Family Therapy: An "Emerging Field"

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Couple and Family Therapy and Theory (also known as marriage and family therapy and theory) has a fairly long history. It started in the 1930s with work on marriage counseling, the child guidance movement, family life education, and social psychiatry (Doherty & Baptiste, 1993); and then moved to work on family therapy in the 1940s, post-World War II with the development of systems theories. However, it is not until more recently that as a field we have begun to examine ourselves as more than practitioners, but as a separate discipline. DuPree, White, Meredith, Ruddick, and Anderson (2009) provided a recent survey of the literature produced by those who are professors in Ph.D. programs accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). They found that professors in these programs, on average, produce about one refereed journal article every 2 years. They suggest that this research productivity needs to increase if Couple and Family Therapy (CFT) as a discipline is to continue to move forward.

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Part of the impetus for their survey was another article published in 2002 by Crane, Wampler, Sprenkle, Sandberg, and Hovestadt that reviewed the status of the scientist/practitioner model in Ph.D. programs. The conclusion of this review was that much of the research being conducted on CFT was being done "outside" of the field. Those that have degrees in CFT are rarely recognized by these other researchers as representing a separate and legitimate profession (Crane et al.). Thus, we have journals in the area of family psychology, where many of the scholars who produce research in family therapy publish. We also have journals in psychology (i.e., *Journal of Consulting and Clinical Psychology,* and *Journal of Counseling Psychology*) that publish articles about CFT and seem to think about it as a modality, rather than a separate discipline.

The requirements for delineating a mental health discipline as separate from others is to have a professional association, a separate literature base, and licensure for practitioners. The American Association for Marriage and Family Therapy has been in existence since 1942. There are several journals that publish family therapy-related literature (i.e., *Family Process*, *Journal of Marital and Family Therapy*, *Contemporary Journal of Family Therapy*, *American Journal of Family Therapy*, and the *Journal of Family Therapy*). As of 2009, CFTs were licensed in all 50 states. California

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was the first state to provide a license for CFT's which occurred in 1963. Thus, although CFT has the required factors that would establish it as a separate discipline, and it has had these factors for quite some time, there is still a sense that CFT is an emerging field. Part of this sense is that the research base for the field has been slow to develop, and many of those who conduct this research are not CFT-trained (Crane et al., 2002).

What appears to be the biggest hurdle for CFT research is the researcher–practitioner gap. Lee and Everett (2004) suggest that as family therapy developed in the early years, many clinicians identified with the founders of family therapy theories and techniques. This identification set the field on a track that seemed to indicate that the only way to be a family therapist was to practice like one of the "gurus" of family therapy. Lee and Everett (2004) also pointed out that there were *family scientists* at the time that were concerned about this trend and suggested that the first and primary area of mastery for a family therapist was "the family," while the intervention or therapy should come second. Doherty and Baptiste (1993) contended that family therapy was born in a research tradition that investigated the role of family interaction in the development of psychological/mental illness, specifically schizophrenia (i.e., Bateson's double bind theory of schizophrenia, 1972). However, family therapy as a field lost this focus as new ideas and techniques with clinical foci emerged during the 1960s and 1970s. Thus, early in the field, similar to many mental health fields, there seemed to be those who were more interested in practice, while others were more interested in some evidence base for the practice. Wampler (2010) would suggest that this is common for mental health disciplines that establish a license at the masters level, rather than requiring a Ph.D. to practice. This researcher/practitioner rift or split has also created a tension between family science as a field and family therapy. Somehow the theories espoused in family therapy are not considered the same as family theory in general by those in family science (see White, 2012). Thus, it was not until 1993 that family therapy was included as a chapter in a family theory and research text book (Doherty & Baptiste, 1993). The authors of this chapter link this timing to the classic researcher/clinician split which they suggest began in the late nineteenth century. They end their chapter with the following:

> Family therapy theory now risks such a split between research-oriented and epistemologically oriented approaches to theory development..... Family therapy theory in the early 1990's is poised between its ambitious social science and system theory roots and the emerging post modern cultural era that emphasizes skepticism, uncertainty, and modesty in theory construction.
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> To balance the old and the new, the modern and post-modern, the traditional approaches to theory construction and empirical validation with the more radical constructivist approaches…are the imposing but exciting challenges for family therapy theory in the decade of the 1990's and beyond (Doherty & Baptiste, 1993, p. 522).

