04 - 28.4 Family Therapy and Couples Therapy

28.4 Family Therapy and Couples Therapy

Zoger S, Suedland J, Holgers K. Benefits from group psychotherapy in treatment of severe refractory tinnitus. J Psychosom Res. 2003;55:134. 28.4 Family Therapy and Couples Therapy FAMILY THERAPY The family is the foundation on which most societies are built. The study of families in different cultures has been a subject of fascination and scientific interest from viewpoints as diverse as sociology, group dynamics, anthropology, ethnicity, race, evolutionary biology, and, of course, the mental health field. The confluence of information gleaned from family studies has set the backdrop against which the contemporary practice of family therapy has evolved. Family therapy can be defined as any psychotherapeutic endeavor that explicitly focuses on altering the interactions between or among family members and seeks to improve the functioning of the family as a unit, or its subsystems, and the functioning of individual members of the family. Both family therapy and couple therapy aim at some change in relational functioning. In most cases, they also aim at some other change, typically in the functioning of specific individuals in the family. Family therapy meant to heal a rift between parents and their adult children is an example of the use of family therapy centered on relationship goals. Family therapy aimed at increasing the family’s coping with schizophrenia and at reducing the family’s expressed emotion is an example of family therapy aimed at individual goals (in this case, the functioning of the person with schizophrenia), as well as family goals. In the early years of family therapy, change in the family system was seen as being sufficient to produce individual change. More recent treatments aimed at change in individuals, as well as in the family system, tend to supplement the interventions that focus on interpersonal relationships with specific strategies that focus on individual behavior. Indications The presence of a relational difficulty is a clear indication for family and couple therapy. Couples and family therapies are the only treatments that have been shown to be efficacious for such problems as marital maladjustment, and other methods, such as individual therapy, have been shown to often have deleterious effects in these situations. Couples and family therapy has also been demonstrated to have a clear and important role in the treatment of numerous specific psychiatric disorders, often as a component within a multimethod treatment. Of course, as with any therapy, the indications for family and couple therapy are broad and vary from case to case. Family therapy is a therapeutic collage of ideas regarding the underpinnings of family

and individual stability and change, psychopathology, and problems in living, as well as relational ethics. Family therapy might better be called systemically sensitive therapy and, in this sense, reflects a basic

worldview as much as a clinical treatment methodology. For therapists thus inclined, then, all clinical problems involve salient interactional components; thus, some kind of family (or other functionally significant other's) involvement in therapy is always called for, even in treatment that emphasizes individual problems. An impressive array now exists of common clinical disorders and problems, including child, adolescent, and adult disorders, for which research has demonstrated family or couple treatment methods to be effective. In a few instances, couple and family interventions are probably even the treatment of choice, and for several disorders, the research argues for family intervention to be an essential part of treatment. Techniques Initial Consultation. Family therapy is familiar enough to the general public for families with a high level of conflict to request it specifically. When the initial complaint is about an individual family member, however, pretreatment work may be needed. Underlying resistance to a family approach typically includes fears by parents that they will be blamed for their child's difficulties, that the entire family will be pronounced sick, that a spouse will object, and that open discussion of one child's misbehavior will have a negative influence on siblings. Refusal by an adolescent or young adult patient to participate in family therapy is frequently a disguised collusion with the fears of one or both parents. Interview Technique. The special quality of a family interview springs from two important facts. A family comes to treatment with its history and dynamics firmly in place. To a family therapist, the established nature of the group, more than the symptoms, constitutes the clinical problem. Family members usually live together and, at some level, depend on one another for their physical and emotional well-being. Whatever transpires in the therapy session is known to all. Central principles of technique also derive from these facts. For example, the therapist must carefully channel the catharsis of anger by one family member toward another. The person who is the object of the anger will react to the attack, and the anger may escalate into violence and fracture relationships, with one or more member withdrawing from therapy. For another example, free association is inappropriate in family therapy because it can encourage one person to dominate a session. Thus, therapists must always control and direct the family interview. Table 28.4-1 summarizes the principles in which the history of the family is examined in an effort to understand how that history informs the current familial interactions. Table 28.4-1 Rationale for Family-Life Chronology

