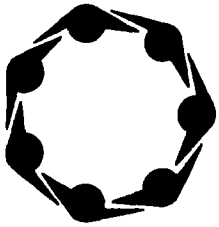

Systemic Family Therapy

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Mrs. Smith calls a psychologist to seek help for her 21-year-old son John, who is living at home. On the phone she sounds desperate and concerned, yet controlled. She says John is verbally abusive to her. He has flunked out of several schools and has never maintained a steady job. The psychologist, a family therapist, inquires who lives at home. Mrs. Smith reports that her youngest daughter, Julie, 19, is home from school for the summer. Mrs. Smith also reports that her husband recently left town to try to find a job. She makes veiled references to her husband's inability to hold down a steady job and his tendency to drink too much. Although Mrs. Smith wants to set up an appointment for John, at the therapist's insistence an appointment is scheduled for the three family members living at home. The initial session finds John hostile and defensive, Mrs. Smith fighting back tears, and Julie attempting to reassure her mother.

In what ways can a family therapist make sense of this intricate, complex group of people called a family? While family therapists may focus on different aspects of family interactions, they probably would all agree on the basic and fundamental concept of the family *system*. While each member of the Smith family has unique problems that might make them appropriate candidates for individual therapy, viewing the family as a system consisting of a complex set of interrelated cause and effect relationships provides the family therapist with a powerful model with which to generate possible hypotheses and interventions.

We suggest that "systemic family therapy" is an effective way of conceptualizing individual and family development, rather than a set of techniques used to work with troubled families. While systems

theory currently permeates the field of family therapy (Guerin, 1976; Hoffman, 1981), it is applied in a myriad of ways. For example, some family therapists may work only with the nuclear family; others may include the extended family; still others (e.g., a college counselor) may work with individual family members. However, regardless of the focus of intervention or techniques employed, each family therapist will likely conceptualize the client's problems using some aspect of systems theory.

In this paper we will explore the relationship between general systems theory and the process of family therapy. After describing the important theoretical concepts of general systems theory, we focus on possible applications of these principles to the course of systemic family therapy.

General Background

The beginnings of general systems theory and its application to family therapy may be traced to two important sets of events. First, the writings of Bertalanffy (1968) and Wiener (1961) laid the foundation for a general systems theory. Bertalanffy brought together information from various disciplines (e.g., biology, physics, and psychology) in forming his general theory that described how parts of systems were inter-related. On the other hand, Wiener contributed an analysis of the functioning of intricate feedback mechanisms in both inanimate and animate systems. Together, Bertalanffy and Wiener formulated the scientific principles that serve as the basis of modern family systems theory.

Besides the scientific reasoning of Bertalanffy and Wiener, the second basis for general systems theory comes from the clinical research of the families of schizophrenics. Researchers such as Nathan Ackerman, Gregory Bateson, Murray Bowen, Don Jackson, Theodore Lidz, and Paul Watzlawick (Berger, 1978; Guerin, 1976; Jackson, 1960; Watzlawick, 1963) observed families with schizophrenic members and laid the groundwork for the application of general systems theory to family therapy. These clinical researchers believed that schizophrenic symptoms could not be fully understood unless they were viewed within the context of their development in the family system.

Concepts of Systems Theory

The systemic model is radically different from the linear cause and effect model typically employed in psychology and other sciences. An example from the biological sciences may help illustrate this difference. Ecologists charting the population growth of a variety of species in a

particular region were puzzled by seemingly inexplicable fluctuations in the population of rabbits. It was not until they applied a systems perspective that they made an important discovery. The rabbits' population fluctuated in direction relation to the population of its primary predator, the wolf. As the wolf population increased, the rabbit population decreased, but only to a certain point. When the number of rabbits decreased beyond the point necessary to support the wolf population, the wolf population began to decrease and the rabbit population once again increased. There probably is no linear reasoning process that can adequately explain this process. The rabbit is not the cause of the increase or decrease in the wolf population. Nor is the reverse true. Rather there is a remarkably stable, *circular relationship* between the rabbit and wolf that produces fluctuations in their respective populations around a certain set point.