We're not sure that family therapy as a field was able to meet these challenges. Johnson (2003), 10 years later, also suggested that although researchers espouse a systemic perspective, they rarely investigate "whole" family functioning and few have investigated change in family functioning in conjunction with changes in outcomes. The purpose of this chapter is to introduce the reader to the classic systems theory framework that informed family therapy theory, review literature on the effectiveness/efficacy of CFT, and promote the use of family therapy theory as family theory. It is our contention that family therapy theory is family theory, and can be used in the study of families in general, not just couples and families who seek services. We believe there are at least two ways of approaching this: (1) use the constructs from family therapy theories, make hypotheses based on those constructs, and assess them on samples of "normal" families; or (2) when investigating the effectiveness of CFT, use the constructs from within the family therapy theory and assess them over time when the family initiates therapy, while the family participates in therapy, and then at structured follow-ups. That is, rather than providing evidence that some symptom or problem outcome has improved during treatment, provide evidence that something inside the family, or something about how the family interacts has changed in conjunction with a change in the outcome or

problem behavior. There are some examples of the first, but very few examples of the second depending on the therapy model in question.

Major Theories

The classic theories in family therapy have as their foundation some combination of General Systems Theory (cf. von Bertalanffy, 1968) and Cybernetics (cf. Broderick, 1993). What delineates CFT from other forms of psychotherapy is its major assumption about the problems or symptoms that bring people to therapy. Individual models of psychotherapy have as their major assumption that problems or symptoms are caused by something in the individual (i.e., a disease or medical model). CFT models have as their major assumption that problems or symptoms are symptoms of the system (cf. Bateson, 1972). That is, Couple and Family Therapists assume that the problem/symptom/complaint is somehow serving a purpose, or is an adaptation to the way the system is currently functioning within its environment. The point of intervention is then impacting how the members of the system interact so that the symptom is no longer adaptive.

There are volumes of family therapy theories (i.e., Gurman & Kniskern, 1981, 1991; Nichols & Schwartz, 2006) as well as original texts written by the authors of the theories (i.e., Bowen, 1978; Haley, 1976; Minuchin, 1974; Whitaker & Keith, 1981, etc.). It is difficult within the confines of a book chapter to review all the theories as well as the research that has been done using these theories or at least, their constructs. Doherty and Baptiste (1993) provide six major assumptions of most family therapy models: family relationships are the principal source of mental health for individuals; family interaction patterns repeat across generations; family health requires a balance of separateness and connectedness; family flexibility (the ability to adapt) is an essential trait that prevents dysfunction; the triad is the minimum unit of analysis to understand the complexity of the family; and, symptoms have meaning within the family's interaction or worldview (pp. 511–512).

Here we provide an overview of a systemic framework about family interaction and how family therapists view problem development. First, from a systemic perspective we have the concept of "wholeness" or "the whole is greater than the sum of its parts." Given this, assessing an individual, and asking their perspective about family interaction is not enough data to understand the family system in its wholeness. Second, systems are goal-oriented, and their primary goal is to maintain their viability within their environment or context. Third, given wholeness, change in one member or part of the system will influence all other parts of the system. Since systems have as their primary goal to maintain their viability and any change in one part of the system can influence change in all parts of the system, the system has to have a way to regulate itself. Thus, the fourth concept to understand from a family systems perspective is feedback and how feedback is processed in the system. There are two kinds of feedback with various labels, one is negative or deviation dampening feedback, and the other is positive or deviation amplifying feedback. Systems use both forms of feedback simultaneously to regulate themselves. Melito (1985) suggests that family systems have to have a way to maintain coherence as well as be able to adapt to the changing context (both from within the system and from outside of it). It is the balancing of these two processes that are the essence of, or "purpose of," family interactions within a family systems perspective.

From these concepts flow concepts about rules within the system, and rules about changing the rules within the system, and rules about changing the rules about changing the rules within the system and so on. Thus, systems have complex sets of patterns that allow them to adapt to their context as well as maintain coherence. From ideas about rules we also get notions of "boundaries" in systems. These boundaries are rules about who is in the family system and who is outside of it, and rules about how the family views the world or its context in general. From all of these concepts, family therapy theories generally maintain the notion that all behavior or all interaction patterns or interaction cycles within the family system serve a function that maintains the system's viability. If a behavior or interaction pattern emerges that does not help to maintain the system's viability it would not be repeated.

Thus, from a family therapy theory perspective, problems develop out of these interaction patterns and they serve a function for the system. Intervention, as stated earlier, is targeted at changing the interaction patterns so that the problem/symptom is no longer necessary for maintaining the viability of the family system. It is how, where, and when the intervention occurs that differentiates classic family therapy models. Below, each of the classic family therapy models are described, along with empirical support for the intervention from controlled clinical studies. While many pre-post designs, uncontrolled studies, clinical guides, and case reports have been published, only studies which included a control group are reviewed (including wait-list control, treatment as usual or a comparison condition). Controlled studies allow conclusions to be drawn regarding the efficacy of the intervention, which cannot be assumed from noncontrolled designs.

