifestations of family system disturbance. Where this view differs from other family therapy approaches is the belief that change in the individual can induce change in the family (Goldenberg & Goldenberg, 1996:126). This view is shared by Bowen who suggests that the achievement of a higher level of differentiation of self on the part of one member from the family-of-origin, may facilitate change in the family.

Interpretation by the therapist, in an attempt to provide insight, is essential, and the therapist adopts a neutral stance, based on the belief that he/she can move outside the family system and observe what is happening in the family and in the self of the therapist. A nurturing therapeutic climate is created to allow family members to reclaim lost parts of the family and of the individual self. Assessment involves exploring the family's shared object relations, the stage of psychosexual development, and the use of various defence mechanisms. Intervention aims at working through interaction patterns and unconscious defensive projective identifications. Treatment is viewed as successful if increased insight or self-understanding is enhanced, with improved capacity to manage developmental stress (Goldenberg & Goldenberg, 1996:127). Gladding (2002:124) believes that psychodynamically-based approaches emphasise linear, cause-and-effect interactions, in contrast to most family therapies, are expensive in terms of time and financial commitments, and require above-average intellectual ability from participants.

The psychodynamic tradition today is largely based on object-relations theory which focuses on the infant's primary need for attachment to a caring person and the analysis of those internalised psychic representations or objects that continue to be a need for satisfaction in adult relationships.

### 2.4.3.3 Attachment-based therapies

John Bowlby was the originator of attachment theory, which attempts to explain the development of significant family relationships and relationship problems from the early bonds between children and their caregivers (Carr, 2000:165; Donley, 1993:4).

Bowlby suggests that attachment behaviour, essential for survival of the species, begins around 6 months of age and lasts until approximately 3 years of age. When a child is faced with danger, he or she will seek closeness with the primary caregiver, before returning to exploring the environment once comforted. The pattern is repeated each time the child perceives a threat and over time he or she will build an internal working model of attachment relationships based on the way in which these episodes are managed by the caregiver. This internal working model is a cognitive map or template based on early attachment experiences, and which presents itself in adult intimate relationships. Four categories of parent-child attachment are identified, the styles of which show continuity over the individual lifecycle, and hence have implications for significant adult relationships (Carr, 2000:166-167). The four attachment styles are:

- **Secure attachment:**

Securely attached children and marital partners react to the parents or partners as if they are a secure base from which to explore the world. Parents and partners in such relationships are in tune and responsive to the child's or partner's needs. Family relationships are adaptable and flexibly connected, and family members are autonomous. The styles described below are all based on insecure attachment.

- **Anxious attachment:**

The anxiously attached child seeks contact with the caregiver following separation but is unable to derive comfort from it – he or she may cling, cry or throw tantrums. Marital partners of this style tend to be overly close but dissatisfied. Family relationships characterised by anxious attachment tend to be enmeshed with blurred boundaries.

- **Avoidant attachment:**

The avoidantly attached child may avoid contact with the caregiver following separation. Marital partners with avoidant attachment tend to be distant and dissatisfied, while families tend to be disengaged with impermeable, rigid boundaries.

- **Disorganised attachment:**

Children with a disorganised attachment style show characteristics of both anxious and avoidant patterns following separation. This style of attachment is correlated with child abuse, child neglect and early parental absence, loss or bereavement. Marital and family relationships are characterised by approach-avoidance conflict, disorientation and alternate clinging and sulking.

Emotionally-focused couple's therapy, the work of Greenberg and Johnson, assumes that marital conflict arises when partners are unable to meet each other's attachment needs for security, safety and satisfaction. Initially this failure to meet each other's attachment needs arouses emotional responses of disappointment, fear, sadness and vulnerability which remain unexpressed. This results in frustration which leads to secondary emotional responses such as anger, hostility, or the desire to induce guilt or get revenge. Behaviour becomes focused on an attack-withdrawal (or pursuer-distancer) pattern which may evolve into attack-attack or withdraw-withdraw patterns. These attempts to elicit caregiving from the partner are based on insecure attachment styles which elicit behaviour that ensures that their attachment needs will inevitably be frustrated. Therapy aims to enable the couples to find ways to meet each other's attachment needs and develop a secure attachment style (Carr, 2000:168).

According to Donley (1993:10), in order to understand the complexity of attachment, one must focus on the 'emotional field' of the entire family. The emotional field refers to the complex emotional stimuli that exist among family members who are in a dynamic process of interaction. Donley believes that the emotional field of the nuclear family emerges from the emotional field of the parents. Included are relationships with the family-of-origin, this view thus sharing a theoretical similarity with

transgenerational family theory. The balance between individuality and togetherness is reflected not only in the couples' relationship but also in the overall emotional involvement with the children.

The work of John Byng-Hall, who trained with Bowlby, proposes a model of family therapy based on attachment theory and script theory. He suggests that predictable rules, roles and routines governing family life are guided by family scripts, learned in repeated interactions in the family-of-origin. These interactions occur in a context, entail a specific plot and involve roles and motives for participants. **Scripts** may be **replicative** (repeating interactions from the family-of-origin in the current family); **corrective** (scenarios which are played out opposite from the way they occurred in similar contexts in the family-of-origin); and **improvised** (scenarios are created that differ significantly from those which occurred in similar contexts in the family-of-origin) (Carr, 2000:169).

According to this theory, family scripts may be inadequate and improvised scripts may be required to manage family lifecycle transitions, stress and so on. A secure family base, allowing for exploration and experimentation is necessary for the effective creation of an improvised script. The role of the therapist is to provide a secure base and containment for family affect so that a new script can be devised. Techniques from structural family therapy may be used to help families explore rules, roles, etc. and explore new possibilities. At the same time this may evoke anxiety in the family and the therapist must avoid being recruited into the family roles, perhaps using live supervision to track the process and reflections on their experience of attempts at recruitment. This approach explores the impact of historical family scripts and attachment styles that impact on family functioning. The aim is the development of secure family attachment that may enhance improvised scripts and thus problem-solving – a further goal may be increased awareness of family interaction patterns (Carr, 2000:170).

As with the contextual theories discussed above, it would appear that a family therapy practitioner favouring this type of approach would need to be comfortable with the position of expert in the therapeutic encounter, as well as have a firm belief in his/her ability to remain outside of the system as a neutral observer.

Attachment based theories focus on the impact of early attachment to a caregiver as a feature of marital and family dysfunction. A secure attachment style enhances adaptive family functioning, while insecure attachment styles predispose families and couples to developing problematic belief systems and behaviour patterns.

#### 2.4.3.4 Experiential family therapy

The focus of experiential family therapy is on highlighting the role of experiential obstacles to personal growth that predispose people to developing problems and problem-maintaining behaviour patterns. Of significance to this approach is affect, or emotion. Experiential family therapy draws from the person-centred approach of Carl Rogers, Gestalt therapy (Fritz Perls), and psychodrama (Moreno), as well as ideas from personal growth movements. Experience, intuition, process, growth, spontaneity and the here-and-now are concepts relevant to experiential family therapists. Therapeutic change occurs in growth experience and not merely in intellectual reflection and insight into the origin of problems. Therapeutic interventions are tailored to the specific and unique needs of the family and psychotherapy must be an interpersonal encounter between therapist and client that is genuine, the aim being to enhance sensitivity, the expression of feelings and personal authenticity. Significant figures in experiential family therapy include Virginia Satir and Carl Whittaker, to be discussed in more depth below (Gladding, 2002:146; Carr, 2000:170; Hanna & Brown, 1999:18; Goldenberg & Goldenberg, 1996:135).