Applying a systemic perspective to family therapy means viewing symptoms very differently than when they are described in linear cause and effect terms. In the vignette with which we began this article, rather than asking what is wrong with John (or Mrs. Smith, or Julie, or the absent father), the systemic family therapist might ask what role John's inability to grow up plays in the Smith's family system. For example, just as the wolves and rabbits interact with each other to maintain their delicately balanced populations, John's symptoms may help his parents maintain a delicately balanced degree of distance. In fact, John's current symptoms may serve the function of bringing his absent father back into the family system.

In addition to the concept of circular cause and effect, the systems concept of *levels* also has influenced the work of family therapists. In our clinical vignette, each family member is, at the same time, an individual and a member of either the sibling or parental subsystem. The sibling and parental subsystems comprise the nuclear family system that, in turn, is part of a larger system including extended family members and friends. Even this larger system is only a part of an encompassing community system. A systems therapist may conceptualize problems at any or all of the above levels. For example, John's problems could be conceptualized as a difficulty in growing up, a way of freeing his sister from parental pressure, a way of diffusing conflict within the marital system, or even as a way of reducing conflict between the nuclear family and its extended family members who may be concerned about Mr. Smith's lack of employment. Often a family therapist must decide at what level or levels of the system to intervene, because there are times when intervening at one level may interfere with or radically alter the functioning of the system at another level. Systemic family therapists must be aware of the effects of their interventions at all systems levels,

and, in some instances, they must make ethically difficult decisions about where to intervene (Sider & Clements, 1982). For instance, should the therapist work solely with John to increase his competence and autonomy, then John's role as the mediator or distractor in his parent's arguing and in regulating their degree of distance may be upset. The resulting increased pressure in the marital system might actually produce increased arguing and eventually divorce.

In addition to needing to consider the different levels of intervention within the nuclear and extended family, a systemic family therapist also must be aware of the social context within which the nuclear family is developing. For example, troubled families are often involved with more than one helping agency, and these agencies may actually be working at cross purposes (Douglas and Jurkovic, 1983).

A systems concept equally important as levels is *equipotentiality*. Equipotentiality refers to the possibility that similar types of systems may be made up of very different parts with very different past histories. For example, family members may be very close to one another for a variety of reasons. If one or both parents had been raised in a nonsupportive environment with very distant or unemotional parents, they may wish to provide their own children with the kind of support they did not receive. Conversely, if the parents had been raised in a very supportive, loving environment, they may wish to recreate that atmosphere for their own children. Equipotentiality also refers to the idea that similar parts may combine in various ways to form very different types of systems and that systems with similar past histories may appear to be quite different in the present. For instance, families may respond in a variety of ways to the loss of a child. Some parents may respond to this loss by becoming very protective of their remaining children while other parents may become somewhat withdrawn, preoccupied, and more distant from the remaining children.

Because they accept the principle of equipotentiality, systemic family therapists tend to spend more time working with family relationships in the present than in clarifying what has happened in the past. Although they believe past events are important, systemic therapists tend to emphasize changing relationships in the here and now. In the case of our Smith family, a systemic family therapist would be more likely to begin by attempting to identify John's current role in maintaining the status quo of the family than by gathering information about John's past that might have caused him to behave immaturely.

In addition to directing therapists to focus their work in the present, the equipotentiality principle has influenced systemic therapists' perceptions of what constitutes "normal" family functioning. Due to the enormous potential for diversity in developing family systems, family

therapists tend to maintain a healthy respect for the many ways families may accomplish their developmental tasks.