Structural Family Therapy: Minuchin (1974)

From a structural school of thought, in order to change interactions, the structure or hierarchy in the family system has to be "reestablished" so that parental figures are in charge, in essence. Minuchin (1974) developed this model or therapy for multiproblem poor families. He posited that all families have a structure which is seen through observation of repeated processes or patterns of interaction. This structure is established in order for the system to maintain its viability, but systems can be stressed beyond their ability to adapt. Minuchin coined the terms enmeshment and disengagement as they referred to boundaries between individuals, subsystems and the family system to its context. Somewhere between these two extremes, were clear boundaries where "normal" families function. Enmeshed boundaries are overly diffuse and do not allow for the differentiation of the functions of subsystems within the family (i.e., the parental vs. marital subsystems). Disengaged boundaries are overly rigid. Both extremes leave the system at a disadvantage when it comes to adaptation. Enmeshed boundaries within a family would lead the system to have little tolerance for difference and evoke an adaptation process for every change from within or outside the family. Disengaged boundaries within a family would lead the system to have a very high tolerance for difference and it would take an extreme change to evoke an adaptation process. Some level of permeability that balances the need for coherence along with the need to adapt to new information would be the ideal for system boundaries.

Interventions from a Structural Family Therapy perspective are aimed at disrupting the status quo. To do that, transgenerational coalitions are interrupted, different boundaries are created around different parts of the system to the extent that the "difference makes a difference." The techniques used are action oriented, so the clinician uses "enactments" by actually moving family members in the room, pointing out how and where family members are seated, as well as, reframing or putting a "positive spin" on the function of the presenting concern.

No controlled studies examining structural family therapy were identified in the literature. However, several empirically supported family systems interventions report using structural (and strategic family therapy described below) concepts especially in the realm of substance abuse treatment for adults (e.g., Stanton & Todd, 1982) and adolescents (e.g., Henggeler & Borduin, 1995; Liddle, 2004; Szapocznik, Hervis, & Schwartz, 2003). In general, these studies report significantly better outcomes for the individual and family as compared to treatment as usual, individual and group therapy.

Brief/Strategic Therapy: Haley (1976), MRI (Fisch, Weakland, & Segal, 1982), and Italian Schools (Palazzoli, Boscolo, Cecchin, & Prata, 1978)

Brief and strategic schools of thought, for the most part, create strategies that illuminate the voluntariness of problem interactions. They use the "therapeutic double bind" to in essence "corner" the family system into admitting that they have control over the behavior and/or the interaction. For example, if a couple comes in complaining that they argue too much, the therapist after

getting a more in depth description of the problem may suggest that the couple schedule their fights. If the therapist has recommended this and the couple wants to continue therapy, they have two options, they can schedule the fights as suggested, meaning they have control over the symptom, or they can refuse to schedule them which would mean they would have to stop fighting, again meaning they have control over the symptom. If they have control over the symptom they can change it. This is the classic technique of "prescribing the symptom." The therapist listens and gathers information about the problem and the interaction around the problem and then prescribes the symptom to the family in a cleverly disguised way. If the family is able to do what is prescribed, then they have control over the problem. If the family gets angry and resists the therapist's prescription, then the system also has control. Once the family as a system realizes this control, they can then change themselves in some way to eliminate the problem. These briefer models use communication and cybernetics as their framework, and are very technique rather than theory-oriented, although the theory is essential in order to perform the techniques.

Few controlled studies were identified which focused on brief/strategic therapies. However, one study, Bressi, Manenti, Frongia, Porcellana, and Invernizzi (2008) used the Milan approach to family therapy as compared to a nonfamily therapy control and showed promising results for individuals diagnosed with schizophrenia. In particular, improved clinical course and better pharmacological compliance was found among patients who received the Milan family therapy as compared to those who were assigned to the control condition.

Intergenerational Approaches: Bowen (1978), Boszormenyi-Nagy and Spark (1973), and Ackerman (1966)

Intergenerational approaches in family therapy have a "big picture" theory that provides explanations for how interaction patterns in the current family of procreation are influenced by interaction patterns in the family of origin. For Bowen (1978) the intergenerational transmission process occurs through his cornerstone construct of differentiation, defined as the ability to separate thoughts from emotions and maintain intimate contact in relationships while also maintaining a solid sense of self. Systems fall on a continuum of differentiation as do individuals. Individuals tend to choose partners with similar levels of differentiation. The lack of differentiation in relationships results in an inability to handle chronic anxiety, which is then projected onto others, including offspring. When offspring bear the brunt of this projection process, they may become less differentiated than their parents and the process continues in the next generation. Intervention in this model is focused on increasing the level of differentiation in an individual by coaching them to detriangulate within their family of origin.

Other intergenerational theories follow this same framework, with issues that have occurred in the family of origin being "relived" in the family of procreation in some way. The target of intervention in these models is acknowledging the issues faced in the family of origin, while also holding the individual accountable for their behavior in the family of procreation. Boszormenyi-Nagy's Contextual Family Therapy/Theory is an intergenerational model that includes the notion of a revolving slate of obligations and entitlements. A child born into a family is entitled to due care. As a parent provides care they gather credit, so to speak, with the child, or pay their debt to the previous generation. When children are not provided with due care, they still maintain their entitlement to it, and according to Nagy, continue to seek that care from others. This may develop into "destructive" entitlement in which the person winds up hurting others to get their needs met. The ultimate goal of therapy is to balance the ledger, so that people engage in relationships of fairness without hurting others to get their needs met, and with the ability to provide care as well as receive care.

