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Demystifying Family Therapy

by Anthony L. Chambers, PhD

Families represent one of the most important contexts for human relationships. When families function well, family relationships can be immensely satisfying. However, when families do not function well, family relationships can be distressingly painful. When problems emerge, families are increasingly turning to family therapists for help. In fact, family therapy is one of the most common forms of mental health treatment.

This article will attempt to demystify family therapy by describing its underlying treatment approach and core concepts. Second, studies will be presented which delineate the effectiveness of family therapy for specific types of individual problems, as well as investigate how family therapy works. Finally, tips will be provided for selecting a good family therapist.

Defining family therapy

"Family therapy" does not necessarily entail the treatment of all family members simultaneously. That is, although the family is the primary focus of treatment, therapists may conduct individual sessions with adolescents, sessions with parents alone, or even sessions with concerned others such as peers, school personnel, or the police (Lebow, 2000). However, a central tenet of family therapy is its *family systems perspective* – that is, the notion that an individual's problems occur within the broader context of the family.

A family systems perspective on family functioning

The family systems perspective contains several basic tenets which are assumed to underlie family functioning. First, a family (typically involving two to four generations) is influenced by the opportunities and constraints of its social context. In order to ensure its own existence, a family adapts available resources to normal and abnormal transitional and crisis stress events (Wilson, Chambers, and Woods, 2005). Family resources involve the ability of family members to contribute tangible help (such as material support, income, childcare, and household maintenance), and nontangible aid (such as expressive interaction, emotional support, instruction, and social training and regulation). How well a family functions depends on such aspects of family life as the clarity of its communication, rules, and ability to mobilize family resources during a time of crisis.

Is family therapy effective?

More than 40 years of research on the efficacy of family therapy supports the conclusion that family therapy is effective. For example, Shadish et al. (1993) used a statistical technique called meta-analysis to summarize the results of 63 previous research studies examining the efficacy of family therapy. Their results showed that clients

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who received family therapy were better off than approximately 70% of clients who did not receive treatment.

Family therapy is at least as effective as other treatment modalities, such as individual therapy, for problems such as depression (Beach & O'Leary, 1992; Emanuels-Zuurveen & Emmelkamp, 1996; Jacobson, Dobson, Fruzzetti, Schmaling, & Salusky, 1991). There is more evidence for the efficacy of family therapy for specific problems (e.g., conduct disorder in children and adolescents) than there is evidence that specific types of family therapy are better than any other specific type (i.e., structural vs. strategic family therapy) (Pinsof, Wynne, & Hambright, 1996). In what follows, research on the efficacy of family therapy in treating four specific problem areas is described.

Adolescent drug abuse

Utilization of family therapy to treat adolescent drug abuse has generally found that family treatment is more effective than other treatments (Liddle, Dakof, & Diamond, 1991). For instance, Szapocznik, Perez-Vidal, Brickman, Foote, and Santisteban (1988) found that family treatments result in approximately 80% of adolescents being drug-free at termination and that family treatments produce twice as many drug-free adolescents at termination when compared to group therapy or family drug education programs. Liddle and Dakof (1994) examined the efficacy of their family therapy approach on a group of adolescents who were abusing drugs. After treatment, only 9% of the adolescents were using drugs, and only 3% were using drugs one-year post treatment. Family treatments also have better retention rates than other treatments (Joanning, Quinn, Thomas, & Mullen, 1992; Liddle & Dakof, 1994).

Delinquency and oppositional disorders

There are several studies demonstrating that family therapy is effective for treating delinquent adolescents (Tolan, Cromwell, & Brassell, 1986). For instance, Henggeler, Bourduin, Melton, Mann, and Smith (1991), and Henggler, Melton, and Smith (1992) demonstrated that delinquent adolescents treated with family therapy have fewer arrests, fewer self-reported offenses, and average 10 fewer weeks of incarceration.

One form of family therapy used for the treatment of oppositional and aggressive children is parent training. Parent training evolved from the observation that inconsistent parenting places children at risk for conduct disorder, delinquency, and adolescent substance abuse. Research has shown that training parents to provide consistent, appropriate discipline is effective (Kazdin, 1991), and that parent training can even increase marital satisfaction (Sayger, Horne, & Glaser, 1993).

