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Integrative Family Therapy

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This paper describes an integrative approach to marital and family therapy in which psychodynamic (particularly object relations), family systems, and behavioral (particularly cognitive–behavioral) theory are blended in a flexible and tailored therapeutic approach. Human personality in its most significant contexts is a consistent focus. Background factors in the development to the approach and illustrative case materials are included.

KEY WORDS: marital and family therapy; integrative therapy; object relations; family systems; social learning theory; behavioral therapy.

> *There has been a consistent theme throughout my work: understanding and dealing with individuals in context.*
>
> Nichols (1990)

The integrative approach to family therapy described in this paper has emerged in the course of several decades of seeking to understand the development and functioning of human persons and of seeking to engage in effective therapeutic work with them (The terms "person" and "individual" are used interchangeably, although it is acknowledged that there are some differences between the two; English & English, 1958). Early in the process it became apparent that attention to both the individual and the major contexts in which human beings are formed and function was crucial to its understanding and therapeutic endeavors. Hence, the occasional reference to "treating the individual in context."

Symbolically, the emphasis on the significant contexts stems from a dramatic experience in the mid-1950s in which I observed a "revolving door"

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policy with mental hospital patients. With the help of major tranquilizing drugs—the Thorazine revolution, as I called it—seriously disturbed persons could get on their feet and become functional. A few months on the outside in the same settings from which they originally came, and they were back in the hospital. It seemed obvious that unless the family and other social situations out of which they came were changed, they could not maintain their gains. Those observations cemented my focus on the need to deal simultaneously and seriously with individuals, their families, and their social situations (The details of this experience and subsequent related educational and training events are described in Nichols, 1990).

The integrative approach presented here is marked by fluidity. As Heraclitus noted in long ago Greece, "all is flux," that is, in constant change. Basic to formulating a truly integrative approach to family therapy, therefore, appears to be an inability to be content with an acceptance of "absolute authority" and an inherent need to remain open and to engage in further searching in order to understand a phenomenon. An integrative therapist cannot tolerate simply being "a true believer" who sees no need to do any further searching to understand something. That is, an integrative therapist needs to embody an ability to tolerate ambiguity. We need to simultaneously record and tentatively hold observations and ideas that are not entirely compatible, holding them firmly for pragmatic purposes while grasping them loosely and being ready to change whenever new information appears.

MAJOR INFLUENCES ON MY WORK

The most important influences in literature on my work have come from personality theory, psychodynamic psychology, anthropology, social psychology, and family studies. These have converged with continuing clinical observation (closely akin to much of what is now referred to as quantitative research), evaluation of findings from the empirical research of others, and incorporation of family systems theory.

Personality Theory and Psychodynamic Psychology

An extensive study of various classical psychological theories of personality, including the original works of Sigmund Freud, Carl Jung, Alfred Adler, Gordon Allport, and others, provided fertile grounds for beginning the formal study of personality theory. Each of those pioneers contributed ideas that persist. Freud's emphasis on the unconscious, the significance of dreams, and other dynamic concepts, for example, have lasting value. The

most significant work in terms of influencing my integrative orientation was that of Harry Stack Sullivan. Ranging far and wide through the social sciences, Sullivan embodied the magnificent integrative mentality characteristic of the University of Chicago in the 1920s. He provided an excellent model for pulling relevant materials together into a theoretical scheme that was flexible and open-ended. (see especially Sullivan, 1953a, 1953b, 1954, 1962, 1964).

Sullivan's interpersonal theory of psychiatry focused on communications and the patterns of interaction between people and described the psychotherapy patient as a participant in an interpersonal situation, rather than as an "isolated and self-contained entity." His definition of personality as "the relatively enduring pattern of recurrent interpersonal situations which characterize a human life" (Sullivan, 1953b, pp. 110–111) was a radical break from the prevailing nineteenth century "rugged individualism" and isolated individual conceptions. At the same time, it was consistent with the new scientific paradigm of General System Theory that would be adapted to living systems. The individual is conceptualized in a family systems approach "as an interdependent, contributing part of the systems that control his or her behaviors" (Minuchin, 1985, p. 291).

English object relations theory has not been formatively influential so much as it has been confirmatory. W. R. D. Fairbairn's conceptualization of the human organism as primarily object seeking, driven by a need to engage in social interaction and relationships, rather than driven by instinctual urges, was compatible with my own observations and thinking (Fairbairn, 1952, 1954, 1963). Viewing internalization of objects as coming from reactions to actual relationships and situations, rather than from fantasy, seemed quite appropriate to family therapy's focus on genuine relationships and their effect in one's development and functioning (Nichols, 1996). Henry V. Dicks' theoretical explanations and clinical descriptions of object relations factors in marital interaction was particularly helpful in understanding collusive processes in marriage and marital interaction (Dicks, 1963, 1967).

Anthropology and Related Areas

Cultural anthropology in particular has been exceedingly helpful in elucidating the plasticity and flexibility of human beings (Homo sapiens). Appreciating the effects of nature, society, and culture, to use Kluckhohn and Murray's term, seems essential to understand a client/client system (Kluckhohn & Murray, 1956) . There are aspects of one's cultural background that are taken so much for granted and unconsciously incorporated by each of us that we cannot directly tell another about them although they

strongly affect our functioning. As therapists, we need to know about the cultural background of clients in order to comprehend what they value and as much as we can about what they are conveying unconsciously as well as what they are consciously conveying. At the same time, we need to understand the idiosyncratic or unique aspects of a client or client system.