In order to understand more fully how families accomplish their developmental tasks, we will now introduce two additional systems concepts, negative and positive feedback mechanisms. Just as a thermostat maintains a constant temperature around a set point, *negative feedback mechanisms* work to maintain stability in living systems. Our earlier rabbit and wolf analogy is an example of a stable, negative feedback mechanism. As the wolf (or rabbit) population changes in one direction, the rabbit (or wolf) population responds in the opposite or "negative" direction. The effect is that both animal populations remain balanced around a set point. In the Smith family, John's immature behavior may be seen as a negative feedback mechanism that helps his parents maintain a stable, distant, but not separate, relationship. John's acting out typically occurred either when his parents became too close and began to argue, or too far apart and each parent feared losing the other. From the systemic family therapy view, if John's symptoms improved, then some other negative feedback mechanism might develop or else the entire system might be forced to change to accommodate to John's new role.

While systems maintain stability through negative feedback mechanisms, they change and grow primarily via *positive feedback mechanisms*. Referring again to the analogy of the rabbits and wolves, if there were a severe climactic change such as a drought or freeze, the homeostatic negative feedback mechanism could be upset. As the rabbit population declined, so would the wolf population until a new balance, or set point, were achieved. Relating this mechanism to the Smith family, the therapist might choose to intervene by preventing John's immaturity from interfering in the marital relationship. For a time, this intervention might upset the homeostatic balance between husband and wife and increase the arguments between them. In fact, the wife might be more prone to nag her husband, instead of John. Or, the husband might become annoyed with his wife's behavior rather than with his son's. In either case, the result would be an escalation of the tension between husband and wife. Thus, by preventing John's role in maintaining a stable system, the therapist produces a crisis within the marital relationship and increases the possibility for change.

Family Systems Development

Family systems are assumed to utilize both negative and positive feedback processes in order to accomplish their developmental tasks. These developmental tasks include providing stability and security for

family members, especially infants and young children. At the same time, family systems must facilitate their members' growth and independence, especially for older children who will eventually establish their own families. A family's developmental tasks tend to occur in predictable stages that have been elucidated by Carter and McGoldrick (1980b). For instance, a young couple with a new child must renegotiate their marital relationship, renegotiate relationships with extended family members, and provide nurturance for the newborn infant. In a later stage of development, a family with adolescent children must learn to delegate increasing responsibility and personal decision-making to the children and renegotiate the marital subsystem as older adolescents leave home.

Both negative and positive feedback mechanisms enable a family to complete its developmental tasks, though in somewhat different ways. Negative feedback allows the family members to develop and grow within each developmental stage of the family. By helping the family members to learn both what they can expect from their family and also what is expected of them, negative feedback mechanisms create an atmosphere of stability, security, and consistency in which family members can feel safe, learn to take risks, and grow.

On the other hand, the mechanism of positive feedback enables a family system to grow by allowing it to respond to different developmental stresses, and thus, to move from one developmental stage to the next. Positive feedback enables the family members to learn to interact differently with one another and to relate differently to people outside the nuclear family. Positive feedback processes are likely operating when parents of adolescents allow their children greater freedom and responsibility and learn to reestablish their own intimate relationship once their adolescent children leave home. In addition to facilitating a family's adaptation to developmental stresses, positive feedback mechanisms also allow a family to cope with unexpected accidental stresses, such as the loss of income or a severe illness.

The ways in which family systems adapt to both developmental and accidental stresses determine, to a large extent, whether the stresses will create opportunities for growth or disordered behaviors. According to the equipotentiality principle, there are an infinite variety of viable and creative ways in which a family system may choose to handle its life stresses (see Carter & McGoldrick, 1980a, and Walsh, 1982, for a more in-depth discussion of the development of healthy family systems).

Family Dysfunction

A family becomes dysfunctional or symptomatic when its previously

adequate resources, coping skills, patterns of interacting, or strategies for dealing with stress are no longer effective. The "symptom" may be seen both as a sign that the previous ways of handling stress are no longer effective *and* as the family's attempt to avoid change. The family may be relying on negative feedback mechanisms in an attempt to stabilize the situation and avoid change, rather than on positive feedback mechanisms that would enable the family to grow or change. When stress reaches an intolerable level, the family may decide to enter therapy.