Frequency and Length of Treatment. Unless an emergency arises, sessions are usually held no more than once a week. Each session, however, may require as much as 2 hours. Long sessions can include an intermission to give the therapist time to organize the material and plan a response. A flexible schedule is necessary when geography or personal circumstances make it physically difficult for the family to get together. The length of treatment depends both on the nature of the problem and on the therapeutic model. Therapists who use problem-solving models exclusively may accomplish their goals in a few sessions, whereas therapists using growth-oriented models may work with a family for years and may schedule sessions at long intervals. Table 28.4-2 summarizes one model for treatment termination. Table 28.4-2 Criteria for Treatment Termination

Models of Intervention Many models of family therapy exist, none of which is superior to the others. The particular model used depends on the training received, the context in which therapy occurs,

and the personality of the therapist. Psychodynamic-Experiential Models. Psychodynamic-experiential models emphasize individual maturation in the context of the family system and are free from unconscious patterns of anxiety and projection rooted in the past. Therapists seek to establish an intimate bond with each family member, and sessions alternate between the therapist's exchanges with the members and the members' exchanges with one another. Clarity of communication and honestly admitted feelings are given high priority. Toward this end, family members may be encouraged to change their seats, to touch each other, and to make direct eye contact. Their use of metaphor, body language, and parapraxes helps reveal the unconscious pattern of family relationships. The therapist may also use family sculpting, in which family members physically arrange one another in tableaus depicting their personal view of relationships, past or present. The therapist both interprets the living sculpture and modifies it in a way to suggest new relationships. In addition, the therapist's subjective responses to the family are given great importance. At appropriate moments, the therapist expresses these responses to the family to form yet another feedback loop of self-observation and change. Bowen Model. Murray Bowen called his model family systems, but in the family therapy field it rightfully carries the name of its originator. The hallmark of the Bowen model is persons' differentiation from their family of origin, their ability to be their true selves in the face of familial or other pressures that threaten the loss of love or social position. Problem families are assessed on two levels: the degree of their enmeshment versus the degree of their ability to differentiate and the analysis of emotional triangles in the problem for which they seek help. An emotional triangle is defined as a three-party system (and many of these can exist

within a family) arranged so that the closeness of two members expressed as either love or repetitive conflict tends to exclude a third. When the excluded third person attempts to join with one of the other two or when one of the involved parties shifts in the direction of the excluded one, emotional cross-currents are activated. The therapist's role is, first, to stabilize or shift the "hot" triangle—the one producing the presenting symptoms—and, second, to work with the most psychologically available family members, individually if necessary, to achieve sufficient personal differentiation so that the hot triangle does not recur. To preserve his or her neutrality in the family's triangles, the therapist minimizes emotional contact with family members. Bowen also originated the genogram, a theoretical tool that is a historical survey of the family, going back several generations. Structural Model. In a structural model, families are viewed as single, interrelated systems assessed in terms of significant alliances and splits among family members, hierarchy of power (parents in charge of children), clarity and firmness of boundaries between the generations, and family tolerance for one another. The structural model uses concurrent individual and family therapy. General Systems Model. Based on general systems theory, a general systems model holds that families are systems and that every action in a family produces a reaction in one or more of its members. Families have external boundaries and internal rules. Every member is presumed to play a role (e.g., spokesperson, persecutor, victim, rescuer, symptom bearer, nurturer), which is relatively stable, but which member fills each role may change. Some families try to scapegoat one member by blaming him or her for the family's problems (the identified patient). If the identified patient improves, another family member may become the scapegoat. The general systems model overlaps with some of the other models presented, particularly the Bowen and structural models. Modifications of Techniques Family Group Therapy. Family group therapy combines several families into a single group. Families share mutual problems and compare their interactions with those of the other families in the group. Treatment of schizophrenia

has been effective in multiple family groups. Parents of disturbed children may also meet together to share their situations. Social Network Therapy. In social network therapy, the social community or network of a disturbed patient meets in group sessions with the patient. The network includes those with whom the patient comes into contact in daily life, not only the immediate family but also relatives, friends, tradespersons, teachers, and coworkers. Paradoxical Therapy. With the paradoxical therapy approach, which evolved from the work of Gregory Bateson, a therapist suggests that the patient intentionally