Bernal and colleagues utilized contextual family therapy with adult methadone maintenance patients (Bernal & Flores-Ortiz, 1991) and found that families assigned to Contextual Family Therapy showed greater improvement on the outcome measures than families assigned to a

psychoeducation control. More controlled studies have examined Bowen's Family Systems theoretical assumptions. Charles (2001) identified eight controlled studies which tested Bowenian concepts. In particular, some support was provided for multigenerational transmission. That is, the proposition that anxiety regulates the amount of emotional closeness or distance within the family and regulates the impact of fusion experienced in the family of origin on current relationships was supported (e.g., Larson & Wilson, 1998).

Most of the empirical work using Bowen theory has been with "normal" samples to provide support for the constructs and propositions of the theory. Skowron (2000) showed that differentiation of self explained a significant proportion of variance in marital adjustment (74 % for husbands, 61 % for wives). However, the notion that individuals seek partners with similar levels of differentiation was not supported in this study. Using varying assessments of differentiation of self, Bartle (1993) did provide some evidence for the similarity in dating partner differentiation of self. Bartle-Haring, Rosen, and Stith (2002) also found support for Bowen's theory of intergenerational transmission, finding that emotional reactivity toward mothers and fathers in a college-age sample predicted current psychological problems. Miller, Anderson, and Keala (2004) reviewed the basic research that applied Bowen Family Systems theory and found support for some pieces of the theory, but not all pieces.

Experiential Approaches: Whitaker and Keith (1981) and Satir (1988)

Experiential approaches to family therapy integrate a systems perspective with humanistic psychology and existential philosophies. Their basic assumption is that provided the "right" environment all humans and all families have a tendency toward growth. Part of the "right" environment is the ability to express emotion in appropriate ways. Families that do not allow for the expression of emotion or have restrictive rules about the display of emotion may create an environment that inhibits growth which will eventually lead to symptoms or problems. The primary target of intervention is enabling families to both experience and express emotions in "safe" ways. Whitaker's symbolic experiential approach uses techniques to increase anxiety in the family to a level that will enable the release of blocked emotion. Satir's experiential approach is similar with interventions designed to increase the intensity of the experience in the therapy room by moving people around and having them be in physical contact with one another.

Whitaker was known to mistrust theory (Whitaker, 1982), believing that though theory can help the therapist, an over-reliance will be more inhibiting than beneficial. While Whitaker espoused a mix of psychodynamic, systemic and intergenerational theories, he "transcended the need to theorize by recognizing that the unknowable is unknowable" (Smith, 1998, p. 151).

No controlled studies were identified that tested Experiential Family Therapies.

Postmodern Approaches: Narrative (White & Epston, 1990) and Solution-Focused (de Shazer, 1985)

In the last several decades, postmodern approaches to family therapy have emerged and become popular. The basis for these approaches is a social constructionist (i.e., Gergen, 1999) or constructivist perspective. On one hand, there are ontological assumptions in these theories that would suggest that for us "to know" anything we must know its opposite. Thus, solution-focused approaches use this assumption when working with clients. If clients complain about a problem, they must know what it is like not to have the problem, which means they have a solution in mind. On the other hand, postmodern approaches use ideas about the interactional or collaborative ways that humans make meaning to intervene. In a narrative approach, clients are asked to "tell their story" while the therapist listens. As the story unfolds it is clear that people have interpreted events in certain ways that have lead to interpreting other events in ways that may

suggest failure, for example. The job of the narrative therapist is to provide alternative meanings to events in collaboration with the client in order for the client to create different meanings for events, enabling them to "retell" their story in a way that does not suggest problems or failure.

A prior review of Solution-Focused brief therapy (Gingerich & Eisengart, 2000) identified five controlled studies using a no-treatment control ($n=1$), treatment as usual ($n=3$) or a viable comparison condition ($n=1$). The study using the viable comparison showed no differences between conditions while the other four studies showed superior outcomes for those who received Solution-Focused therapy. While these findings suggest that Solution-Focused therapy can positively impact behavior, less support for its differential effectiveness is offered. Similar findings were reported more recently by Corcoran (2006). In this study, solution-focused family therapy was compared to treatment as usual for behavior problem children. Those families who received Solution-Focused therapy had better treatment engagement but no significant differences were found between groups on perceptions of child behaviors from either the parent or child perspective.