A humanistic orientation guides experiential family therapy, the basic premise of which is the drive to self-actualisation, given that the social and familial environment is adequate. Within this framework, it is presumed that the healthy family is able to cope

with stress, acknowledge personal differences and differing needs, communicate clearly and resolve problems. Problems occur when family members are subjected to rigid, punitive rules, roles and routines that result in a distortion or denial of their experiences in order to be accepted by the family. Such denied or distorted experiences lead to an incongruity between the self and experience. Incongruity within the individual, a result of the prohibitions and injunctions internalised from the family-of-origin, is played out in the marital and parental relationships. Denial of strong emotion such as anger may be projected onto one child who becomes scapegoated and labelled ‘mad, sad or bad’ (Carr, 2000:171). Gladding (2002:149) describes the underlying premise of the experiential approach as a lack of awareness of emotion, or suppression of emotion, thus creating a climate of **emotional deadness**.

According to Satir (in Thompson & Rudolph, 2000:339), all families may be divided into two types: nurturing and troubled. Nurturing families assist members to develop self-worth, whereas troubled families diminish these feelings. In addition, the nurturing family is characterised by a number of attributes: effective listening; a lack of fear; friendliness; openness; affection; real communication about feelings; freedom to express feelings; parents being able to own both good and bad judgment; parents being able to correct children in ways that do not devalue the child. Troubled families on the other hand, would tend to display attributes opposite to those of the nurturing families.

The experiential family therapist believes that unresolved issues from childhood must be resolved in adulthood if self-actualisation is to occur. Such unresolved issues in this context refer to feelings about relationships with parents or significant others, or about disowned aspects of the self. Therapy focuses on the growth of each family member rather than on the resolution of specific problems. Personal growth entails increased self-awareness, self-esteem, self-responsibility and self-actualisation. In this process of realising one’s full human potential, communication becomes more congruent, awareness of experiences is heightened, responsibility is assumed for one’s actions, and the disowned parts of the self become integrated (Gladding, 2002:161; Carr, 2000: 171-172).

Intervention is active, spontaneous, idiosyncratic and often self-disclosing, making use of various ‘evocative’ techniques to facilitate awareness of feelings and inner experiences. The role of the experiential family therapist is that of facilitator, helping families discover their strengths and promoting better communication (Gladding, 2002:159).

The therapist strives to be real and **authentic**, rather than a blank screen or wearing a therapeutic mask – in this process of encounter with clients, therapists may have to deal with their own vulnerabilities (Goldenberg & Goldenberg, 1996:136). Carr (2000:172) too, discusses the necessity for an authentic “...therapeutic alliance...” and stresses the point that the more authentic the therapeutic relationship between client and therapist, the more effective the therapy. The conditions for facilitation of the therapeutic process are: **warmth; unconditional positive regard; congruence; and non-judgment**. A further factor necessary for facilitation of change is the degree to which the therapist can help clients to experience deeply, a wide range of emotional responses to significant experiences of their lives within the therapy session.

Because of their importance in the field of family therapy, the work of Carl Whitaker and Virginia Satir deserve particular mention (Gladding, 2002:146-148; Carr, 2000:173-176; Thompson & Rudolph, 2000:340-346; Goldenberg & Goldenberg, 1996:136-162). The work of these two charismatic family therapists is highlighted as follows:

- **Carl Whitaker:**

According to Carr (2000:137) and Snow (2002:298), Whitaker epitomises the experiential family therapist – unconventional, colourful and provocative, an advocate for the ‘active’ therapist who strives for growth and integration (maturity) rather than merely offering insight to promote adjustment to society. Whitaker held strong views on the process of **scapegoating** in the development of family problems. When a person becomes symptomatic, he or she has been scapegoated, by having the negative feelings within the family displaced onto him or her. Whitaker assumed that families will resist

engaging in family therapy, as this would entail accepting that the symptom-bearer is indicative of wider family difficulties. In addition, family therapy opens up the possibility that denied family difficulties would have to be explored. Scapegoating also implies that the family, if they did attend therapy, would avoid taking responsibility for resolving problems and look to the therapist to solve problems for them.

Within this framework, Whitaker suggested that for family therapy to be effective, two confrontative interventions are essential in the first stage of therapy, namely the **battle for structure** and the **battle for initiative**. With the former, the therapist offers a therapeutic contract which specifies that all sessions must be attended by all family members. In the battle for initiative, the therapist places the primary responsibility for content, process and pacing of therapy sessions on the family. These two interventions maximise the opportunity for confronting and undoing the scapegoating process, and thus help the family resolve denied difficulties.

Once therapy was underway, Whitaker would concentrate on **being with** the family rather than on specific techniques. To Whitaker, being with the family involved the intuitive use of self-disclosure and ‘craziness’, both being creative, non-rational, lateral-thinking yet non-directive in the process. A context is created within which the family can experience new ways of being, be more comfortable in the expression of impulses and fantasies, thus opening up new possibilities for them. Whitaker often worked with a co-therapist, in order to maximise his being ‘crazy’ while the co-therapist took on a more rational role in the team.

Valuing openness and spontaneity in interaction with the family above theoretical formulations, Whitaker often borrowed concepts from other approaches (e.g. enmeshment, triangulation, life cycle transitions) to describe what he believed may be blocks to family growth and role flexibility. Whitaker described his idiosyncratic therapeutic style as the “psychotherapy of the absurd” and views his intervention as being controlled by his ‘unconscious’, not always knowing why he says or does something – however, his interventions consistently challenge the meanings people give

to events, allowing them to take risks and explore alternative ways of being together as a family. One may speculate that the creativity and idiosyncrasy of this way of being in a therapeutic encounter has a postmodern flavour, allowing for differences of perspective and meaning to occur, and thus to create the possibility of change.

Of great significance to Whitaker is the person of the therapist. He stressed the need to 'stay alive' as a human being and as a therapist, insisting that the therapist must uncover his/her own belief system and symbolic world, and then use the self (rather than specific techniques) to grow and help families to do the same. Whitaker urged therapists to take care of their own needs in the process of caring for others, to abandon rigid rules that inhibit growth, and to remain flexible and available to new experiences without knowing what the 'right' answer is.

- **Virginia Satir:**

Satir, a social worker described as inspirational and charismatic, was one of the founders of the family therapy movement. Described as a prolific writer, Satir published the first groundbreaking text of conjoint family therapy. In her later writings, Satir identified her approach as a Human Validation Process Model, wherein therapist and family join forces to facilitate health-promoting processes in the family (McLendon & Davis, 2002:170).