The broad and comprehensive framework for understanding personality formation offered by Kluckhohn and Murray (1956) has been a useful part of my approach to personality theory and therapy for the past four decades. They presented four factors that, combined with the interaction of the four, determine personality formation: constitutional, group membership, role, and situational determinants. I adapted these, changing the last to idiosyncratic experiential determinants. More comprehensive discussions of my adaptation and use of these constructs are found in Nichols and Everett (1986, pp. 93–99) and Nichols (1996, pp. 12–16).

Social Psychology

Several years of teaching courses in social psychology and studying pertinent books and articles in that area helped to advance the process of bringing together personality theory and social and cultural materials. Eventually, I began to posit personality theory as a major organizing principle for social psychology.

Family Studies

Exceedingly influential were the materials from family social science. These included the theoretical orientations to family study described in Christensen (1964), the institutional, structural-functional, interactional and situational, and developmental approaches. The developmental approach continues to be particularly helpful in understanding and working with families and individuals (Hill, 1949, 1971; Nichols & Pace-Nichols, 2000).

The integrative approach described in this paper has emerged as a result of my pilgrimage through a complicated background of growing up partly in a nuclear family and partly in a large extended family, spending early years in three- and even four-generational households, and multiple moves between my small hometown and other towns and cities during middle childhood. The formative years experiences encouraged a process of introspection and identity questioning (Nichols, 1990, p. 173):

> How do we get to be like we are? How did I turn out with such different questions, perceptions and interests from the people around me? How do some persons come through some circumstances relatively unscathed, while others are done in by them ?

This led to an adult interest in personality theory and eventually to an ongoing professional concern with family and marital dynamics and therapy.

THE THEORIES THAT ARE INTEGRATED

Personality in the broadest analysis, and perhaps in a somewhat over simplified sense, breaks down into "inside" and "outside" dimensions. The selection of theories for a reasonably comprehensive integration must give attention to both those dimensions, the factors and processes that are associated with the internal workings of a person and the factors that impinge on the person from his or her context. Obviously, the inside and the outside dimensions cannot always be separated in the real world but only in theory (Table I).

Psychodynamic Theory

Psychodynamic theory in part refers to "a psychological process that is changing or causing change" (English & English, 1958). Psychodynamic approaches in general tend to represent an "inside-out" orientation (i.e., starting with the individual and intrapsychic factors). The portions of psychodynamic theory selected for this integrative approach to therapy specifically emphasize relatedness. In contrast to the one-person intrapsychic approach

Table I. Selected Emphases of Therapeutic Models

Psychodynamic	*Systems*
"Inside-out" dimension (individual, intrapsychic)	Contextual dimension (interactive, systemic)
Unconscious processes	New epistemology
Dream processes	Systems perspective
Interpersonal (Sullivanian) emphasis	Organization
Object relations (dyadic and choice emphasis)	Subsystems
Projective identification	Wholeness, boundaries, hierarchy
Introjection	Open systems
Projection	Closed systems
Collusion	Equifinality
Behavioral	Feedback
"Outside-in" dimension (individual, observable behavior)	Nonsummativity
Learning processes	Communication
Cognitive emphasis	Stability and change
Teaching-learning emphasis	Structure
Techniques for change	Process
Emphasis on change	Emphasis on change

Source: Reproduced by permission from Nichols (1996, p. 52).

provided by classical psychoanalysis, Fairbairnian object relations theory and Sullivan's interpersonal theory offer a two-person psychological model. In developmental terms, they view the interaction between the developing person and the environment as "being responsible for personality development and psychopathology" (Slipp, 1988, p. 13).

At the same time, there are important differences between these two approaches. Fairbairn offers a significant "inside" psychodynamic emphasis. He describes important aspects of the internal organization of the person and emphasizes the organization of the interaction processes. Sullivan accentuates the importance of culture and, as noted, stresses the role of communication processes in human interaction and development. Object relations theory offers much more assistance than other approaches in explaining the choice of a mate and continuation in a marital relationship, as well as the persistence in unhealthy relationships.

Clinically, the major import of the work of Fairbairn and Sullivan is the emphasis on taking other persons and the environment into account in working with a troubled client or client system (Nichols, 1996, p. 24). Psychodynamic psychotherapy, considered from a broad perspective, helps not only in explaining and working with the client's intrapsychic functioning, but also contributes to comprehension of both healthy and pathological interactive processes. Sullivan's (Sullivan, 1953b) explanation of the role of anxiety in human experience and the induction of noxious feelings in an infant during mother–child interaction is helpful in working therapeutically with persons in a variety of intimate relationships (Nichols, 1996).

Behavior Theory

How do human beings learn and how may knowledge of learning contribute to change in therapy? Behavioral approaches represent largely an "outside-in" orientation. That is, they tend to focus on individual, observable behavior. Behavioral approaches to individuals and families also emphasize the central role of interaction, and offer some implications for explaining and altering human interaction. Problems with both individuals and families tend to result primarily from interpersonal problem stimulation and reinforcement in interaction. Actions by an individual or group elicit dysfunctional emotions, cognitions, and behavioral responses in another or other persons. Such responses may result in the increased probability of the recurrence of dysfunctional behavior, thus reinforcing the problems (Feldman, 1992).