Behavioral Models: Jacobson (1981)

While a small number of controlled trials have tested the Solution-Focused therapy approach, the most researched, empirically supported of the marital therapies is Behavioral Marital Therapy (BMT; Shadish & Baldwin, 2005). BMT is considered a brief intervention with a focus on behavioral self-control, and learning new coping skills to improve individual and relationship functioning. Meta-analyses conclude that BMT is more effective than no-treatment and individual therapy approaches for a range of presenting problems including marital discord and substance abuse (Epstein & McCrady, 2002; Powers, Vedel, & Emmelkamp, 2008; Shadish & Baldwin, 2005).

Some evidence suggests that disregarded issues of relational traumas and unmet emotional needs inhibit behavioral change among families facing prolonged disturbances (Suchman, Mayes, Conti, Slade, & Rounsaville, 2004). In other words, focus on behavioral change alone without attention to emotional connection might limit the impact of behavioral interventions (Suchman et al.). Alternatively, the extent that behavioral family therapies impact behavior might depend more upon their impact on an individual's sense of connection and less on increases in coping or behavioral skills, although future research will need to evaluate this assumption. Postmodern and behavioral approaches do not have a systemic framework at their base, and thus these will not be reviewed further in this chapter.

Testing of Underlying Theoretical Propositions

As reviewed above, testing of the theoretical propositions underlying the change process is rare. Much of the extant family therapy literature regarding the major/classic theoretical schools of family therapy include case reports detailing positive therapeutic findings, with only a limited number of controlled studies reported.

Furthermore, in the prior 10 years, family therapy as a treatment for various problem behaviors has been tested using hybrid family therapy approaches. Many more controlled studies examining hybrid models (compared to classic models) have been conducted. For instance, these CFT interventions have been evaluated for bullying (Nickel et al., 2005, 2006), intimate partner violence (Stith, Rosen, & McCollum, 2004), depression (Christensen et al., 2004; Diamond, Reis, Diamond, Siqueland, & Isaacs, 2002; Miller et al., 2005; Solomon, Keitner, Ryan, Kelley, & Miller, 2008; Trowell et al., 2007), delinquency and criminal behavior (Gordon, Graves, & Arbuthnot, 1995), anorexia nervosa (Eisler et al., 1997, 2000; Lock, Couturier, & Agras, 2006), schizophrenia (Bressi et al., 2008), anxiety disorders (Siqueland, Rynn, & Diamond, 2005), adolescent running away (Slesnick & Prestopnik, 2005, 2009), physical problems such as diabetes (Harris & Mertlich, 2003), as well as adolescent (Austin, Macgowan, & Wagner, 2005; Coatworth,

Santisteban, McBride, & Szapocznik, 2001; Waldron & Turner, 2008) and adult (Powers et al., 2008) substance abuse.

Many of the interventions described in these studies include elements of different theoretical orientations such as structural and strategic (e.g., Coatworth et al., 2001) or psychodynamic and behavioral (Nickel et al., 2005). Successful integrative therapies are not rigid but allow further development of theory and practical techniques after being clinically tested with specific populations as noted by Lebow (1997). Integrative therapy can offer more intervention choices and better tailoring of treatment to specific clinical issues (Lebow). However, compared to the classic theoretical models described earlier, integrative therapies may pose special challenges for identifying mechanisms of change and therefore might challenge attempts to identify necessary targets of intervention. Even so, the majority of these studies report clear advantages to family therapy over alternative and viable individual and group-based treatments.

Of note is that the research base described in this chapter has done little to support the underlying theoretical assumptions of the various family therapy theories. With few exceptions, family therapy studies focus on clinical outcomes and not on the mechanisms underlying change on these outcomes. Indeed, theoretically, a family systems framework does not recognize an individual as an isolated being. However, family therapy studies commonly report findings based upon individual dysfunction (e.g., referred patient diagnoses with schizophrenia, substance abuse/dependence, anorexia) with the primary outcomes being individually focused. Many of the family therapy outcome studies described above do not adhere to a reciprocal understanding of behavior, but instead adhere to a linear or reductionistic approach to behavior change. That is, the family system does not cause dysfunction within the individual system and the individual does not cause dysfunction in the family. The family and individual systems are not isolated systems but function within the larger social system in which they are embedded. The reciprocal and dynamic processes that maintain behavior are at the root of systemic thinking, and research is needed that attempts to measure such processes, and especially change associated with these complex processes.

Overall, little attention is afforded to the underlying theoretical propositions guiding the intervention approaches. In fact, those that have, for example in regard to Bowen's family systems theory, have done so outside the family therapy context. Of interest is how families, their members, and the broader system, adjust to changes initiated through the therapy context. It is important to know how and why change occurs, how it is maintained, and which intervention targets lead to greater well-being and adjustment.