Satir (in Goldenberg & Goldenberg, 2000:153; 1996:154) believed that all humans strive for growth and development, that people have the resources to fulfil their potential, albeit that these resources may become blocked or distorted. The family is viewed as a balanced system – symptoms in one family member indicate a blockage to growth and have a homeostatic function of keeping the family in balance. The rules that govern a family are related to how the partners achieve and maintain their own self-esteem, which in turn creates the context in which children develop their self-esteem.

Four problematic styles of communicating may evolve in families where affect is denied or distorted. **Blaming** is a communication style used to avoid taking

responsibility for resolving conflict – it is characterised by complaining, bullying, judging and comparing, with no ownership of ones’ role in the conflict. **Placating** is a communication style used to defuse, rather than resolve conflict – conflict is denied, differences are covered up and attempts to please and pacify are characteristic.

**Distracting**, also referred to as being irrelevant is characterised by avoiding conflict by changing the subject, pretending to misunderstand, feigning unawareness of what is happening. **Computing** or being super-reasonable involves avoiding emotional involvement with others, characterised by an overly intellectual and logical approach, lecturing, taking the higher moral ground (Gladding, 2002:151; Carr, 2000:174; Goldenberg & Goldenberg, 2000:156; 1996:157). According to Satir, the only congruent communication style is **levelling**, characterised by emotional engagement, congruence between verbal and non-verbal messages, directness and authenticity, all of which foster personal growth. According to Satir (in Goldenberg & Goldenberg, 1996:157), the problematic communication styles are essentially poses that keep distressed people from exposing their true feelings because they lack the self-esteem to be themselves.

Satir’s therapy involved subtly modelling and coaching family members in levelling with each other - she taught people congruent ways of communicating to enhance their ability to get in touch with and accept their feelings. In this way she helped people build their self-worth, opening up possibilities for choice and change in their relationships.

In addition to enhancing verbal communication, Satir used touch- and movement-based techniques. Family **sculpting** involves positioning each family member spatially, so that their positions and postures represent their inner experience of being in the family, and conveys their psychological representation of family relationships. Future-orientated family sculptures can be used to help family members to envisage how they would like things to be, and to compare with how they experience the family at present (Gladding, 2002: 152; Carr, 2000:175.)

Family **reconstruction** is a technique which allows the family to reconstruct and re-experience significant events from earlier stages of the family life cycle. The purpose of the technique is to help family members discover dysfunctional patterns in their lives stemming from their family-of-origin. Blending elements of psychodrama, Gestalt therapy, guided fantasy and role-play, the aim is to re-enact multi-generational events that keep people trapped in entrenched perceptions, feelings and beliefs. This technique may activate strong emotion that may have been beneath the level of awareness – experiencing and owning these feelings may promote personal growth (Gladding, 2002:154; Carr, 2000:175; Goldenberg & Goldenberg, 1996:162). Related to this technique is the **parts party** – family members are directed to role-play different parts of their personality and to interact in a way that metaphorically reflects the way these different aspects of the self coexist within the person. Again, strong emotion may be evoked, the ownership of which may promote growth.

In some cases, Satir would initiate treatment by compiling a **family life chronology** to understand the history of the family's development. This goes beyond merely gathering historical information – it is an attempt to explore family patterns and relationships. The **wheel or circle of influence** aims to explore those individuals who have been important in the family (Gladding, 2002:155; Goldenberg & Goldenberg, 1996:162).

Criticism of the approach focuses on its dependence on the charisma, intuition and sensitivity of the therapist, as typified by Satir and Whitaker, which are impossible to emulate. The researcher speculates that any attempt at emulation may be undesirable and possibly inauthentic, given the significance of the fit between a chosen approach and the self. While the experiential approach may typify the charismatic and idiosyncratic styles of Whitaker and Satir, it does not suggest that no other family therapist would have the necessary qualities to facilitate the growth of family members. Other criticism centres on the focus of therapy being on present issues which may inhibit the exploration of historical patterns or events. According to Gladding (2002:163), while personal growth may be an admirable goal, it may be insufficient to alter family dysfunction.

Experiential family therapy emphasises the therapeutic encounter as fundamental in the human drive towards growth and the achievement of potential. Major practitioners included Whitaker and Satir – their humanistically orientated practices were characteristically unique, charismatic and often unconventional in the quest for increased self-awareness, self-responsibility, self-esteem and self-actualisation.

#### 2.4.3.5 Multisystemic family therapy

The central premise of multisystemic family therapy is that family members engage in problem-maintaining interactions within the family because of concurrent involvement in certain types of social systems beyond that of the family. Multisystemic family therapy has shown effectiveness with multi-problem families where delinquency and drug abuse have been identified issues (Carr, 2000:176).

This form of therapy is grounded in the theory of Bronfenbrenner, wherein the social ecology influences people's behaviour. With the individual at the centre, influences occur first within the family system, the peer group, neighbourhood, school/work environment, health/social/other services and, finally the wider community.

Assessment involves evaluating the identified problems, the factors that contribute to and maintain them, as well as potential resources within the multisystemic context. Interviews may be conducted with the child, family, school or work, as well as with other professionals and agencies.

Intervention is focused on the present and on taking action. Specific problems are identified during assessment and targeted for intervention – such intervention must fit with the social ecology and stage of development of the person. Other individually focused approaches may be used concurrently, such as cognitive-behavioural therapy to improve self-esteem or lessen anxiety. Behavioural, structural and strategic family therapy interventions are used to enhance family functioning. Multiple agencies may be consulted in order to enhance cooperation and problem management.

The implementation of this form of family therapy is delivered by small teams of professionals who are closely supervised. Sessions may be home-based with crisis intervention services offered. The aim of multisystemic family therapy is to modify contextual factors in the wider social systems around the family (Carr, 2000:176-177).

A similar form of family therapy is Multiple Impact Therapy, described in Goldenberg and Goldenberg (2000:101; 1996:292-294). This involves the use of a team of mental health professionals over an intensive two day period – the team works with the family in crises to develop a therapeutic plan to intervene in mobilising resources, using various interventions to assist the family and to change problematic systemic interactions, and make relevant recommendations for dealing with day-to-day problems.

It appears that multisystemic family therapy is an eclectic model of intervention, suggesting the necessity of an in-depth understanding of different approaches to family therapy, as well as knowledge of relevant resources available in the community. In the South African context, this model would be more suited to the urban environment, since resources in rural areas remain scarce. However, aspects such as home-based intervention may be valuable in communities where transport is an issue for the family members, assuming of course that the family therapy practitioner has transport.

Thus, multisystemic family therapy aims to modify predisposing contextual factor's in the wider social systems.

#### 2.4.3.6 Psychoeducational family therapy

Certain empirical research indicates that some individuals are genetically or constitutionally predisposed towards the development of psychological problems (e.g. schizophrenia, mood disorders). The course of these disorders may be influenced by stress and the degree of available support in the psychosocial environment.

Psychoeducational family therapy intervenes to assist families to understand the factors contributing to the etiology and course of these illnesses, and provides family members

with the skills to promote a supportive home environment. Thus, instead of searching for the source of the illness, symptoms, causes etc., skills are taught in order to overcome obstacles to family functioning. According to Goldenberg and Goldenberg (1996:323), the psychoeducational approach has more in common with the medical model than with systemic thinking. Lefley (1996:132) concurs, stating that this type of intervention is better suited to family treatment in dealing with chronic mental illness.