engage in the unwanted behavior (called the paradoxical injunction) and, for example, avoid a phobic object or perform a compulsive ritual. Although paradoxical therapy and the use of paradoxical injunctions seem to be counterintuitive, the therapy can create new insights for some patients. It is used in individual therapy as well as in family therapy. Reframing. Reframing, also known as positive connotation, is a relabeling of all negatively expressed feelings or behavior as positive. When the therapist attempts to get family members to view behavior from a new frame of reference, “This child is impossible” becomes “This child is desperately trying to distract and protect you from what he or she perceives as an unhappy marriage.” Reframing is an important process that allows family members to view themselves in new ways that can produce change. Goals Family therapy has several goals: to resolve or reduce pathogenic conflict and anxiety within the matrix of interpersonal relationships; to enhance the perception and fulfillment by family members of one another’s emotional needs; to promote appropriate role relationships between the sexes and generations; to strengthen the capacity of individual members and the family as a whole to cope with destructive forces inside and outside the surrounding environment; and to influence family identity and values so that members are oriented toward health and growth. The therapy ultimately aims to integrate families into the large systems of society, extended family, and community groups and social systems, such as schools, medical facilities, and social, recreational, and welfare agencies. COUPLES (MARITAL) THERAPY Couples or marital therapy is a form of psychotherapy designed to psychologically modify the interaction of two persons who are in conflict with each other over one parameter or a variety of parameters—social, emotional, sexual, or economic. In couples therapy, a trained person establishes a therapeutic contract with a patientcouple and, through definite types of communication, attempts to alleviate the disturbance, to reverse or change maladaptive patterns of behavior, and to encourage personality growth and development. Marriage counseling may be considered more limited in scope than marriage therapy: Only a particular familial conflict is discussed, and the counseling is primarily task oriented, geared to solving a specific problem, such as child rearing. Marriage therapy, by contrast, emphasizes restructuring a couple’s interaction and sometimes explores the psychodynamics of each partner. Both therapy and counseling stress helping marital partners cope effectively with their problems. Most important is the definition of appropriate and realistic goals, which may involve extensive reconstruction of the union or problem-solving approaches or a combination of both.

Types of Therapies Individual Therapy. In individual therapy, the partners may consult different therapists, who do not necessarily communicate with each other and indeed may not even know each other. The goal of treatment is to strengthen each partner’s adaptive capacities. At times, only one of the partners is in treatment; and, in such cases, it is often helpful for the person who is not in treatment to visit the therapist. The visiting partner may give the therapist data about the patient that may otherwise be overlooked; overt or covert anxiety in the visiting partner as a result

of change in the patient can be identified and dealt with; irrational beliefs about treatment events can be corrected; and conscious or unconscious attempts by the partner to sabotage the patient's treatment can be examined. Individual Couples Therapy. In individual couples therapy, each partner is in therapy, which is either concurrent, with the same therapist, or collaborative, with each partner seeing a different therapist. Conjoint Therapy. In conjoint therapy, the most common treatment method in couples therapy, either one or two therapists treat the partners in joint sessions. Cotherapy with therapists of both sexes prevents a particular patient from feeling ganged up on when confronted by two members of the opposite sex. Four-Way Session. In a four-way session, each partner is seen by a different therapist, with regular joint sessions in which all four persons participate. A variation of the four-way session is the roundtable interview, developed by William Masters and Virginia Johnson for the rapid treatment of sexually dysfunctional couples. Two patients and two opposite-sex therapists meet regularly. Group Psychotherapy. Group therapy for couples allows a variety of group dynamics to affect the participants. Groups usually consist of three to four couples and one or two therapists. The couples identify with one another and recognize that others have similar problems; each gains support and empathy from fellow group members of the same or opposite sex. They explore sexual attitudes and have an opportunity to gain new information from their peer groups, and each receives specific feedback about his or her behavior, either negative or positive, which may have more meaning and be better assimilated coming from a neutral, nonspouse member, for example, than from the spouse or the therapist. During the middle phase of a couples group comprising four couples, the theme of whether to have children arose. One couple had just come from a visit to the gynecologist, who informed them that they were running out of time because of the wife's age. The woman in the couple did not want to have children, but her husband