Not surprisingly, family therapy theories guiding intervention have rarely been compared to each other, therefore, knowledge of whether one family systems intervention is more effective than another is not known. It is unlikely, however, that given the overarching similarity in the underlying systemic understanding of behavior, that the different family theory models would result in different (clinically or statistically) outcomes. Targeting behavior change depending upon an emphasis on the here and now vs. an emphasis on multigenerational influences, or an emphasis on boundaries and triangles vs. an emphasis on interpersonal needs would likely result in only small comparative effect size differences. However, that begs the question, "Why bother having multiple family therapy theories?" Does each offer meaningful knowledge, above and beyond a general systems understanding of families and behavior change? According to Whitaker (1982), the choice of theory to guide one's therapy is a personal choice, influenced by personal experience. The general systems framework offers a working model upon which many family therapy theories are based. Truth is subjective, and the therapist's chosen theory, used to make goals for clients, might not fit for that client even though it fits for the therapist. However, without theory, family therapy researchers will continue to produce outcomes and facts perpetuating the current atheoretical empiricism.

Family Therapy Theory as Family Theory

As an "exploratory study" we used PSYCHINFO to search the literature about family therapy from 1999 through the beginning of 2009. The search included the words "data and family therapy." This resulted in 907 hits. Many of the articles listed were about group therapy so we eliminated those from our review. Of those left, 194 of the citations were from peer reviewed journals, 40 were from books, 37 from international journals, 15 were reviews, 10 were case studies, and 77 were dissertation abstracts. In essence, over the last 10 years or so, on average about 19 articles that have both of the words "family therapy" and "data" are published each year. Many of these articles are reports about the practices of couple and family therapists, or the satisfaction of CFT trainees. Those that are theory-focused tend to be few and far between. We also used specific schools of family therapy and "data" in PSYCHINFO searches. For "structural family therapy" and "data" we got 16 hits, for "strategic family therapy" and "data" we got 9 hits, for "Bowen Family Systems Theory" and "data" we got 10 hits, and for "Contextual Family Therapy" and "data" we got 3 hits. That gave us a total of 38 citations with no limit on publication year. Of those 38 publications, 19 were dissertation abstracts, three were case studies, five tested constructs within the theory, one investigated the process of therapy and four were in books about evidence-based practice.

Although this is a fairly "rough" way to gauge the amount of empirical literature that is available about family therapy theory, we clearly have a dearth of empirical data that tests constructs from family therapy theories, and even fewer about actual change in family processes related to outcomes. Since family therapy theory is based primarily in a family systems perspective, any of the research that uses a systems perspective could be used in support of (or not of) the constructs in family therapy theory. The reader is invited to review the chapter by Anderson, Sabatelli, and Kosutic (2012) to get a sense of the progress of research in this area as well as the needed future directions.

Johnson (2003) and others (cf. Manders et al., 2007) have suggested that family systems research tends to be constrained by at least three factors which seem to widen the gap between clinical family systems theories and empirical family research. The first constraint is measurement. Family Systems Theory suggests that the family is a "whole," while the measurements we use for family systems do not assess families at that level or researchers only ask one person about the family, rather than collecting multiple perspectives about the family. Another constraint highlighted by Johnson (2003) is that many theories suggest that there are family types (i.e., the Circumplex Model, structural family therapy, Bowen Family Systems Theory), however few studies examine the validity of family typologies. This again would be an issue of assessment or measurement. Finally, Johnson (2003) suggests, as has been highlighted previously, few studies track changes in family processes and outcomes across time to support the notion that it is change in the family as a whole that has influenced the change in the outcome.

Measurement

As Family Systems researchers, we struggle with measuring the system in terms of what and who to ask. A plethora of family therapy theories that label constructs differently, although they may be describing the same thing, does not make this any easier. For example, Minuchin (1974) describes boundaries in families as enmeshed or disengaged, while Bowen (1978) refers to poor family distance regulation as fused or cut off. Contextual Family Therapy relies on the clinician's understanding of the family's transactional processes rather than labeling the processes themselves. The Circumplex Model of Families (Olson, 2000) uses terms like cohesion and adaptability, and other theories use terms like mutuality and hostility. As fields, both Family Science and Family

Therapy need to come to some agreement about what is important to measure about family functioning, and stop taking "ownership" of "new" constructs that actually mean the same thing as other constructs that have already been introduced (Halverson, 1995), or, if a new construct is introduced it needs to be contrasted with similar constructs that may sound the same, but, at least to the author, mean something different. It may be time in the development of family therapy theory to admit that many of the founding clinicians created their theories at roughly the same time, and did not confer with each other. Thus, like many "discoveries" or "inventions." more than one person had the great idea (i.e., the telephone). The first author and a colleague (Bartle-Haring & Sabatelli, 1998; Sabatelli & Bartle, 1995) have highlighted these issues before and suggested that perhaps a systems view of family process could be, dare we say it, reduced to a fewer number of constructs that provide the domain of content that most family systems theories and family therapy theories use. Some common themes in these theories include boundaries, intimacy, autonomy, attachment, etc. These could be labeled "distance regulation." That is, families have consistent and perhaps idiosyncratic ways of regulating distance (the continuum of closeness to separateness) within their systems. Some families may appear to struggle with allowing individual members the experiences of autonomy, while others may appear to struggle with allowing individual members the experience of intimacy or closeness to others within or outside the family. Optimal distance regulation, at least theoretically, would provide both experiences of intimacy and autonomy at developmentally appropriate times, and even simultaneously. This highlights the complexity of family systems.