This approach aims to make families aware of the psychological difficulties of the identified individual, providing a theoretical framework and plan of action to assist with problem-solving, communication and the management of medication, as well as providing social support through resource networks and support groups. A diathesis-stress model is used to explain psychological disorders as being the result of a genetic predisposition in conjunction with excessive stress in the absence of mitigating protective factors (e.g. medication, social support, coping skills).

The psychoeducation format may take the form of working with individual families or with multiple families simultaneously. Corcoran and Phillips (2000:432) identify the goals of psychoeducation with multi-family groups as being:

- To provide information about the nature and course of the illness to the family.
- To teach families about medication and its side effects.
- To reduce stress.
- To provide information on treatment options and community resources.

Single family interventions may also provide these psychoeducational components, often in conjunction with other forms of treatment such as behavioural or systemic family therapy. The aim is to provide a stabilising environment in which families feel that they are not being blamed or criticised, and where they can learn coping skills for maintenance and prevention of relapse (Goldenberg & Goldenberg, 1996:327).

According to Lefley (1996:130), family therapy may covertly 'blame' the family for the illness of their relative, and many families may not be helped by traditional approaches

that are based on systemic thinking, which conflicts with the reality of mental illness as a chronic source of stress to the family.

A distinction is made between controllable and uncontrollable stress – for the former, problem-focused strategies are appropriate, for example, planning, instrumental help, problem-solving. Regarding the latter, emotion-focused strategies such as relaxation, reframing and social support are used. This enables the family to have various strategies at their disposal to be used in different circumstances (Carr, 2000:177-179).

Psychoeducational approaches equip family members with the skills to manage physiological or constitutional vulnerabilities that predispose individuals to developing psychological problems. The researcher is of the opinion that this form of intervention is more suited to a multi-disciplinary setting, where different professionals are able to coordinate their interventions for the benefit of the family.

#### 2.4.3.7 Multi-cultural considerations in family therapy

According to Lee (2003:393), culturally sensitive practice in a diverse society is extremely complex. Lee suggests that minority groups are under-served by most mental health services, and that issues of power, equal access to services, and language and cultural barriers have been obstacles to obtaining help for many families. Gladding (2002:319) concurs with this view, adding that cultural minorities are also affected by the same social pressures that impact on other families. The researcher believes these aspects are only too apparent when related to the South African context. However, in South Africa we have a paradoxical situation, whereby services have historically been aimed at a dominant minority, with few resources spared for the majority. Currently, a more equitable provision of resources is hampered by various factors, including the economic climate.

Gladding (2002:317) defines culture as the “...customary beliefs, social forms, and material traits of a racial, religious, or social group”. It incorporates the behaviours and

traditions and the “...collective realities of a group of people” (Lee in Gladding, 2002:317). Culture involves both conscious and unconscious aspects and practices. According to Worden (1999:44), the broader cultural context is the family’s ethnic heritage, a heritage that is steeped in the norms and values transmitted over generations that provided the family with an identity and expectations regarding behaviour. It is through culture that we understand and organise our experiences of the world, while ethnicity provides a common ancestry, historical continuity and sense of belonging.

Thompson and Rudolph (2000:349) describe the fairly recent entry of families of many different cultures into the family therapy arena. Although these authors are exploring this in the context of the USA, this aspect has as much relevance for South Africa. These authors suggest that counsellors need to familiarise themselves with the customs, styles, norms, communication patterns and standards of behaviour of diverse groups. This requires openness to the uniqueness of every family and how the family responds to distress in relation to its culture. Current counselling practices reflect Western, white middle-class values that may be antithetical to the belief systems of different ethnic and racial groups (Lyddon, 2001:582). Gladding (2002:319) concurs, stating that family therapists are typically middle-class, socialised in terms of mainstream values regardless of their ethnic origin. These values may be at odds with the values of some families they encounter, again highlighting the importance of self-awareness and reflexivity. Gladding (2002:319) refers to the “...culturally encapsulated...” counsellor who is insensitive to difference, makes assumptions about groups of people, and may even display overt or covert prejudice that negatively impacts on the therapeutic process.

According to Worden (1999:45), ethnicity exerts a powerful influence on the individuals in a family, and on the nuclear family from the extended family. Observations of black families in therapy show that traditional sources of help have been the extended family, church leaders and close friends. The legacy of racism in the USA has meant that black families have been reluctant to enter therapy. In the opinion of the researcher, this is equally valid for the South African context, albeit one that has

changed significantly over the past few years and evidenced by the fact that more families of different cultures are entering into counselling at the organisation under exploration.

Reiss (in Worden, 1999:45) speaks of the family's capacity to construct its own view of reality and refers to the 'family paradigm' which guides the behaviour of family members and serves as a map to make sense of their world. This concept of the family paradigm is similar to the social constructionist view of family narratives, with shared interpretations of reality which are reinforced by ethnicity.

Lee (2003:385) sees a major challenge facing clinical social work practice in the changing demographics of society. People in diverse ethnic and racial groups are demanding to speak for themselves and seek legitimacy for their groups. The challenge of working with different cultures lies in how to provide intervention that fits the cultural context. Lee (2003:386) believes that despite certain universal aspects, human behaviour can only be understood in the specific cultural context.

Lee (2003:386-387) suggests a number of characteristics required for cross-cultural practice. They are:

- Incorporating clients' multiple worldviews – practitioners should refrain from making assumptions based on any specific theory with regard to the family, their functioning, what the goals and solutions should be. Treatment should be adapted to suit the specific needs of the family.
- Empowerment-based practice and a collaborative approach – this involves participative relationships with families, and mutual problem-solving and decision-making. Respect for client self-determination and the identification and building of client strengths are important aspects of practice.
- Utilising cultural strengths and resources - a strengths perspective is based on the assumption that all people and environments have resources and abilities that are either underused or not used at all, and that people are capable of continual growth

and change. Curiosity and appreciation of the cultural strengths of clients, and assisting clients to identify, expand and use these resources typify a solution-focused approach to helping.

Gladding (2002:332) states that for family therapists to be competent in their work with culturally diverse families, they need to examine their own values and biases. This exploration is both emotional and intellectual, and requires: awareness of own cultural heritage and respect with regard to differences; comfort with cultural differences; sensitivity to cultural circumstances that may dictate referral; knowledge of own attitudes, beliefs and feelings with regard to cultural differences.

According to Holland and Kilpatrick (1993:302), social workers, or for that matter any practitioner of family therapy, can develop greater sensitivity to the themes and issues arising in practice with clients from different cultures, through reflective examination of the stories families share about themselves, which reflect the meanings of their culture. Thus, understanding narratives is fundamental to the practice of social work, and Holland and Kilpatrick (1993:308) suggest that reflective exploration of stories across many cultures is useful practice in working with clients from diverse backgrounds. Such exploration may enhance the capacity of social workers to understand and appreciate the diverse ways in which people develop meaning and express their problems-solving skills, resulting in creative and empowering ways to re-author lives.