Decision to Enter Therapy

The decision to enter therapy may be made in a number of ways and for a variety of reasons. Typically, one or more members of the family may be a "symptom bearer." The identity of the symptom bearer may change over time. For example, over the course of treatment, the symptom bearer of the Smith family could change from John to Mr. or Mrs. Smith. In other cases, difficulties may arise in a previously asymptomatic sibling following resolution of an identified symptom bearer sibling's difficulties. Or, an asymptomatic spouse may develop symptoms when a previously symptomatic spouse begins to recover. These possibilities illustrate the importance of viewing the presenting problem as a systems issue rather than as an individual problem. When the problem is viewed and treated solely as an individual issue, the systemic or family difficulties often remain unresolved and a new symptom bearer may be required to maintain stability.

The manner in which a family enters therapy depends to a large extent upon the particular symptoms shown by the symptom bearer. If an adolescent boy has been caught stealing or setting fires, then the family therapy may be court ordered. If a third-grade girl exhibits behavior problems in school, then the teacher may recommend family therapy. If a spouse/parent has had a series of psychosomatic complaints, then the physician may be the impetus for family therapy. Regardless of who the symptom bearer is or what the particular symptom chosen, in systemic family approaches, the therapist's job is to conceptualize the difficulty in systemic terms.

Family Members Seen in Therapy

As was mentioned previously, since systemic therapy refers to a way of thinking about families, there are no specific requirements for how many family members should participate. For example, systemic therapy

may be conducted with an individual family member, a particular dyad, an intact nuclear family, or even a group of individuals from several different families of origin.

A critical assumption of systemic family therapy is the fact that absent members are always present. That is, therapists must always consider how their interventions may affect the absent members and the subsequent effect of the absent members' reactions on the family members who are physically participating in the therapy process. Absent members may be included in the therapy process through a variety of techniques utilized both during the therapy process (e.g., imagery, role-playing, Gestalt techniques, conference calls to absent members) and outside the therapy sessions (e.g., letter-writing to the absent member, homework assignments including the absent members). The systemic family therapist also must continuously evaluate the effect of any family member's nonparticipation and decide how strongly to encourage or require physical participation by an absent member.

No decision about which family members to include in the therapy process is final. Decisions are influenced by a number of factors, including practical considerations, family members' willingness to participate, and the nature and severity of the particular presenting problem. Family members may be added to or excused from therapy sessions throughout the course of treatment to accommodate to and capitalize upon changes in the family system. In the case of the Smith family, therapy might begin with the three family members living at home. Mr. Smith would likely be included in the therapy sessions should he return home. Eventually, Mr. and Mrs. Smith might be seen in couples therapy, alternating with individual sessions involving John.

Tasks and Techniques

Since systemic family therapy is first and foremost a way of thinking about families, it is not associated with a specific set of techniques. A systemic family therapist has several general tasks to perform, each of which may be accomplished in a variety of ways with a great number of techniques (see Minuchin & Fishman, 1981). The selection of techniques is influenced by a number of factors, including the following: the therapist's personal style and theoretical beliefs, the characteristics of the family system, the personalities of the individual family members, the developmental stage of the family, the nature and severity of the presenting problem, the particular family members present, and the desired therapeutic goals.

The first task of systemic family therapists is assessment. Assessment

begins prior to the first session and continues throughout the course of therapy. Therapists constantly gather and use data to develop, test, and revise hypotheses within the systems framework. Examples of the questions therapists may be evaluating include the following: "What function is the symptom serving?" "How does this family function vis-a-vis the outside world?" The answers to these questions may be gathered through a variety of techniques. One such technique, circular interviewing, is a method that encourages family members to think in a systemic way. Questions that illustrate circular interviewing with the Smith family might be "Who is most concerned about John?" and "If John were fine, who would the family worry about most?" Another assessment technique, the observation of nonverbal interaction patterns, also can provide the family therapist with valuable information. In the Smith family, for instance, if both children were to look to Mrs. Smith before talking, then the therapist might hypothesize that Mrs. Smith is a very powerful person in the family. Or, if John were to distract other family members from their conflicts by laughing, scowling, or turning around in his chair, then the therapist might speculate that one of John's roles in the family is to diffuse tension. Assessment techniques may be utilized both during and outside the therapy sessions. Family therapists often obtain valuable information about a family's resources or motivation to change by assessing the family's willingness or ability to perform specific homework assignments. The family's success or failure with the assignments often becomes an important focus of subsequent therapy sessions.