Cook and Kenny (2006) suggest that the measurement of the family should specify this complexity. "It is the architecture of the system, the way the individuals fit together, that distinguishes the family from other groups in which there is less interdependence" (from Manders et al., 2007, p. 606). Thus, research on family therapy theory or family systems theory needs to assess families with their complexity, and not make assumptions about families as wholes without all the pieces to the puzzle. Cook and Kenny (2004) suggest that the items we use to assess families should be relationship-directed and from multiple perspectives. That is, if we ask questions of one person about the family as a whole then the answers we get contain too many sources of variance for us to be able to have confidence in what exactly we are measuring. According to Cook (2005) a single item about the family as a whole contains at least five sources of variation: a family effect, relationship effects, actor effects, partner effects, and rater effects. For example, one of the Family Adaptability and Cohesion Scales III (FACES; Olson, Portner, & Lavee, 1985) items for cohesion is "members of my family get together often." We might assume that Olson and colleagues wanted the family effect, or family level answer. However, there may be relationship effects here as well in that some members of the family, because they have better or worse relationships, get together more often than others, but when the participant answers the question, they are thinking about those members of the family, and not the "cut off" members of the family. The participant may also be the one (i.e., the mother) who feels responsible for ensuring that family members get together often, so there may be actor variance or an actor effect. On the other hand, the participant may also be someone who likes to get together with family—and others like to get together with them (partner effect)—so, the participant may say, this is very true of the family as whole. Finally, the participant may have their own idiosyncratic way of reading the items (social desirability bias, halo effects, etc.), which leads to another source or level of variation.

The problem with items that target the "whole" family is that they are "double barreled" (Cook, 2005). Methodologists have criticized these types of items because they have more than one logically possible response, and the researcher is not able to distinguish which of those responses underlies the participant's answer. In order to decrease the many sources of variation that are present in "whole family" items, Cook and Kenny (2004) suggest that items should be relationship specific. That is, if we were to make the FACES

item an example, it would include "my mother tries to get together with me often," "I try to get together with my mother often," "my father tries to get together with me often," and "I try to get together with my father often." These types of items acknowledge that relationships are two-sided, with intentions not necessarily reciprocated. Bartle-Haring, Kenny, and Gavazzi (1999) used these types of items to measure family differentiation and found that all three of the family members' perspectives shared common variance for dyadic relationships in the family, and these dyadic relationship latent variables were all highly correlated, suggesting some sort of a system level of differentiation. Usually, however, analyzing data from multiple perspectives, with scales that use relationship-directed items requires large amounts of data.

Samples

Cook (2005) suggests that understanding the sources of variation from participants'/clients' answers to relationship-directed questions (i.e., family level, relationship specific, dyadic and individual level variance) reflects the ways that families differ from each other. That is, they can provide us with assessments that show differences between families that have a dysfunction and those that do not. Cook (2005) suggests, then, that knowledge of these various levels of variation are fundamental to the process of clinical family assessment, not just assessment of family functioning for research in family science. Cook (2005) also suggests that if we collect these sorts of data from larger samples as "norming" samples, we can then use *Z* scores to create the Social Relations Model (SRM: Kenny & La Voie, 1984) for an individual family. The SRM would then provide information about how the father as an actor (his unique contribution to relationships) compares to other fathers as actors. It could provide information about how a child as a partner (what the child elicits from others) compares to other children in families. It would also provide relationship effects or information about the unique fit of a mother and father, or father and one of the children, etc. It would also allow us to "pull out" the family effect, or the part of the variance in scores that is due to being part of that particular family, rather than being part of a particular dyad, or a particular person. Cook (2005) provides a case example of this method using interpersonal affectivity, interpersonal self-control, and attachment security as variables of interest for a clinical family. Typically, SRM analyses are done on large samples, which make them seem less pertinent to clinicians and clinical researchers. However, Cook (2005) provides a unique way of assessing clinical families as a whole, as unique relationships and individuals that does not require a large sample. Cook (2005) would not have created this unique way of assessing clinical families without a thorough knowledge of more sophisticated statistical techniques.

Statistical Sophistication

The need for more sophisticated statistical techniques to be applied to families is not unique to research in family therapy. Family science research also appears to lag behind in this as well (we refer the reader to Acock and Washburn, 2012). However, in order to support the efficacy and effectiveness of family therapy models and theory, as researchers we need to be able to conceptualize families as being complex organisms as well as analyze the data with that complexity in mind. Perhaps one of the many constraints for family therapy as a field is that for many of us, statistical techniques seem far removed from clinical practice. Many of the researchers in CFT who conduct outcome research were trained in psychology. Psychology as a discipline has more advanced statistical theorists, but does not necessarily use a systemic framework when teaching statistical analyses. Thus, the researchers who conduct outcome research in CFT seem to know the statistics that served them well in clinical trials of individually based treatments, and use those same techniques when analyzing the data from family therapy treatments. This is more than likely why we rarely find articles that demonstrate a change in family process occurring in conjunction with a change in the outcome measure.