Soal and Kottler (1996:123) discuss a South African study with a social constructionist quality, which suggests that problems experienced by families cannot be seen to have an objective existence or to be 'within' the family unit. Rather, the problems presented by families are shaped by an investment in socially constructed discourses which ascribe meaning to experience. These authors conclude that local families experiencing problems cannot be viewed in isolation from the dominant discourses that pervade the South African social order. In the process of challenging dominant beliefs, it is suggested that narrative family therapy has the potential to assist families to question "...regimes of truth" that determine their experiences and subjugate their lives (Soal &

Kottler, 1996:133). The researcher is of the opinion that the usefulness of social constructionist concepts in understanding the dominant discourses, and how they shape family narratives is very relevant to the unique context of South Africa.

The family therapy approaches described above predominantly focus on contextual factors, highlighting the view that people may be predisposed to the development of behaviours and beliefs because of factors in their history, the wider social network or personal constitutional factors such as genetic vulnerability. Approaches which focus on the role of early experiences in the family-of-origin in the etiology of problematic behaviours and beliefs were explored, with experiential family therapy differing in that it includes both problem resolution and personal growth as therapeutic goals.

Multisystemic family therapy addresses factors in the wider social system, as well as individual factors such as skills deficits, while psychoeducational models consider constitutional and genetic factors in predisposing people to problematic behaviours and beliefs. Family therapy shows promise in working with families from diverse cultures, but requires awareness and understanding of such diversity.

The previous sections focused on the historical roots of family therapy, its evolution from inception to the present day, and on the various approaches to family therapy based on categories of behavioural systems, belief systems and contextual factors. In the section that follows, the focus is on intervention, based once again on the categorisation of Carr (2000).

## 2.5 INTERVENTION

Carr (2000:522) states that the results of research indicate that family therapy interventions are shown to be effective for child-focused and adult-focused mental health problems and relationship difficulties, and while it is suggested by Carr that postmodern practitioners in family therapy may object to the notion of evidence-based practice because of its modernist assumptions of objectivity, his position on this critique

is that postmodernism does not mean an abandonment of rigorous scientific methods of inquiry – rather, it requests that we accept the limitations of the findings of such an inquiry.

Certain criteria are suggested in selecting interventions for particular types of families and family issues. Interventions need to be compatible with the family's readiness to change. Where families are ambivalent or uncommitted, it is proposed that these issues be the focus of treatment, rather than on plans of action. In addition, intervention should be compatible with the family's rules, roles, beliefs, culture, as well as focusing on their strengths and resiliencies, in preference to those that fail to utilise family strengths and resources.

Sometimes interventions are selected because they are in fashion, even if evidence is lacking with regard to effectiveness. In other instances, unacknowledged countertransference biases the selection of intervention. This highlights the relevance of being self-aware and reflexive, otherwise the chosen therapies may inadvertently maintain the family problems rather than facilitate resolution. Essential too, is the need to consider when family therapy is called for, and when other services and referrals are necessary (e.g. medical intervention, psychiatry, social welfare) (Carr 2000:256).

Carr (2000:255) uses the categories of context, belief systems and behaviour patterns to delineate appropriate intervention according to the schools of family therapy. In keeping with his categorisation system, the researcher will use this as a guideline to briefly explore the various interventions within the context of the theoretical approaches. Gladding (2002:173-184), Carr (2000:257-273) and Worden (1999:128-152) describe many of the techniques used in intervention with families.

### 2.5.1 Interventions for Behaviour Patterns

The following interventions aim to disrupt or replace problem-maintaining patterns within the family:

- **Creating a therapeutic context:**

In every session the contract and rules for a therapeutic encounter are established and re-established, either implicitly or explicitly. This creates a climate which disrupts problem-maintaining behaviours, promotes collaborative problem-solving, and enables all family members to be 'heard'. Problems can be reframed and different perspectives explored. Tasks may be given to be completed between sessions (Carr, 2000:257).

- **Changing behaviour patterns within sessions:**

In sessions, families may be invited to attempt to solve an issue in their usual way. By observing these enactments (a typically structural technique), the therapist is able to witness first-hand the ways in which the problem is maintained. The therapist intervenes when the family becomes 'stuck', perhaps giving directives to coach family members in more effective ways to problem solve. Structural family therapy assumes the importance of clear intergenerational boundaries in effective family problem solving and therapists will use boundary-marking to prevent alliances across the generations (Carr, 2000:259).

- **Tasks between sessions:**

Families may be requested to complete tasks between sessions which aim to disrupt or replace problem-maintaining behaviour patterns. **Symptom monitoring** (a technique often used in solution-focused therapy) is useful to ask clients to record information about the presenting problem. Intensity rating, frequency counts, duration, etc. may be recorded, as well as intrapsychic and interpersonal events that occur around the problem. Information obtained should be monitored regularly and the family may be asked to speculate on reasons for changes in the problem. **Encouraging restraint**, often used in MRI therapy, is a request to stop trying to solve the problem in the usual way and to postpone any new attempt to solve it. **Practising symptoms** involves requesting clients to practice the symptoms of the problem (e.g. involuntary tics) in order to gain control over it. This can reduce anxiety and begin to allow the client to attain some measure of control. **Graded challenges or systematic desensitisation** may be appropriate in situations where clients' anxiety prevents the achievement of

certain behaviours (e.g. phobias). They may be invited to gradually work towards facing the threatening situation, using small steps to overcome the problem (Gladding, 2002:184). **Skills training** encompasses a number of aspects such as communication skills training and problem-solving skills. Therapists can model communication skills, however clients also need to be given an intellectual understanding of what is required. Many obstacles to effective communication exist, for example, interrupting, attributing negative intent to the other person, not listening, blaming, and so on. The challenge of communication skills training is positive encouragement for gradual improvements, rather than criticism for mistakes which may affect the therapeutic alliance and the modelling of effective communication. In problem-solving training specific guidelines are provided on how to: define the problem, deal with one problem at a time, brainstorm for solutions, evaluate options, implement a plan of action, review and revise if necessary. Often families may require communication skills training before embarking on problem-solving skills training. Again, positive feedback is essential, while criticism should be avoided (Carr, 2000:260-263).

- **Changing behavioural consequences:**

Derived from behavioural family therapy, the use of reward systems and behaviour control routines can be effective in dealing with child-focused problems. **Reward systems** use age-appropriate points, tokens, etc. earned during effective management of the problem, and backed up with tangible rewards or prizes after the agreed upon target is reached (Gladding, 2002:173). Guidelines for behavioural control skills include the targeting of specific negative behaviours. For example, the child is commanded to stop a certain behaviour, given two warnings if the behaviour does not cease, followed by time-out (appropriate to the child's age). No anger is shown or explanation given at this time. If compliance is achieved after the set time, the child is invited to join the parent again in a rewarding encounter. If not, time-out is given again. **Behavioural control programs** may be stressful and negative behaviour may initially escalate as children test their parents. Consistent application by both parents, support for the other parent, and family support for single parents are necessary to assist the child to achieve self-control (Gladding, 2002:176; Carr, 2000:268).