Important aspects of learning theory for therapy stem from the emphasis on learning and interaction. Reciprocal coercive patterns in family

interaction in which a person's behavior elicits and reinforces other members' aversive acts have been portrayed, for example (Baucom & Epstein, 1990). Patterson (1982) and the Oregon Group have described how some parents use ineffective forms of punishment in their attempts to alter their children's undesired behavior. For example, parents threaten but do not back up their threats with serious punishment such as consistent suspension of privileges, or use physical force that results only in a temporary cessation of the child's behavior.

Reciprocity (Thibaut & Kelley, 1959) is a widely used construct in marital therapy. It refers in a general sense to the tendency for couples to reward each other at essentially the same rate (Jacobson & Margolin, 1979; Patterson & Reid, 1970). Some persons offer another something in a quid pro quo (literally "something for something") manner (Lederer & Jackson, 1968), offering to do something in exchange for a different behavior of an equal weight from his or her partner. Alternatively, Weiss and colleagues (Weiss, Hops, & Patterson, 1973) proposed the use of the "good faith" contract. A third type, the "holistic" contract, has been offered by Stuart (1980).

A shortcoming of behavioral approaches to marital therapy was noted by Gurman (1980). Such treatment would have to give heed to the fact that family members require integration as individuals for a system to function effectively, he indicated. This idea fits well with the idea that individual, intrapsychic factors give significance to interpersonal events and must be taken into consideration with both behavioral therapy and systems conceptions in an adequate integration.

Family Systems Theory

Family systems theory emphasizes connectedness and that interaction occurs in a systemic fashion. Once a systems paradigm was acknowledged by therapists, it was no longer possible to regard clients as isolated individuals. At the same time, it is important to recognize that General System Theory (GST) has limitations when applied to living beings. Oriented toward matter and essentially mechanistic in nature, GST does not apply smoothly to human beings, who do not follow presumably inexorable laws of physics. Unlike the closed mechanical systems, human systems tend to be open, so that energy in the form of information may enter, thus permitting the system to become more organized rather than to run down Bateson (1979). Some therapists have urged that certain constructs adopted earlier from GST, including the family homeostasis concept, be dropped (Dell, 1982, 1986; Slipp, 1984, 1988).

Fortunately, thinking systemically and using adapted or modified family systems concepts in family therapy does not mean that one needs to or can use GST concepts in a tight or literal fashion. Slipp (1988) has pointed out that therapists observe GST principles at a highly abstract level. Rather than a circular approach, in practice they tend to use a linear approach to causality and intervention. Recently, correctives have been issued in family therapy to the uncritical acceptance of a "circular" epistemology in which feedback and circularity are involved. Pioneering family researcher Lyman C. Wynne (1986) has argued that the effectiveness of most family therapists stems significantly from the use of powerful lineal techniques. In the practice of therapy, the timeline that is involved prevents genuinely circular processes from occurring. Also, therapists' orientations toward goals of relieving symptoms (Haley, 1976), producing growth (Whitaker & Keith, 1981), or balancing the ledger of merit and obligation (Boszormenyi-Nagy & Ulrich, 1981) mitigate against circularity. Spiral transactions rather than circular transactions usually prevail in family therapy (Nichols, 1996).

When a systems perspective is integrated with object relations and interpersonal theory, it is easy to recognize that the individual is not passively acted upon by outside forces, but, as Gordon Allport (1955) and others insisted, is proactive. Fairbairn's notion of an active object-seeking ego from birth supports the idea that the developing person is proactive at the beginning as well as in continuing years (Fairbairn, 1963). Family systems theory offers helpful constructs and explanations for how individuals function in their significant contexts and some of the roles that the context takes in shaping interaction.

METHODS TO BE INTEGRATED

This integrative approach is one in which the therapy is tailored to the needs of the client system and shaped also by the abilities of the therapist. In a sense, what is involved is more an integration of orientations than of methods as such. Integration here does refer to the combination of therapy formats—individual, marital, family (e.g., Nichols, 1988, 1996). The factors that determine the nature and form of the therapeutic intervention (adapted from Nichols, 1996) are

- The presenting problem(s) of the client: These include the nature and severity of the problems and any symptoms presented at the outset, as well as any problems that appear subsequently.
- The client's strengths and present functioning: This includes any historical elements that affect the current functioning.

- The developmental level of the client and client effectiveness in meeting appropriate developmental challenges. (Nichols, 1996, pp. 122–298).
- The orientation and ability of the therapist: This includes the kind of alliance that one is able to form and maintain with the client.

The major mode of assessing client systems in this approach is the interview. Details of how interviewing is focused and used have been illustrated elsewhere (Nichols, 1988, 1996; Nichols & Everett, 1986).

Family Systems Approach and Methods

This approach always includes attention to family systems. The greater the extent to which presenting problems reflect family systems functioning or malfunctioning, the more likely it is that the interventions will be aimed specifically at affecting systems processes. That is, the more prominent contextual issues are, the more directly and immediately they will be addressed. Do total family issues such as the requirements of life cycle issues and developmental stages require immediate attention? Do family boundary and hierarchy matters require restructuring? Are there important intergenerational problems and relationships to be faced?