For many researchers trained in psychology, having more than one dependent variable that changes is a complex model—rarely encountered in their training. However, for those of us interested in demonstrating support for family therapy and theory, this is the analytical issue we face, along with what to do with multiple perspectives on the same construct. These sorts of analytical issues require structural equation modeling, latent growth curve analysis, dyadic and triadic data analysis, multilevel models, and mixed models. Hopefully, as more sophisticated techniques become available in user friendly software, this gap in statistical sophistication will decrease. In the meantime, family therapy researchers have a lot of catching up to do. Regression models simply cannot be used when assessing families from more than one perspective which is what is needed, and what is done when a clinician assesses a family. The problem is regression's major assumption of the independence of the data, at least for the dependent variable. In this case, "independence" means that it was randomly sampled and that the analyst has no reason to believe that one participant's answers were influenced either directly or indirectly, by another participant's answers. As family clinicians, and family systems researchers, we know this is not the case.

Of course, this only speaks to quantitative research and not qualitative research on family therapy and theory. Qualitative research on the processes of family therapy has been published and provides a unique perspective for clinicians to understand just what clients' think is happening in therapy. Again, however, qualitative research does not, and perhaps cannot, answer the question of whether the change in some outcome is related to a change in some family level process. The qualitative researcher would have to interview multiple members of the same family and tease apart areas of agreement and disagreement, leading, more than likely, to the same sources of variation in the interviews as Cook (2005) highlights. Observational ratings of families may also be a productive avenue to pursue. Family process coding schemes are available (Kerhig & Lindahl, 2001) that purport to measure families as whole units. Again, sources of variation would need to be teased out of these ratings, but having videotapes of families at the beginning of therapy, during therapy and sometime after therapy would provide a way to assess whether something within the family changed in conjunction with changes in outcome.

Conclusions

In this chapter we provided the theoretical foundations of family therapy theories and how the varying schools of family therapy can be distinguished. We also provided a review of the controlled studies that have been conducted that provide evidence that family therapy works. For CFT to continue to move forward and grow as a discipline, however, we also provided a critique of the field and its lack of empirically based research. We provided some reasons for why CFT researchers continue to struggle and provided some suggestions for moving the field forward. What we believe to be most imperative for the CFT field to move forward include

1. When integrative approaches are used in clinical trials research, the theoretical constructs used need to be clearly defined and identified
2. Assessments of the family need to occur more than once, and preferably at baseline, during treatment and at structured follow-up times
3. Assessments of families need to reflect the complexity of the family, and at least include relationship specific items and data from multiple members of the family and preferably all members of the family involved in the treatment

In stark contrast to most psychotherapy models including CFT models, individual Cognitive Behavioral Therapy (CBT) is a commonly studied treatment intervention across a range of problems and populations. Research generally shows that individual CBT can reduce a variety of problem behaviors (Butler, Chapman, Forman, & Beck, 2006). However, research also indicates that these treatment gains are moderate and often dissipate significantly over time (Lynch, Laws, & McKenna, 2010). Family therapists know the power of relationally based interventions to inter-

rupt problematic behaviors, and some research indicates the superiority of family therapy over individual and group therapy for some problem behaviors (Graves, Shelton, & Kaslow, 2009; Liddle, 2004). Family therapy researchers need to stay motivated to continue the search for an understanding of family interaction because of a

> theoretical and personal conviction that relationships are more than the individuals who comprise them; that interaction is a separate phenomenon not currently predictable, perhaps ever predictable, from knowledge of the interacting individuals; and that psychopathology is something that happens between people as well as within people. Furthermore, this motivation is not founded just on the belief that families, interaction and psychopathology represent phenomena uniquely different from individual processes, but on the belief that these differences are extremely important—that we will never completely understand either individuals or psychopathology unless we understand relationships and interaction (Christensen & Arrington, 1987, p. 293).

As discussed in this chapter, the dearth of research on family therapy, as compared to individual cognitive behavioral therapy, is likely due to the difficulty in operationalizing, measuring, and agreeing on the core components of systems-based interventions. It is more difficult to quantify and measure interactional events such as connection, boundaries, differentiation, trust, and communication than it is to measure an individual's self-reported behavioral symptoms. Greater dissemination and utilization of family therapy and its theories might require clarity regarding the essential elements that underlie change, the use of creative and innovative methodologies to test the underlying theoretical concepts, and sophisticated statistical analytic techniques that capture the multiple interdependent relationships among family members.

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