- **Invitations to complete tasks:**

According to Carr (2000:273), when inviting families to carry out the tasks described above, the therapist must consider that adherence and compliance to medical advice and treatment is around 50%, an estimate with which Brown-Standridge (1989:487) concurs - thus one can expect that about half the time the family will not cooperate with tasks. According to Carr, this level of expectation can prevent unnecessary self-criticism, client criticism and other counter-transference reactions. Brown-Standridge (1989:471-487) describes the parameters of task intervention and classifies them as: direct versus indirect; behavioural versus non-behavioural; and paradoxical versus non-paradoxical. This results in eight flexible therapeutic options that consider the family's willingness to try something different to promote change, e.g. direct/behavioural/non-paradoxical; direct/behavioural/paradoxical; direct/non-behavioural/non-paradoxical, and so on.

### 2.5.2 Interventions for Belief Systems

A number of interventions aim to transform belief systems and narratives that maintain problematic behaviour patterns, thus helping clients to develop more empowering beliefs about themselves and their ability to solve their problems (Carr, 2000:273-287).

- **Addressing ambivalence:**

Commitment to counselling may fluctuate over the course of therapy and resistance may occur because family members are ambivalent about the process of change. When this occurs the task of family therapy is to address this ambivalence, and suspend attempts to achieve the stated therapeutic goals. Clients need to explore the costs of maintaining the status quo and those of change, before returning to the issues that brought them into counselling. Understanding the nature of ambivalence and overcoming it without alienating family members is a challenge for the family therapist. Attempts to overcome, avoid or use ambivalence to produce change will be based on the practitioner's theoretical orientation. However empathy and acceptance of the ambivalence are essential to the therapeutic process (Gladding, 2002:97; Carr, 2000:274).

- **Highlighting strengths:**

The importance of formulating strengths and exceptions to problems is necessary during all stages of the family therapy process. Chronic problems can be demoralising and clients may feel powerless to change their situation. Highlighting strengths may reduce these feelings and enable clients to re-focus and construct a personal and family narrative that encompasses growth. **Relabeling** occurs when the therapist offers positive or optimistic labels for ambiguous behaviour as a substitute for negative attributions. **Pinpointing** is a way of drawing attention to frequently used but unacknowledged individual and family strengths (Gladding, 2002:121; Carr, 2000:275).

- **Reframing problems:**

Clients are offered a new framework within which to conceptualise a problem that enhances the likelihood of it being resolved. The problem is reframed in interactional terms (rather than individual terms), and as solvable rather than unsolvable. A shift to a new perspective is crucial to movement toward change in family therapy (Gladding, 2002:206; Carr, 2000:276).

- **Presenting multiple perspectives:**

Family members with different viewpoints may present either/or arguments and find a both/and position difficult to consider. Listening to multiple viewpoints on a problem allows the therapist to empathise with each family member, and understand a polarisation of perspectives that hamper problem resolution. The idea of presenting the family with multiple perspectives evolved from the work of the original Milan school and Tom Andersen's reflecting team – two distinct practices can be identified: presenting families with **split messages** that validate the differing perspectives, allowing family members to find a shared perspective rather than a 'right' one; **reflecting team** practice wherein the family are given the opportunity to observe the team reflect on the problem, speculated explanations for it, and possible solutions, i.e. multiple perspectives (Carr, 2000:277).

- **Externalising problems and building on exceptions:**

The aim of these strategies is to help clients separate the problem from the person, identify the effects of the problem on the person, identify situations when the person was able to modify or avoid the problem, and develop a self-narrative that empowers the client to overcome the problem. Externalising the problem may involve giving it a name to personify it. When change and mastery of problems begins to occur, clients are helped to consolidate new personal narratives and belief systems about themselves through questions that link exceptions and competency to their past and future (Gladding, 2002:252; Carr, 2000:280).

### 2.5.3 Interventions for Contexts

Interventions that aim to modify the impact of historical, contextual and constitutional factors or mobilise protective factors include the following (Carr, 2000:283-296):

- **Addressing family-of-origin issues:**

Unresolved family-of-origin issues may prevent family members from making changes. The following issues may be the focus of exploration: **major family-of-origin stresses** such as bereavements, separations, child abuse, social disadvantage, institutional upbringing; **family-of-origin parent/child problems** such as insecure attachment, authoritarian/ permissive/neglectful/inconsistent parenting, scapegoating, triangulation; **family-of-origin parental problems** such as parental psychological/drug/alcohol problems, parental criminality, marital discord or violence, family disorganisation. Clients may be invited to explore transgenerational patterns, scripts and myths relevant to their difficulties – a genogram may be a useful starting point to understand how family-of-origin issues may be interfering with effective problem-solving in the family-of-procreation. The genogram provides a visual representation of the family that is useful in tracking change in the context of historical and contemporary events (Gladding, 2002:130). **Re-experiencing** is a way to help clients create a context in which they can remember and re-experience highly emotional situations in which destructive relationship habits were learned, and integrate these into a conscious

narrative. Visualisation of specific memories and the accompanying affect, writing (but not sending) detailed letters, responding to an empty chair are processes which may allow the client to re-experience and respond differently to early formative experiences to allow them to gain control over destructive relationship habits. **Reconnecting** is a process of coaching clients to reconnect with cut-off family members – this involves accessing, expressing and integrating emotions that underpin destructive relationship habits, and may result in mutual understanding and forgiveness (Carr, 283-287).

- **Addressing contextual issues:**

It may be that factors in the family's wider social context are hindering progress. Such factors include: **changing roles** whereby family members may be invited to extend their role or include other roles where appropriate, e.g. a peripheral father may be requested to be more involved with the children; **building support** where lacking, perhaps in the form of self-help groups, extended family support, or community support; **rituals for mourning losses**, an uncontrollable aspect of the family lifecycle, may enable family members to be liberated from unresolved and paralysing grief and help them to alter their belief system to accept the loss – this is not to erase the pain of the loss but to unblock the grieving process and allow people to move on with their lives; certain behaviours (e.g. bullying in school) maintain children's problematic beliefs and **liaison with the home/school** may be necessary if the therapy is to move forward – all parties are invited to contribute to and collaborate on problem-resolution; **network meetings** can provide a forum within which the family and all involved professionals share information, resources, etc. in an effort to resolve issues in multi-problem families; **child protection** services may be required if the family are failing to respond to therapy and child abuse/neglect is suspected; **advocacy** may be called for to assist families dealing with issues in the larger social environment, such as poverty, housing problems, discrimination; **exploring secrets** - secrets may be individual, known by some family members but not all, or known by all the family but kept from the community, and can be destructive in nature – secrets offered to the therapist in confidence by one family member may have implications for the family and need exploration of relevance to the problem, consequences to keeping the secret, possible

reactions of family members, issues of atonement and forgiveness (Carr, 2000:287-295).

- **Addressing constitutional factors:**

Constitutional factors such as injury, debilitating somatic states, learning difficulties or difficult temperaments may render therapy less beneficial and psychoeducation may be called for. **Psychoeducation** provides families with information about the problem, engenders hope by giving feedback and focusing on family strengths and protective factors, and promotes adherence to medical regimes (Gladding, 2002:179; Carr, 2000:295).

According to Carr (2000:298), the selection of intervention should ideally be based on empirical efficacy, therapist skill, and an awareness that family therapy may not be the most appropriate intervention in all cases.