Methods used include sessions with the entire nuclear family in which "live" interventions are made, with an individual whose changes subsequently affect other parts and members of the family, through work with family subsystems, and with combinations of these interventions. Sibling subsystems work can be used effectively either in ongoing intact families with such problems as parent–teenager conflicts (Nichols, 1996, pp. 211–213) or with divorcing and reorganizing families (Nichols, 1986).

Where family-of-origin problems are concerned, in which there are unresolved issues between an adult client or clients and the family out of which they came, the methods of intervention may involve bringing in affected family members such as parents or a sibling, bringing in the entire family of origin, coaching the client on how to go back home and deal with specified issues, aiding the client in writing to a parent or other close relative, and related actions.

Reviewing family photographs, slides, or videos can be particularly powerful in aiding clients to recall and work with childhood conflicts and in reworking their feelings and discovering positive aspects of family relationships and events that they missed (Nichols, 1985).

Genograms (McGoldrick & Gerson, 1985) may be used with clients, although this is not done routinely. A simple background information form (Nichols, 1988, 1996) typically completed by clients prior to the initial

interview provides a considerable amount of straightforward information that assists in assessment and sometimes offers valuable leads for follow-up. It can provide the basis for constructing much of a genogram and can be explored for its psychodynamic implications. For example, what is recorded erroneously or obviously omitted? What kinds of discrepancies exist between common data recorded by spouses?

Psychodynamic Approach and Methods

This approach to integrative family therapy sometimes includes the use of dream work. Such work, however is different from classical dream work in psychoanalysis. Rather than focusing on wish fulfillment as the sole meaning of dreams as posited by Sigmund Freud (1900/1953–1974), it follows a current model of dream interpretation that emphasizes their "integrating, organizing, problem-solving function" (Glucksman, 1987). Dreams are considered more for their reflections of one's present life problems and unresolved emotional affairs from daily living (Mishne, 1993). In accordance with this current emphasis, Fairbairn viewed dreams as representing dramatizations of situations existing in one's inner reality. The situations, therefore, were relationships between the self and its internalized objects.

Incidentally, Fairbairn and Sullivan's emphasis on interpersonal relations and actual events and relationships rather than fantasied situations is consistent not only with such contemporary dream interpretation but also with the orientation of other psychodynamic theorists. Heinz Kohut's interpersonal emphasis (Kohut, 1971, 1977), especially his view of actual traumatic events as the major factors in producing pathology (Eagle, 1984), is compatible with Sullivan and Fairbairn's notion that pathology stems from actual noxious interaction with significant persons, rather than fantasied encounters. Kohut's view that we continue to need objects in normal development also is compatible with an interpersonal orientation.

Although demographic factors and ethnic considerations require attention where mate selection and marriage are concerned, the perspective here is that in the final analysis it is crucial to look to internal psychological factors in order to comprehend both a person's choice (Nichols, 1978) and much of the subsequent marital interaction (Dicks, 1967; Scharff & Scharff, 1989; Willi, 1982, 1984). From descriptions given by clients in interviews and from probing questions, important indications can be obtained regarding the level of object relations at which they are operating. Do they function essentially at the need-gratification level or at the stage of object love or object constancy? In the former, "the need is primary and the other

person exists only to serve it" (Blanck & Blanck, 1968, p. 70). At the object constancy/object love level, the partner is valued whether or not he or she is fulfilling a particular desire. Exploration of the expectations one has of the other partner after the manner of Sager's comprehensive lists (Sager, 1976) or through such simple exercises as asking each partner to "name five things a good husband (or wife) does" and discussing their answers are simple techniques that also elucidate object relations capacities.

Object relations theory is helpful in understanding and working with a number of areas of family life in addition to the marital area (Scharff, 1989; Scharff & Scharff, 1987; Slipp, 1984, 1988).

Social Learning Theory Approach and Methods

When faced with current interactional sequences and an assessed need to focus on present behaviors, behavioral interventions can be exceedingly helpful. Clients can be assisted to learn that some of the symptoms are learned responses that are not adaptive. (Principle of the functional autonomy of motives by Gordon Allport, 1937, in which he posits that motives do not necessarily trace back to earliest life but can be developed later in the course of living, helps to explain many learned behaviors.) Use of and elucidation of learning principles can help clients change and learn how to change behaviors and thus affect two-party and family interaction. For example, for the therapist to emphasize to a client that "any response to the behavior of another is a reward" that contributes to the continuation of the behaviors of another often can be heeded by the client. Coaching clients to make no response if they wish to extinguish undesired behaviors has proven to be highly productive in dealing with parent–child situations and other forms of interaction.

Helping clients to reward desired behavior in another person appropriately and to use effective communicational behaviors is also used. Applying learning principles in skill training by means of modeling, including imitative learning through observation of other family members, and by "shaping" of behavior through role playing and role rehearsal (Liberman, 1970) similarly is helpful.

Operating on the principle that much of psychotherapy is educational in nature, this integrative approach involves a considerable amount of cognitive–behavioral work (Nichols, 1997). Observation of the work of many psychotherapists of various persuasions has tended to reveal that cognitive behavioral interventions probably are used by most therapists, and possibly more often than they recognize.

Summary

Which methods are employed and when they are used depends on the initial and continuing assessment of the problem(s) and the conclusion ("diagnosis") about what must be focused on in order to bring about change, as already indicated. If it seems that there are physical bases or other sources of the problems, consultation with a physician or other professionals is, of course, indicated at the outset. Similarly, efforts are made to provide information in cases in which information is needed (e.g., in cases involving concerns about infertility, Nichols & Pace-Nichols, 2000).