Schizophrenia

Studies have found the relationship between a person with schizophrenia and his or her family members has a significant impact on the functioning of the schizophrenic patient. These studies led to the development of family therapy treatments for schizophrenia. For example, Falloon, Boyd, McGill, Williamson, and Razani (1985) and Hogarty, Anderson, Reiss, Kornblith, and Greenwald (1986) developed psychoeducational programs that combined education, medication, interpersonal skill training, and family therapy. They found that family therapy focused on reducing "expressed emotion" (high levels of hostility, emotional over-involvement, and criticism) significantly reduced relapse and symptomatic behavior. Research also shows that rates of recidivism have been reduced by as much as 50% through the addition of family treatment strategies (Goldstein & Miklowitz, 1995). Furthermore, research shows that such family treatment is more cost effective than individual therapy, hospitalization, and standard, non-family treatments (Pinsof, Wynne, & Hambright, 1996).

Anorexia nervosa

Family therapy is the most researched treatment for anorexia nervosa (Wilson, Grilo, & Vitousek, 2007). Russell, Szmukler, Dare, and Eisler (1987) were among the first to examine the efficacy of family therapy for the treatment of anorexia nervosa. The family therapy involved 10–20 family sessions over 6–12 months. All family members were seen together, and parents were directed to help the child take control of his or her eating. They found that in a subset of younger patients with a recent onset diagnosis of anorexia nervosa, family therapy had a strikingly high recovery rate, with about 90% of patients becoming symptom free five years after treatment ended. This result is significantly more effective than those attained by most individual treatments (Eisler et al., 1997; Russell, Szmukler, Dare, & Eisler, 1987), leading to the general consensus that family therapy is the treatment of choice for younger patients.

How does family therapy work?

Given the conclusion that family therapy is effective for a variety of problems, how does family therapy lead to enhanced functioning, improved communication and relationships, and decreased symptoms? One important finding is that a strong *therapeutic alliance* between the therapist and the family is central for positive change to occur. Bordin (1979) defined the therapeutic alliance as a strong bond between the therapist and patient, as well as their agreement on the tasks and goals of treatment. Pinsof and colleagues (Pinsof, 1994; Pinsof & Catherall, 1986) define the alliance in family therapy as being composed of four separate components: each individual family member's alliance with the therapist, the family's alliance as a whole with the therapist, each family member's view of the therapist's alliance with the other family members, and the alliance between all the family members with respect to their participation in the treatment.

Friedlander, Wildman, Heatherington, and Skowron (1994) and Hetherington, Friedlander, and Greenberg (2005) have identified several key processes in family therapy. Family therapists tend to take a more assertive and active role in therapy than do most individual therapists. When family members make positive changes in therapy, these changes tend to cross the dimensions of cognitive, affective, and/or behavioral change. Finally, the effectiveness of a family therapy session is influenced by the family's level of cooperation and their active participation in the problem-solving process.

How to select a good family therapist

Balancing the needs of multiple family members while working in the best interest of the family as a whole can be quite challenging. Given this complexity, finding a good family therapist is important. For starters, ask people you know and trust to identify a referral for you.

Second, make sure your prospective therapist has specific training in family therapy. Inquire about your therapist's educational background (many therapists today even post their biography online), and do not hesitate to interview the therapist during your initial phone conversation.

Finally, your family therapist must not just be competent – he or she must also be comfortable for you to work with. Use your initial phone conversation, or your first consultation appointment, to assess the therapist's interpersonal style and approach to treatment. After the first appointment, make sure you and your family members agree on the therapist's initial recommendations and treatment plan.

Consistent with decades of family therapy research, the right therapist can create a context where families are able to make the changes necessary for healing and thriving.

References

Beach, S. R. H., & O'Leary, K. D. (1992). Treating depression in the context of marital discord: Outcome and predictors of response for marital therapy versus cognitive therapy. *Behavioral Therapy*, 23, 507-528.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16, 252-260.

Eisler, I., Dare, C., Russell, G. F. M., Szmukler, G. I., le Grange, D., & Dodge, E., (1997). Family and individual therapy in anorexia nervosa: A 5-year follow-up. Archives of General Psychiatry, *54*, 1025-1030.

Emanuels-Zuurveen, L., & Emmelkamp, P. M. G. (1996¬). Individual behavioural-cognitive therapy for depression in maritally distressed couples. *British Journal of Psychiatry, 169*, 181-188.

Falloon, I. R. H., Boyd, J. L., McGill, C. W., Williamson, M., & Razani, J. (1985). Family management in the prevention of morbidity of schizophrenia: Clinical outcome of a two year longitudinal study. *Archives of General Psychiatry, 42(8),* 87-96.

Friedlander, M. L., Wildman, J., Heatherington, L., & Skowron, E. A. (1994). What we do and don't know about about the process of family therapy. *Journal of Family Psychology, 8(4),* 390-416.