Interventions may be categorised in terms of a particular area of focus. Some interventions aim to disrupt problem-maintaining behaviour patterns, others to transform belief systems and narratives that underlie these behaviours, while the last category explored the impact of historical, contextual and constitutional predisposing factors, and the types of intervention that assist in addressing these factors.

In keeping with the belief that theory must be an embodiment of the self of the therapist, any attempt made by the researcher to integrate any of the concepts of the different approaches would be presumptuous. Integration, if considered at all, would of necessity be a personal, unique and individualistic exercise that fits with the sense of reality and authenticity of the therapist. However, it may be of interest to the reader to consider the views of certain authors with regard to the notion of integration of modern and postmodern ideas, and in the next section their viewpoints are briefly considered.

## 2.6 INTEGRATION

According to Auerswald (1987:322), of the five paradigms in the field of family therapy, the first (psychodynamic) has been largely abandoned by family therapists, while the second to the fourth (family systems, general systems and cybernetics) have merged into what is known as family systems theory. The last paradigm (ecosystemic) is based on New Science which proposes a view of alternative realities – this has major implications for how we organise our knowledge base, how we think about families and how family therapy is practiced.

Auerswald (1985:4-5) draws some parallels between the New Science/physics and Newtonian physics. In the former, a monistic (both/and) universe is assumed; linear causative relationships are not established; abstract ideas are part of the field of study; certainty is discarded and truth is seen as heuristic. With regard to the latter, a dualistic (either/or) universe is assumed; linear causality is accepted; the field of study is mechanistic; certainty is accepted and truth is absolute. Auerswald (1987:325) believes that family therapy based on ecosystemic epistemology is radically different from Western/Newtonian thinking. Traditional concepts are pragmatic, reductionistic, medical-model based and researched on the basis of usefulness. On the other hand, an ecosystemic paradigm is usable in the design of community-based and human service delivery systems, and according to Auerswald, as a basis for solutions to even larger human problems.

Kvale (1992:1) poses the question of whether the modern social sciences (psychology and social work) can be developed and enriched by drawing on postmodern knowledge, or if the latter undermines and transforms modernist thinking. Similarly, Geurin and Chabot (in Carlson & Kjos, 2002:156) question the future of the family therapy movement as the “...pioneers...” make way for a new generation of family therapy practitioners. These authors see the goal of family therapy as the development of an integrated system of interventions that will enhance the ability of the practitioner to

guide the process towards the growth of the individuals within the family, as well as the family as a whole.

Rivett and Street (2003:48-49) discuss the work of Lerner who provides an integrative model of modernism and postmodernism, and Pocock who explores the difficulties of a single theory to best explain a family's difficulties. The suggestion is that family therapists should not be forced to choose between a cybernetic or discursive theory, but encompass both. The complexity of working with families means that we cannot afford to dismiss any theoretical ideas available to us – any and all ideas should be used to serve the therapeutic process. This view highlights for the researcher the necessity for family therapy practitioners to have a sound theoretical knowledge base from which to draw, as well as the self-awareness of knowing which ideas are an authentic fit. Thus, an understanding of one's paradigm is essential – without such an understanding one runs the risk of being swayed by every passing whim, or of rigidly adhering to a particular position with little consideration of its relevance to the client family. Pocock (in Rivett & Street, 2003:49) believes the overriding issue is which model is congruent for the family, suggesting that a particular model is to be favoured only if it is clinically useful at a particular moment, to a particular therapist, with a particular family. The complexity of family dynamics and thus family therapy means we can ill afford to dismiss any theoretical ideas available to us. According to Rivett and Street (2003:51), postmodern family therapy practice is "...one story but it brings as many paradoxes and contradictions as any other story".

In a paper that attempts to combine a 'both/and' approach to family counselling, Atwood (1995:1) explores how traditional and constructivist thinking that operates from an 'either/or' perspective leaves out half the picture – traditional approaches operate from a deficit standpoint, while in opposition, more solution-focused therapies focus on strengths, competencies and resources. Amundson (1994:87) also suggests that to argue for the ascendancy of one approach over another is to miss the point, and that we can explore the unity of certain experiences while appreciating diversity.

According to Bertrando (2000:100), the conflict between text (language) and context, and between the narrative and systemic metaphor may impoverish family therapy. His synthesis of the two ways of thinking views **text** as useful for understanding the subjective, idiosyncratic meaning dimensions of experience, while **context** is useful in understanding the parts of our experience of which we tend to be unaware. Shifting between the two can enrich the client-therapist relationship. Bertrando (2000:84) sees value in the introduction of narrative/constructivist thinking in systemic therapy, such as respect for people's stories and ideas, but believes that taking an either/or position by embracing one approach and rejecting another obscures the "...most precious contributions of both".

A compatible view is held by Gergen (in Hoyt, 1998:xiv) who states that despite the problematic ground on which modernist therapies were grounded, they can be viewed as contexts for the generation of meaning, and continue to have relevance for significant sectors of the therapeutic culture. The aim of constructive therapies is to broaden the way in which transformation is achieved, and thus according to Gergen, there is no reason to exclude traditional therapies which may expand dialogue. According to Rivett and Street (2003:47), the difficulties of adopting postmodern ideas in family therapy have been recognised in the field, and attempts have been made to integrate modernist and postmodernist ideas into a framework that allows co-existence and movement between the two, thus celebrating difference and ambiguity.

Dallos and Urry (1999:163) view social constructionism as offering some "...important departures but also connections and continuities..." rather than signalling the end of systemic therapies. However, they believe there are important practical, ethical and moral issues attached to the differences between first and second-order approaches that require recognition if we are to attempt to integrate them. Awareness of difference does not imply a rejection of one position, but rather a contrast of positions. These authors go on to suggest a number of key organising themes (Dallos & Urry, 1999:164):

- Theoretical assumptions

- Theoretical links and connections
- Views of problems and pathology
- The role of the therapist
- Views of individuals and individual experience
- Ideas about the nature of family relationships
- Development and change (both natural and therapeutic)
- Moral and political implications

Dallos and Urry (1999:165) suggest three stages in family therapy theory development: a first-order perspective that focuses on patterns and regularities in families' lives and experiences; a second-order view which focuses on meaning and uniqueness; and a third-order perspective which allows the family therapist to consider the rules and predictability of family life, while recognising that this is socially constructed by the cultural context.

Not all authors are equally in favour of postmodern ascendancy, or even of integration. In an article that questions the postmodern trend, Pilgrim (2000:7) states that the affinity between family therapy and postmodernism is understandable for a number of reasons. Both explore ambiguity and shifting interconnections, with diversity of perception within a range of family relationships. Postmodernism may appear to unify conceptual thought that in fact "...simply disguises differences" (Pilgrim, 2000:8). Pilgrim believes that postmodernism will fail family therapy, basing this view on a lack of confidence in its practical utility and the unlikelihood of it providing an intellectual foundation for clinical practice. Systemic thinking in family therapy retains a strong presence and according to Pilgrim (2000:11) is a relevant reference point for postmodernism.