ADVANTAGES AND RATIONALE FOR THIS INTEGRATION

There have been three major revolutions in the psychotherapy field: the psychoanalytic and psychodynamic, the behavioral, and the family therapy/family systems. The foci of these approaches have been mentioned already. The major rationale for trying to include elements of all in an integrative approach is the simple idea that each has significant contributions to make to the understanding and psychotherapeutic treatment of human beings. Conversely, important elements will be omitted if attention is not given to each of these approaches.

Briefly, my approach involves the effort to cover adequately both the "inside" and the "outside" aspects of human personality and functioning. Psychoanalysis and much of psychodynamic theory and practice generally offer grounds for comprehending what occurs in the thinking and feeling of humans, but do not give adequate attention to the role of social skills in human behavior and therapy (Wachtel & McKinney, 1992). Behavioral theory and practice not only emphasize that therapy should be a learning experience for all who are involved in the process but also provide practical ways of helping clients to develop social skills and adaptive, as opposed to maladaptive, behaviors.

There are similarities between behavioral approaches and each of the other two. Decades ago, Liberman (1970) pointed out similarities between therapy techniques used by psychodynamically oriented family therapists and by behavioral therapists. Specifically he noted that Framo (1965) had indicated a preference for techniques that prompt family interaction, concentrate on here-and-now feelings, and involve taking active, forceful positions in order to loosen a family from its rigid positions; and he highlighted Framo's examples of clinical work in which the therapists provide differential reinforcement for approved, desired behavior. Zuk's techniques were characterized as fitting into a reinforcement pattern (Zuk, 1967).

Family therapy and behaviorism have highly consistent emphases on change. In contrast to the stress in traditional psychoanalysis, and in much of continuing psychodynamic psychotherapy, on insight as essential to behavioral and personality alteration, behaviorism and family therapy place insight in a secondary position. New behaviors provide change and new insights, which in turn generate increased motivation to attempt new behaviors, according to Wachtel and McKinney (1992). They also emphasize that good behavior therapists provide clients with the opportunity to experience corrective emotional experience (Wachtel & McKinney, 1992, p. 338). Family therapy's focus on altering the context does similar things.

The integration of these theories provides the therapist with a much larger range of useful interventions than would be found in a unilateral approach to working with clients. At the same time, it realistically increases the therapist's confidence that the systems' concept of equifinality prevails. That is, a number of different interventions lead to the same outcomes.

FORMULATION OF CAUSALITY, PSYCHOPATHOLOGY, AND THERAPEUTIC CHANGE PROCESSES

Five distinct but interrelated levels of psychological problems can be dealt with in psychotherapy, according to Prochaska and DiClemente (1992). These are symptoms/situational problems, maladaptive cognitions, current interpersonal conflicts, family system conflicts, and intrapersonal conflicts. The interrelationship comes from the facts that the symptoms often reflect interpersonal conflicts, maladaptive cognitions frequently come from family system rules or beliefs, and change at one level of problem is likely to result in change at another level. Three of the five levels are clearly compatible with interactive and family factors.

Unfortunately, the descriptions of symptomatology and diagnostic categories in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), the major source used in the United States, are based on an individual orientation (American Psychiatric Association, 1994). Although it is a major achievement "in research and clinical consensus, DSM-IV is best regarded as an important base for ongoing clinical research in classification" (Reiss, 1996, p. xiii). Efforts to make room for relational diagnoses may eventually break into the traditional focus on the individual. A strong start has been made in Kaslow's *Handbook of Relational Diagnosis and Dysfunctional Family Patterns* (Kaslow, 1996), which contains a wealth of information and helpful conceptualizations accenting the role of relationship and family factors in the formation and maintenance of symptoms. The integrative approach presented in this paper is highly congruent with a relationship diagnostic approach.

Change also falls into five basic stages: precontemplation, contemplation, preparation, action, and maintenance (Prochaska & DiClemente, 1992). There are particular processes of change (consciousness raising, self-liberation, social liberation, counterconditioning, stimulus control, self-reevaluation, environmental reevaluation, contingency management, dramatic relief, and helping relationships) to be emphasized during specific stages of change, according to Prochaska and DiClemente (1992). Most of these would appear to be processes that would apply to families, couples, and other forms of multiple-person relationships as well as to individuals.

Three mechanisms of change have been identified: intentional change, developmental change, and environmental change (Prochaska & DiClemente, 1992). Recognition and the use, as possible, of developmental and environmental change information within the intentional change process is an informed and prudent way to proceed (Prochaska & DiClemente, 1992, p. 79). Clients change themselves in intentional change. The point has been made by Andersen (1993) that a client cannot be changed but a client can change.

Some of the early statements by family therapists that the therapist was responsible for change are regarded here as an overstatement. Rather than being a director/manager who is totally responsible for change, the therapist is a facilitator. Sullivan (1954) emphasized that the patient (client) brings some expectation of gaining benefits from the interviews and stressed the role of the therapist as an expert in interpersonal relations. As experts in interpersonal relations, therapists are responsible for creating conditions (of relationship and of realistic hope) and for bringing appropriate knowledge and interventions to the client system and situation. With therapeutic assistance, clients are helped to deal with their difficulties through the use of their own resources as self-changers. Incidentally, clinical experience has raised the possibility that clients sometimes find it more possible to go back into the past and to open up old hurts and long-concealed (repressed, suppressed) fears and anxieties than to face current problems and threat that call for them to change now.