did. His complaint about the marriage was that his wife never was demonstrative in showing her loving feelings for him. He felt her to be detached, distant, and sexually inhibited. The prevailing sentiment among the other couples who had children was that children only added additional stress to an already stressed relationship. One other couple, however, voiced their different view by describing how their children had enriched their lives. As the talk about going forward and getting pregnant progressed, the group leader noted the nonverbal communication between the ambivalent couple. Whenever the tone of the group leaned toward having children, the wife would reach out and grasp the hand of her husband in a tender way. This invariably had the effect of stopping him from pursuing the topic for fear of the withdrawal of the affection he hungered for. All this occurred without words. Once identified, this repetitive nonverbal pattern was available for examination in the group, and the supportive elements provided by other members and the leader encouraged a frank, direct, and open conversation between the partners, who eventually chose to go forward and attempt to have a child. (Courtesy of H. I. Spitz, M.D., and S. Spitz, ACSW.) Combined Therapy. Combined therapy refers to all or any of the preceding techniques used concurrently or in combination. Thus, a particular patient-couple may begin treatment with one or both partners in individual psychotherapy, continue in conjoint therapy with the partner, and terminate therapy after a course of treatment in a married couples' group. The rationale for combined therapy is that no single approach to marital problems has been shown to be superior to another. A familiarity with a variety of approaches thus allows therapists a flexibility that provides maximal benefit for couples in distress. Indications Whatever the specific therapeutic technique, initiation of couples therapy is indicated when individual therapy has failed to resolve the relationship difficulties, when the onset of distress in one or both partners is clearly a relational

problem, and when couples therapy is requested by a couple in conflict. Problems in communication between partners are a prime indication for couples therapy. In such instances, one spouse may be intimidated by the other, may become anxious when attempting to tell the other about thoughts or feelings, or may project unconscious expectations onto the other. The therapy is geared toward enabling each partner to see the other realistically. Conflicts in one or several areas, such as the partners' sexual life, are also indications for treatment. Similarly, difficulty in establishing satisfactory social, economic, parental, or emotional roles implies that a couple needs help. Clinicians should evaluate all aspects of the marital relationship before attempting to treat only one problem, which could be a symptom of a pervasive marital disorder.

Contraindications Contraindications for couples therapy include patients with severe forms of psychosis, particularly patients with paranoid elements and those in whom the marriage's homeostatic mechanism is a protection against psychosis, marriages in which one or both partners really want to divorce, and marriages in which one spouse refuses to participate because of anxiety or fear. Goals Nathan Ackerman defined the aims of couples therapy as follows: The goals of therapy for partner relational problems are to alleviate emotional distress and disability and to promote the levels of well-being of both partners together and of each as an individual. Ideally, therapists move toward these goals by strengthening the shared resources for problem solving, by encouraging the substitution of adequate controls and defenses for pathogenic ones, by enhancing both the immunity against the disintegrative effects of emotional upset and the complementarity of the relationship, and by promoting the growth of the relationship and of each partner. Part of a therapist's task is to persuade each partner in the relationship to take responsibility in understanding the psychodynamic makeup of personality. Each person's accountability for the effects of behavior on his or her own life, the life of the partner, and the lives of others in the environment is emphasized, and the result is often a deep understanding of the problems that created the marital discord. Couples therapy does not ensure the maintenance of any marriage or relationship. Indeed, in certain instances, it may show the partners that they are in a nonviable union that should be dissolved. In these cases, couples may continue to meet with therapists to work through the difficulties of separating and obtaining a divorce, a process that has been called divorce therapy. REFERENCES Dattilio FM, Piercy FP, Davis SD. The divide between "evidenced-based" approaches and practitioners of traditional theories of family therapy. J Marital Fam Ther. 2014;40(1):5–16. Goldenberg I, Goldenberg H. Family Therapy: An Overview. 6th ed. Pacific Grove, CA: Brooks/Cole; 2004. Gurman AS. Brief integrative marital therapy. In: Gurman AS, Jacobson NS, eds. Clinical Handbook of Couple Therapy. 3rd ed. New York: Guilford; 2003:180. Gurman AS, Jacobson NS, eds. Clinical Handbook of Couple Therapy. 3rd ed. New York: Guilford; 2003. Johnson SM, Greenman PS. The path to a secure bond: Emotionally focused couple therapy. J Clin Psychol. 2006;62(5):597–609. Johnson SM, Whiffen VE, eds. Attachment Processes in Couple and Family Therapy. New York: Guilford; 2003. McGoldrick M, Giordano J, Garcia-Preto N, eds. Ethnicity and Family Therapy. 3rd ed. New York: Guilford; 2005. Nichols MP, Schwartz RC. Family Therapy: Concepts and Methods. 6th ed. Boston: Allyn & Bacon; 2004. Nichols M, Tafuri S. Techniques of structural family assessment: A qualitative analysis of how experts promote a systemic perspective. Fam Process. 2013;52(2):207–215.

Revision #1
Created 2026-01-04 19:51:30 UTC by Omar Ayman
Updated 2026-01-04 19:51:30 UTC by Omar Ayman