Goldstein, M. J., & Miklowitz, D. J. (1995). The effectiveness of psychoeducational family therapy in the treatment of schizophrenic disorders. *Journal of Marital and Family Therapy, 21,* 361-376.

Heatherington, L., Friedlander, M. L., & Greenberg, L. (2005). Change process research in couple and family therapy: Methodological challenges and opportunities. *Journal of Family Psychology, 19(1)*, 18-27.

Henggeler, S. W., Bourduin, C. M., Melton, G. F. B., Mann, B. J., & Smith, L. A. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly, 1,* 40-51.

Henggeler, S. W., Melton, G. B., & Smith L. A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60(9),* 53-61.

Hogarty, G., Anderson, C. M., Reiss, D. J., Kornblith, S. J., & Greenwald, D. P. (1986). Family psychoeducation, social skills training and maintenance chemotherapy in the aftercare treatment of schizophrenia: One-year effects of a controlled study on relapse and expressed emotion. *Archives of General Psychiatry, 43(6),* 33-42.

Jacobson, N. S., Dobson, K., Fruzzetti, A. E., Schmaling, K. B., & Salusky, S. (1991). Marital therapy as a treatment for depression. *Journal of Consulting and Clinical Psychology, 59,* 547-557.

Joanning, H., Quinn, W., Thomas, F., & Mullen, R. (1992). Treating adolescent drug abuse: A comparison of family systems therapy, group therapy, and family drug education. *Journal of Marital and Family Therapy, 18(3),* 45-56.

Kazdin, A. E. (1991). Effectiveness of psychotherapy with children and adolescents. *Journal of Consulting and Clinical Psychology, 59(7),* 85-98.

Lebow, J. L. (2000). What does the research tell us about couple and family therapies. *Psychotherapy in Practice,* 56(8), 1083-1094.

Lebow, J. L., & Gurman, A. S. (1995). Research assessing couple and family therapy. *Annual Review of Psychology,* 46, 27-57.

Liddle, H. A. & Dakof, G. A. (1994). Familiy-based treatment of adolescent drug use: State of the science. In E. Rahdert (Ed.), *Adolescent drug abuse: Assessment and treatment.* Rockville, MD: National Institute of Drug Abuse.

Liddle, H. A., Dakof, G. A., & Diamond, G. (1991). Adolescent substance abuse: Multidimensional family therapy in action. In E. Kaufman & P. Kaufmann (Eds.), *Family therapy with drug and alcohol abuse.* Boston: Allyn & Bacon.

Pinsof, W.M. (1994). An integrative systems perspective on the therapeutic alliance: Theoretical, clinical, and research implications. In A.O. Horvath & L.S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (pp. 173-195). New York: Wiley.

Pinsof, W. M., & Catherall, D. R. (1986). The integrative psychotherapeutic alliance: Family, couple and individual therapy scales. *Journal of Marital and Family Therapy,* 12, 137-151.

Pinsof, W. M., Wynne, L. C., & Hambright, A. B. (1996). The outcomes of couple and family therapy: Findings, conclusions, and recommendations. *Psychotherapy*, 33(2), 321-331.

Russell, G. F. M., Szmukler, G. I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Developmental and Behavioral Pediatrics, 15,* 111-116.

Sayger, T. V., Horne, A. M., & Glaser, B. A. (1993). Marital satisfaction and social learning family therapy for child conduct problems: Generalization of treatment effects. *Journal of Marital and Family Therapy, (19),* 393-402.

Shadish, W. R., Montgomery, L. M., Wilson, P., Wilson, M. R., Bright, I., & Okwumabua, T. (1993). Effects of family and marital psychotherapies: A meta-analysis. *Journal of Consulting and Clinical Psychology, 61,* 992-1002.

Szapocznik, J., Perez-Vidal, A., Brickman A., Foote, F. H., & Santisteban, D. (1988). Engaging adolescent drug abusers and their families into treatment: A strategic structural systems approach. *Journal of Consulting and Clinical Psychology, 56(5)*, 52-57

Tolan, P. H., Cromwell, R. E., & Brassell, M. (1986). Family therapy with delinquents: A critical review of the literature. *Family Process,* 26(6), 19-50.

Wilson, M. N., Chambers, A. L., & Woods, L. (2005). Fathers in minorities families: The importance of social and cultural context. In W. M. Pinsof, and J. Lebow (Eds.) *Family Psychology: The Art of the Science*. Oxford/New York: Oxford University Press.

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist*, 62(3), 199-216.

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