The perspective here is that client responsibility is closely tied with the client's growth. Clients tend to be significantly helped and to gain an increase in their sense of achievement and control over their own life when they are primarily responsible for change. Clients, whenever possible, are expected to exit from therapy with an increased knowledge of how they function and how they can function better. Successful treatment frequently involves the amelioration of unresolved trauma from the past (e.g., sexual abuse), previous failure to resolve relationship problems with their family of origin, or problematic current relationships so that those barriers to their future healthy functioning have been significantly diminished (Nichols, 1996).

This approach to therapy shares with Pinsof's Integrative Problem-Centered Therapy (Pinsof, 1995), the assumption of a principle of least pathology. In practical terms, this refers to asking oneself whether the client's complaint or problem stems from major pathology or whether a less complex and more parsimonious and commonplace explanation can be found for the behaviors, and whether the problems necessarily require depth exploration and lengthy treatment. Can the problems be dealt with in a simple and straightforward manner? If the more ingenuous and direct ways are not effective, then it may be more appropriate to plan longer term and more depth-oriented interventions (Nichols, 1996, pp. 80–81).

THE NATURE AND ROLE OF THE THERAPEUTIC RELATIONSHIP

The therapeutic relationship refers to everything that exists between the therapist and the client or client system and starts with the initial contact with the therapist (Pinsof, 1995). It requires active participation by both the therapist and the client or client system. Based on past and some current medical approaches, "patient" is a respectable term, but it implies passivity on the part of one receiving treatment. The term client or client system is employed because, today, it carries the meaning of "customer" and implies that the person or persons actively participate in the therapy process. This is especially important and vital to the effectiveness of therapy in the case of marital treatment. In this voluntary relationship in which it takes "two to make a marriage and one to break it," one spouse can desire to change and preserve and continue the relationship, whereas the other can defeat the treatment and bring a halt to the marriage. Similarly, a client can refuse to enter and remain in a viable relationship with a therapist.

The centrality of therapist–patient relationship factors in expediting positive therapy results appears to have been established. The formation of a relationship of trust and the formation of a therapeutic alliance appear to be intimately related (Nichols, 1996). At the least, it is necessary to maintain a relationship in order to enter into a therapeutic alliance—an agreement to cooperate in a mutual endeavor to conduct therapeutic tasks and achieve therapeutic goals.

Family therapy is obviously different from individual therapy in terms of the complexity of the relationship between therapist and client system. Both involve the same need for the therapist to treat the client(s) in a respectful manner, to grant their right to participate as fully as possible in exercising their strengths, and learning how to deal with their problems in an equitable process. As indicated earlier, there are some differences between forming

a relationship with one person present and with a couple or total family. Distrust may exist between the partners or family members and they may have concerns with fairness, objectivity, and similar issues that are much more complex than with an individual client. There is a need in family therapy for the clients to experience what Boszormenyi-Nagy (1966; Boszormenyi-Nagy & Krasner, 1986) has called "multidirected partiality" in the therapist's attitudes, behaviors, and methods.

THE NATURE AND ROLE OF ASSESSMENT AND ITS RELATIONSHIP TO CASE FORMULATION AND TO THE SELECTION OF INTERVENTIONS

Two salient points need to be stressed with regard to assessment in this version of integrative family therapy. First, it is distinguished from "diagnosis," which is restricted here to the classification of individuals into psychological/psychiatric nosological categories. Clinical assessment refers primarily to the family system, its subsystems, processes, and functioning and its problems, strengths, needs, and potentialities. Second, assessment is a continuing process. One makes an initial assessment and continues to make additional assessments as treatment proceeds. New problems and prospects tend to be uncovered in the process of therapy and new problems develop as clients change

The most pertinent levels for assessment include individual (intrapsychic) and interpersonal (systems) factors and the sociocultural context in which the individuals and system function. Reference has already been made to assessment of the object relations capacities of individuals. Reiss' choice points for family assessment are used in a flexible manner (Reiss, 1980). These include focusing on developmental versus cross-sectional issues (longitudinal or current family functioning), family direction versus environmental direction (the impact of the broader network of relationships on internal patterns in the family or on the shaping forces inside the family), crisis versus character (immediate difficulties or the family's enduring patterns of defense and adaptation), pathology versus competence (disorder or the family's competence), and thematic versus behavioral (the underlying experiences and motives or the surface phenomena).

Integrative family therapy lends itself to both tailored assessment and standardized assessment approaches. Which approach is used depends on such factors as the orientation, abilities, and purposes of the clinician; the setting (whether a training or research center or a private practice or clinical service delivery setting); and the presenting complaints or problems and the severity of the problems. As a working clinician dealing with clients on an

outpatient basis, I favor the tailoring approach, one in which assessment and treatment occur simultaneously.

The methods, part of which have already been described, include interviews, conjoint (total family or couple) and, often, individual sessions, the use of genograms or background information forms (or both), broad "projective" types of questions followed by probes, "focused" questions (focused on certain topics), and specific questions, and observation of the behaviors of the clients in the interview situation.

In addition to what has been mentioned, the assessment process includes attention to family and individual development—the developmental stages of the family, marriage, and individual and related tasks need to be addressed (Nichols, 1996)—ethnic factors, and gender considerations.