Besides assessment, a second task of the systemic family therapist is to "join the system." Analagous to the development of the therapeutic relationship in individual therapy, this is a necessary but not sufficient ingredient for effective therapeutic intervention. Therapists may gain the trust of the family by using such joining techniques as story-telling, self-disclosure, acknowledging or validating a family member's opinion, or empathizing with a family member's perception of the problem.

In addition to assessment and joining the family system, the third important therapeutic task is intervention. Seemingly there are as many different ways of intervening in family systems as there are family therapists. Some family therapists intervene through story-telling or metaphors, believing that learning, and thus change, occurs outside the family's conscious awareness (Erickson, Rossi, & Rossi, 1976; Neill & Kniskern, 1982). Other therapists engage in direct teaching with the family using such techniques as role-playing, teaching of communication skills, discussion of limit-setting, and assertiveness training (Alexander & Parsons, 1982). Still other systemic therapists utilize techniques designed to confuse the family and create a crisis (Haley, 1980; Madanes, 1981; Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1978; Minuchin, 1974).

Finally, there are those systemic therapists who rely on less dramatic techniques to help the family members learn to relate differently to one another and gain insight into their own behavior or role in the family system (Napier & Whitaker, 1978). In addition to how they intervene, therapists also differ in the level at which they prefer to intervene. As we mentioned previously, systemic family therapists should consider how their interventions will affect all levels of the system. They may choose to intervene with one individual, a particular dyad, or with the entire nuclear family. Relating once more to the Smith family, one systems goal might be to help the parents renegotiate their relationship. In order to achieve this goal, one therapist might choose to work individually with John in an attempt to help him leave home and relieve him of the burden of being his parents' distance regulator. In contrast, a second therapist could choose to work directly with the marital couple, while a third therapist might decide to see John and his parents together. Each systemic therapist intervenes at a different level, but is attempting to achieve the same therapeutic goal.

As well as knowing how to intervene, systemic family therapists should also know how to disengage or distance themselves from the system. While joining a family system is critical to successful family therapy, a family therapist should always be aware of the danger of becoming too integral a part of a family system and actually retarding the process of change. To help become aware of, achieve, and maintain appropriate therapeutic distance, therapists rely on numerous techniques, including periodic live consultations by other therapists, the use of co-therapists, and the use of a team approach with one therapist in the room and one or more colleagues behind a one-way mirror.

Parameters of Therapy

The parameters of treatment are as diverse as the therapeutic techniques that are employed. There are no hard and fast rules governing the length or number of systemic family therapy sessions. The duration and scheduling of sessions depends on such variables as the therapist's style, the phase of therapy, and the nature and severity of the presenting problem. Therapy may take anywhere from one to hundreds of sessions that span several years. Some families may return for brief check-ups for years after they complete therapy. Families may be seen weekly for one to two hours, or once a month. In some instances, therapists might choose to schedule marathon sessions of several hours in length on consecutive days to take advantage of an out-of-town visit by an im-

portant extended family member. At other times, particularly during the termination phase, a therapist might choose to see a family once a month to assess the family's ability to maintain the therapeutic gains without the aid of weekly therapy.

Termination

As with the other parameters of systemic family therapy, there are no rigid guidelines for determining when a family is ready to stop treatment. The decision to end is influenced by such factors as the family's subjective level of discomfort, the family's psychological and financial resources, and the degree of change a family is motivated to attain. For example, the Smiths may be satisfied with John moving out and successfully maintaining his own apartment, provided that they have someone (an extended family member, for example) who can replace John's function as the couple's distance regulator. However, the couple may be motivated enough to remain in therapy until a second-order change is achieved (e.g., husband and wife achieve greater intimacy). While it is the therapist's responsibility to work with the family and provide treatment recommendations, the decision about when to terminate therapy usually is the family's responsibility.