Speed (1991:398) sees the value of constructivism in its emphasis away from viewing one model of therapy as the absolute truth, but feels the movement has gone too far in its assertions that reality has no relevance to what we know. She proposes a co-constructivist stance which holds that both ideas and reality contribute to knowledge.

Speed (1991:398) goes on to state that we can never know reality, we can only have views on reality – however, reality can be discovered in an objective way which determines what we know. Thus, reality is reflected in knowledge.

Applying a co-constructivist epistemology to family therapy implies therapist and family constructing an account of events, patterns and problems – this account is one possibility of a number of possibilities, but according to Speed (1991:403), there are not infinite possibilities. If we adopt a co-constructivist position, i.e. acknowledging the contribution of ideas and a reality to what we know, Speed (1991:405) believes this has implications for practice. The first is that we have a responsibility to be aware of how our ideas determine what we see, and the second is to research the reality of what exists, which determines what we know.

According to Minuchin (1991:50), the strength of the constructivist approach is its emphasis on the limitations of therapy and the realisation that truth is always partial. His objection to constructivist therapy, is its emphasis on the idiosyncratic story of the family which ignores the implications of the social context of their lives, i.e. poverty, disease, class, race, gender and many more factors. Therapy cannot be only a matter of inventing new and better stories.

Minuchin (1991:50) sees it as ironic that constructivists, with their appreciation of multiple realities, seem to have forgotten the “...richness...” of family therapy theories, techniques and interventions, and the field’s diversity and eclecticism. He refers to a “...treasury of therapies...” that the skilled family therapist is able to draw on to enrich their work and the lives of their clients. Hanna and Brown (1999:4) prefer to use the word “...integrative...” rather than eclectic, believing it relates to making connections between parts. They see the field of family therapy as diverse, but with a history of integration.

Anderson (1999:2) quotes Minuchin’s suggestion that postmodern theory should be examined with a “...critical eye”, but her own view is that any theory of family

functioning should be examined with a critical eye. She sees critical examination as integral to a postmodern paradigm, in particular its critique of metanarratives and the belief that one description is ‘truer’ than another. Anderson (1999:3) disputes claims that the postmodern paradigm is a ‘fad’, believing it to be an extension that goes beyond the “...original gift of family therapy”.

According to Eron and Lund (1993:291), the postmodern movement has challenged the foundations of structural and strategic approaches. However these authors question the differences of the approaches, and suggest that the new orientation is merely an elaboration of old ideas. Many of the aspects of strategic therapy, such as joining with the family, starting where they are and harnessing resources to facilitate change have strong postmodern overtones. In addition, Eron & Lund (1993:293) question whether terms such as ‘re-storying’ and ‘co-creation’ are more enlightened than the more old fashioned term ‘reframing’, and suggest that it matters less what terminology is used to describe a redefinition of a problem, than that this definition has meaning for the family. Narrative therapists could perpetrate the very same transgression they accuse the strategic therapists of doing, namely, inventing their own new realities and imposing them on clients while reframing this as co-construction. Eron and Lund (1993:293) believe that in combining the “...richness and breadth of scope of the narrative perspective with the precision of a strategic approach” many advantages are to be had.

Mills and Sprenkle (1995:372) suggest one need not abandon strategic interventions in order to honour second-order principles such as respect for clients and the place of the therapist within the system. Strategic concepts may be appropriate when informed by second-order thinking that openly acknowledges them as ideas that may or may not be helpful to families. Bertrando (2000:85) believes that theories develop through “...epigenetic evolution...” as does the therapist. He states that to adopt a postmodern position wherein not having a preferred theory is ‘correct’ while having one is ‘incorrect’ imposes a prescription on the therapist that risks losing the many positive sides of modernist theories.

Gibney (1999:31) believes that one of the ambivalent legacies of Bateson's influence in the development of family therapy is his ability to draw from other disciplines, which this author believes Bateson did with sensitivity and a regard for context. However, many family therapy theorists evidence an "...undisciplined borrowing..." from other fields with little explanation as to why, and for what purpose. In the opinion of the researcher this has relevance for the practice of family therapy at the organisation under study. The eclectic use of techniques holds both advantages and disadvantages, contingent on the depth of theoretical knowledge, as well as capacity for reflexivity of the family therapy practitioner.

Goldenberg and Goldenberg (2000:113) state that the borrowing of techniques from different schools must be based on the therapist identifying the theoretical orientation from which he/she operates, before using interventions that are congruent with that theory. These authors explore the controversy of integration, suggesting that there are many inherent incompatibilities in the major theoretical constructs of the major theories for such conceptual integration to be undertaken. Different schools of thought have different assumptions about human nature, different goals, and different criteria for evaluating success. Goldenberg and Goldenberg (2000:113) go on to state however, that theories are hypotheses offered in the hope of solving a problem of family dysfunction. Thus they are never true or false – they are all tentative.

According to Anderson (1999:7), the postmodern perspective "...invites self-reflection on our traditional beliefs..." valuing multiple voices, diversity and difference. In addition, postmodern beliefs value connection and response to the broader socio-cultural context. The aim is not to subvert or dispense with earlier thinking about working with families but to reconceptualise practice in terms of how we are and want to be in relationships with others. The postmodern perspective accommodates traditional theories, and according to Anderson (1999:7), offers the potential for extending their potential. It is not an abandonment of tradition, more an extension of the ideological shift that family therapy initiated. Gergen (in Anderson, 1999:7) states that social constructionism is not antithetical to tradition, and that tradition is in fact

“...essential to the construction of all meaning”. Postmodernism challenges us to continue the practice of “reimagining” which implies consideration of the new, the expanded and the revolutionary as opposed to the acceptance of the traditional and the known, in other words, what family therapy has always done and what will take us beyond (Anderson, 1999:7-8).

In conclusion, postmodernism has ensured that family therapy remains sceptical of its assumptions, respectful of the unique solutions of families, and according to Rivett and Street (2003:51) has brought “...the reflexivity of the therapist into central stage”.

## 2.7 SUMMARY

In this chapter the epistemological revolution that constitutes the historical basis of family therapy was explored, from the concepts of a first-order cybernetic view to a postmodern paradigmatic shift. Various scientific and clinical advances paved the way for family therapy to advance, including general systems theory, the role of the family in personality development, marital and child guidance in mental health, and group therapy as an intervention.

The evolution of family therapy over the decades, beginning in the 1950s to the present day was explored, as well as the growth of family therapy within the South African context.

A review of the numerous different approaches to family therapy detailed the various schools of thought, based on the classification system of Carr (2000) (but including feminist and existential approaches) whereby theories are categorised according to their fundamental focus of concern, i.e. behaviour patterns, belief systems and context. The review considered aspects such as the basic premises of each approach, founders or major proponents of the approach, typical concepts and techniques, views on assessment and treatment, and the role of the therapist.

Family therapy interventions within the context of the various theoretical approaches were described, again grouped according to the focus of concern, namely, behaviour patterns, belief systems, and context.

Finally, the viewpoints of various authors on the subject of integration of modern and postmodern thinking were explored.

The following chapter explores the reflecting team as an approach to family therapy intervention. Reflecting team practice involves a team of family therapists and the family in a collaborative, therapeutic process.