The Beavers Family System Model (Beavers & Hampson, 1990) provides nine types of groupings that are clinically useful to experienced clinicians, who can use them to make a quick assessment and place families into appropriate categories. Ranging from categories of Severely Dysfunctional through Healthy on a horizontal health/competence continuum, families also are described on a vertical dimension as centripetal (possessing an almost impenetrable outer boundaries and little room for individuality) or centrifugal (marked by weak outer boundaries and little internal cohesiveness) or mixed centripetal–centrifugal. The model also helps in efforts to link family patterns with problematic behaviors and symptomatology and individual pathology. Six of the types tend to produce children with particular types of pathology. These family types include Midrange Centrifugal (often produce behavior disorders in the offspring), Midrange Centripetal (neurotic), Borderline Centrifugal (borderline), Borderline Centripetal (severely obsessive), Severely Dysfunctional Centrifugal (sociopathic), and Severely Dysfunctional Centripetal (schizophrenic).

At the same time, individual characteristics need to be assessed, and appropriate individual diagnostic labels may need to be applied. Individual symptoms may or may not serve family functions (Denton, 1990). Biological, temperamental, and personal factors may be involved with the individual. The family and external systems, such as the occupational and the educational, often interact in ways that make a simple one-to-one association of family and family member difficulties questionable. Neither assessment nor treatment has to be restricted to a single level of functioning (Nichols, 1996).

Marital evaluation is particularly complex. Couples may present for evaluation/therapy in several ways: Both partners may claim/acknowledge that they have a marital problem. One may claim that there is a marital problem, whereas the other denies it. Both may deny that there is a marital problem, saying that they have come in at the recommendation/suggestion

of their clergy, parent, physician, or friend. Marital assessment and treatment are described in detail elsewhere (Nichols, 1988, 1996).

Where an initial assessment leads to therapy, the clinician formulates a diagnostic description for the individual where that is appropriate and an assessment of the marital partners or the family (or both) and the problems in those areas. I have adapted the following schema, by Olson (1988), on family therapy studies to family therapy classification and treatment planning: Individual level (*DSM* symptoms as symptoms/presenting problems), Marriage (marital problems), Parent–child (parent–child problems), Family (nuclear family and extended family problems), and Community (social and community levels).

In this integrative approach, the techniques selected depend basically on the nature of the problem(s) disclosed. General guidelines include the following: straightforward and direct interventions are favored if there is a discrete problem. This was mentioned earlier in connection with the principle of least pathology. Specific behavioral approaches are available for parent training, divorce mediation, and marital enrichment. Behavioral and educational interventions are selected first when the problems pertain primarily to communication and the need for skill training. Psychodynamic approaches are generally the first choice when the issues deal basically with attachment between persons. This may include a combination of marital and individual treatment. When the problem is complex with indications that it is maintained by family systems patterns, intervention at the family systems level is indicated. This takes the form of focusing initially on altering the present family system when the problems are associated with the maintenance of symptomatology. When transgenerational issues appear to be maintaining symptoms and problems, family of origin work is the initial treatment of choice.

As with other forms of effective therapy, the initial focus needs to be on crisis intervention when there are things that constitute a crisis present, such as family violence or severe substance abuse. Then, the attention shifts to systemic factors and interventions that affect both the family's functioning and individual symptomatology.

SOME ILLUSTRATIVE CASE MATERIALS

This presentation of illustrative case materials involves two different cases. The first is a brief description of a complex case of a young married couple in their late 20s who manifested a significant amount of individual and marital problems and were having major difficulties in differentiating from their respective families of origin. The other case was that of a young

female who was also in her late 20s and who presented with problems of overeating that had lasted for nearly a decade and a half. The first is notable for the variety of treatment interventions that were required and the second for the illustration it provides of the ways in which two different treatment modalities can be mutually supportive and powerful.

Carol and Paul's initial complaints were that they had difficulty in communicating and in relating to each other. They had worked primarily on communication skills in a previous year of conjoint marital therapy without notable improvement. Carol explained that she wanted some relief from both personal and marital problems. Paul reluctantly entered therapy, voicing a desire to avoid being blamed for the marital conflict. The initial assessment disclosed that Carol and Paul both came from "mid-range" families (Beavers & Hampson, 1990) in which the families tended to hold on to their children and produce neurotic offspring. Both had been parentified to some extent by their parents and both manifested significant amounts of unconsciously determined behavior. The centripetal dimension was stronger in Carol's family. Comparatively, Paul's family was more mixed centripetal–centrifugal and a bit closer to the healthy family range on Beavers' scale than was Carol's family.

A clinical decision was made to work first primarily with Carol and, after the commitment of both partners to the marriage, to stabilize the marital interaction and determine whether the relationship could be developed that would provide adequate satisfaction for both Carol and Paul. Reduction of Carol's anxiety and fear, moderation of her depression, and increasing her individual and interpersonal coping skills were established as immediate goals. Outcome goals focused on helping her to become essentially free of the kind of dependency that caused her to latch on to others, especially males, in ways that frightened both herself and her husband. Individual sessions with Carol were interspersed with conjoint marital sessions. This was followed by a pattern in which Paul was seen individually and the couple seen conjointly every fourth session. A pair of family-of-origin meetings was held with Carol and her parents and siblings. In the initial individual sessions with Carol, there was a movement back and forth between the present and the past. She was supported in following a different route in her marriage and individual life than her mother had chosen and was helped to cope with the resultant loyalty conflicts that she experienced. Paul's help was enlisted whenever possible.