Therapist Characteristics

Family therapists must be able to conceptualize individual or dyadic symptoms in a systemic way. Rather than searching for linear cause and effect relationships, systemic family therapists conceptualize circular patterns of complex inter-relationships. In addition to understanding the individual dynamics of each family member, therapists consider the family system as a separate entity that is greater than and often very different from the sum of its parts.

To accomplish these therapeutic tasks, systemic family therapists have to be flexible and creative. Therapists must constantly seek new information and revise their hypotheses. They need to be flexible enough to work in ways that are appropriate for particular families. The techniques available to systemic family therapists are limited only by their creativity in developing and utilizing them.

Finally, systemic family therapists must be aware of their own blind spots that might interfere with their ability to work effectively with family systems. An important aspect of this self-awareness is some degree of insight into the dynamics of the therapist's own family of origin.

Closing Comments

Perhaps the greatest danger to the family therapy movement comes from within the field itself. Now that schools of family therapy are being firmly established, followers may rigidly assume, on faith alone, that their perspective is the "correct" one and all other approaches are wrong. Rather than engaging in polemics, family therapists from different schools of thought might best serve the field by focusing on and clarifying the beliefs they hold in common. At the same time, it would be important to evaluate different family therapy models and techniques in an attempt to specify which approaches work best with which types of families under which circumstances. Once systematic, well-designed outcome studies have been conducted, we may be able to apply the powerful techniques developed by the family therapy movement more efficaciously.

References

Alexander, J., & Parsons, B. V. (1982). *Functional family therapy*. Monterey, CA: Brooks/Cole.

Berger, M. M. (Ed.). (1978). *Beyond the double bind: Communication and family systems theories and techniques with schizophrenics*. New York: Brunner/Mazel.

Bertalanffy, L. von (1968). *General systems theory: Foundations, developments, applications*. New York: Braziller.

Carter, E. A., & McGoldrick, M. (Eds.). (1980a). *The family life cycle: A framework for family therapy*. New York: Gardner Press.

Carter, E. A., & McGoldrick, M. (1980b). The family life cycle. In F. Walsh (Ed.), *Normal family processes* (pp. 167–195). New York: Guilford Press.

Douglas, C., & Jurkovic, G. J. (1983). Agency triangles: In agency-family relationships. *Family Process, 22*, 441–451.

Erickson, M. E., Rossi, E. L., & Rossi, S. I. (1976). *Hypnotic realities: The induction of clinical hypnosis and forms of indirect suggestion*. New York: Irvington.

Guerin, P. J. (1976). *Family therapy*. New York: Wiley & Sons.

Haley, J. (1980). *Leaving home*. New York: McGraw-Hill.

Hoffman, L. (1981). *Foundations of family therapy: A conceptual framework for systems change*. New York: Basic Books.

Jackson, D. D. (Ed.). (1960). *The etiology of schizophrenia*. New York: Basic Books.

Madanes, C. (1981). *Strategic family therapy*. San Francisco: Jossey-Bass.
Minuchin, S. (1974). *Families and family therapy*. Cambridge: Harvard University Press.
Minuchin, A., & Fishman, H. C. (1981). *Family therapy techniques*. Cambridge: Harvard University Press.
Napier, A. Y., & Whitaker, C. A. (1978). *The family crucible*. New York: Harper & Row.
Neill, J. R., & Kniskern, D. P. (Eds.). (1982). *From psyche to system: The evolving therapy of Carl Whitaker*. New York: Guilford Press.
Selvini-Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox*. New York: Aronson.
Sider, R. C., & Clements, C. (1982). Family or individual therapy: The ethics of modality choice. *American Journal of Psychiatry, 139*, 1455–1459.
Walsh, F. (Ed.). (1982). *Normal family processes*. New York: Guilford Press.
Watzlawick, P. (1963). A review of the double bind theory. *Family Process, 2*, 132–153.
Wiener, N. (1961). *Cybernetics: Or control and communication in the animal and the machine*. New York: MIT Press and Wiley.