As improvements were manifested in his wife and positive results came from the periodic conjoint marital sessions and his individual sessions, Paul began to trust therapy and to conclude that it was helpful. Talking with him in "structural" terms and using diagrams where appropriate connected rather well with his engineer's approach to problems and the world in general. His

stance shifted from a wary defensiveness to active participation in looking for and working on ways to change personally and in the marital and parental roles.

At this point in treatment, Paul and Carol were ready to work consciously on differentiating themselves from their respective families of origin. A major factor in this work was the encouragement and enlistment of each spouse in supporting the other. Paul constructed a structured relationship with his family in which he, Carol, and their children would visit periodically or have his family over to their house. Significantly, he ceased to go over to his parents' home to solve their problems, as he had tried to do previously when they placed such expectations on him. Similar stances were taken with Carol's family. Instead of conforming to the efforts of Carol's mother to involve them in "mandatory" family vacations and so forth, they began to move in the direction of spending time with her family while maintaining separate vacation time with their own children, taking the responsibility for securing their own vacation lodging.

Simultaneously, the partners explicitly explored the "models of relationships" (Skynner, 1976) from their families that were affecting their current family and marital behaviors. Role-play was used in anticipation and rehearsal of how Paul could cope with both his family of origin and his work issues. As he was more able to deal effectively with his work situation, Paul built on his successes by facing more directly and intentionally the more sensitive issues of family of origin interactions and participating in his current nuclear family. Carol had several "Aha" experiences in which she recognized how she was inducing "bad" behaviors in her oldest child and then punishing the youngster for misbehaving. This pattern had enabled her to identify with her own mother as a "good" mother who did not allow "bad" behavior—by carrying out her mother's childrearing patterns and thus being loyal, while at the same time, punishing a mother substitute with some impunity. Another "Aha" experience came when she tied together the view that her children were "passing through" family life with her, as she perceived that she also needed to "pass through" and be released from her own family of origin.

(A much more complete description of this case, including an examination of the effects of using family slides to open up memories and understanding of family-of-origin experiences and the effects of a long-held family secret in Carol's family, is found in Nichols, 1985.)

The overeating case provides an example of how direct psychodynamic work and indirect (paradoxical) approaches can be used together. The 28-year-old client has struggled with overeating and obesity for half of her life. Hypnosis, diets, Overeaters Anonymous, and work with a half-dozen therapists has not brought any lasting change, and, indeed, had resulted in little change of any kind.

A careful exploration of the history of the symptoms resulted in an agreement between client and therapist that she was an "angry" overeater. Overeating was not enjoyable for her but, on the contrary, was exceedingly bothersome and painful, because she also was a "sneak" eater. At the same time, attention was given to other parts of her life, such as her marital relationship. When she described how she would become angry with her husband and physically attack him, straightforward directions were given to her. She was instructed to pay attention to her feelings and, when she first began to feel upset and before she went into what I termed "automatic actions" and began to attack her husband, excuse herself and go out for a walk until she had calmed down. This resulted in a considerable amount of healthy exercise and fresh air over the following weeks.

A directive regarding the overeating that ran basically as follows was given to her:

> This is painful for you. You don't enjoy hiding in the basement when you binge or sneaking food in your automobile so that your husband won't know what you are eating. What I want you to do is to eat only where it is pleasurable and enjoyable for you and when it is enjoyable. When you get home from work (which was several hours before her husband arrived) and wish to eat, set up the best arrangement that you can. Put a good tablecloth on your dining room table, get out your best silver and china, and eat whatever you wish to eat. We're not going to be concerned about what you eat or how much, but we do want it to be pleasurable for you. Why don't you keep a record for the next week in which you put down what you eat? That way we'll know something about whether you are only eating when it is pleasurable. If you are not, we'll try to make some changes so that you are.

The binges stopped within two days. At the next therapy session, the behavioral changes resulted in a return to dynamic considerations, to the production of important insight and further change. The client recalled a previously forgotten incident when she had been a high school junior. Her mother had promised that she would have more friends, be popular, and be attractive to boys, if she lost weight. She lost 10 pounds. None of the promised things happened. As the long repressed anger with her mother emerged over the next few sessions, the client was coached in dealing with her mother regarding unresolved issues between them.

Another aspect of dealing with anger was highlighted in the client's eventual disclosure that "Until you started getting me to think about my anger to go take a walk when I felt myself getting upset, I didn't have any idea that you could control your anger." In her family of origin, there had been no in-between stage: one was either calm and not upset or one exploded. The new awareness that one could control anger had rather far-reaching implications not only for dealing with her husband but also for coping with all manner of issues in her daily living.

Eventually the client lost 80 pounds and made some lifestyle changes that fit with her new "think thin" orientation. Except for one brief period in which she "tested out" some things with her parents, the changes persisted. She had not resumed overeating at a checkup 2 years after the termination of therapy. (A more detailed description of this case is found in Nichols, 1988.)

CONCLUDING NOTE

Given the fluidity and changing nature of integrative family therapy, there is no realistic way of drawing conclusions. The process is a developing one and such treatment, as noted, varies with the nature of the cases and problems and with the orientation and skill of the therapist.

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