Constructions of family normality, health, and dysfunction, which are embedded in our cultural and professional belief systems, underlie all clinical theory and practice. These assumptions exert a powerful and largely unexamined influence in every family assessment and intervention.

THROUGH A DARK AND NARROW LENS

The field of mental health has long neglected the study and promotion of health. In the concentration on mental illness, family normality became equated with the absence of symptoms, a situation rarely, if ever, seen in the clinical setting. Assumptions about healthy families were largely speculative and utopian, extrapolated from experience with disturbed clinical cases. Scant attention was given to the stressful challenges and strengths of ordinary families in the community or their larger social context.

Clinical practice and research in the mid-20th century, grounded in medical and psychoanalytic paradigms, focused on the understanding and treatment of psychopathology. The family was viewed darkly in terms of damaging influences in the etiology of individual disturbances. Indeed, throughout much of the clinical literature, families were portrayed as noxious and destructive influences. Focused narrowly on a dyadic view of early childhood attachments, “parenting” was equated with “mothering,” with the terms used...
interchangeably. Maternal deficits were blamed for all problems, as in the following family case analysis in a leading psychiatric journal:

In this paper, it has been possible to examine minutely a specific family situation. The facts speak rather boldly for themselves. The mother and wife is a domineering, aggressive, and sadistic person with no redeeming good qualities. She crushes individual initiative and independent thinking in her husband, and prevents their inception in her children. (Gralnick, 1943, p. 323)

Such mother-blaming indictments have persisted, deduced from theories of family pathogenesis, often without any direct contact with the mother or assessment of the family system and its social context. “Parent-ectomies” were frequently recommended, keeping families at bay, without “intrusion” in treatment, which offered a corrective relationship with the therapist or therapeutic community. Family assessment, skewed toward identification of deficits and conflicts, has tended to be blind to family strengths and resources to such an extent that—only half jokingly—a normal family might be defined as one that has not yet been clinically assessed!

**FAMILY SYSTEMS THEORY AND PRACTICE**

The systems paradigm (von Bertalanffy, 1968) advanced conceptualization of the family from a deterministic linear, causal view, focused on parent–child dyadic bonds, to the recognition of multiple, recursive influences within and beyond the family that shape individual and family functioning through ongoing transactions over the life course and across the generations. Yet early family assessment and treatment tended to focus on dysfunctional family processes thought to cause or maintain individual symptoms. Over recent decades, family therapy theory and practice have been reformulated and expanded, with greater recognition of the diversity and complexity of contemporary family life and greater attention to sociocultural and biological influences. Focus has shifted from family deficits and dysfunction to family challenges and resources in community-based collaborative approaches aiming to strengthen family functioning and resilience (Goldenberg & Goldenberg, 2008; Nichols & Schwartz, 2008; Walsh, 2011b).

Although family therapy approaches vary, they share a common conceptual foundation in systems theory, with basic assumptions about the mutual influence of family members. Combining ecological and developmental perspectives, the family is viewed as a transactional system that functions in relation to its broader sociocultural context and evolves over the multigenerational family life cycle (McGoldrick, Carter, & García-Preto, 2011; Minuchin, 1974). Stressful events, environmental conditions, and problems of an individual member affect the whole family as a functional unit, with reverberations for all members and their relationships. In turn, family processes—in relating
and handling problems—contribute significantly to positive adaptation or to individual and relational dysfunction.

MAJOR APPROACHES TO FAMILY THERAPY

It is important to examine the views of family normality, health, and dysfunction embedded in major approaches to family therapy because of their critical influence in clinical practice. Earlier editions of this text surveyed the most influential founding models and more recent developments in the field, considering the four perspectives on family normality I outlined in Chapter 1 of this volume. Although generalizations in an evolving field must be made with caution, it is useful to highlight some basic premises about family normality, health, and dysfunction in various approaches. Two questions frame consideration:

1. *Family processes:* What are the explicit and implicit assumptions about normal—typical and optimal—family functioning and views of dysfunction?

2. *Therapeutic goals and processes:* How do these beliefs influence therapeutic objectives, intervention methods, and the stance of the therapist?

As the following overview reveals, various aspects of family and couple functioning receive selective focus in assessment and intervention fitting different views of problem formation/maintenance, therapeutic goals, and change processes (see Table 2.1 on pp. 32–33).

**Brief Problem-Solving Approaches**

In early models, therapeutic interventions were problem-focused, designed to alter dysfunctional interaction patterns. Since the mid-1980s, approaches have focused increasingly on identifying and expanding strengths, resources, and potential.

**Structural Model**

Structural family therapy approaches emphasize the importance of organizational processes for family functioning and the well-being of members. Therapy focuses on the patterning of transactions in which symptoms are embedded, viewing problems as an indication of imbalance or rigidity in the family’s organization (Minuchin, Nichols, & Lee, 2006).

Minuchin (1974) directly challenged the myth of “placid” normality—the idealized view of the normal family as nonstressful, living in constant harmony and cooperation. Such an image crumbles, he argued, when looking
at any family with ordinary problems. Through interviews with effectively functioning families from different cultures, Minuchin described normal (i.e., typical) difficulties of family life transcending cultural differences. In an ordinary family, the parents face many problems in relating, bringing up children, dealing with extended family issues, and coping with the outside world. He noted, “Like all normal families, they are constantly struggling with these problems and negotiating the compromises that make a life in common possible” (p. 16).

Therefore, Minuchin cautioned therapists not to base judgments of family normality or abnormality on the presence or absence of problems. Instead, he proposed a conceptual schema of family functioning to guide family assessment and therapy. This structural model views the family as a social system in transformation, operating within specific social contexts and developing over time, with each stage requiring reorganization. Each system maintains preferred patterns, yet a functional family must be able to adapt to new circumstances, balancing continuity and change to further the psychosocial growth of members. Symptoms are most commonly a sign of a maladaptive reaction to changing environmental or developmental demands. Normal (i.e., common, expectable) transitional strains may be misjudged or mislabeled as pathological. Minuchin advised:

With this orientation, many more families who enter therapy would be seen and treated as average families in transitional situations, suffering the pains of accommodation to new circumstances. The label of pathology would be reserved for families who in the face of stress increase the rigidity of their transactional patterns and boundaries, and avoid or resist any exploration of alternatives. (1974, p. 60)

These distinctions led to different therapeutic strategies: In average families, the therapist relies more on the motivation of family resources as a pathway to transformation. With greater dysfunction, the therapist becomes more active in order to realign the system.

Minuchin viewed patterns of closeness and separateness as transactional styles or preferences and not as qualitative differences between functional and dysfunctional families, although extremes of enmeshment or disengagement were most often problematic. Structural patterns normally shift over the family life cycle to meet varying needs and challenges, from rearing young children, through adolescence, and launching to caring for ill or disabled members.

Structural family therapists have emphasized the importance of generational hierarchy and the clarity of family rules and boundaries to protect the differentiation of the system and parental/caregiver authority. Minuchin (1974) noted that although the ideal family is often described as a democracy, this does not mean that a family is leaderless or a society of peers. Effective family functioning requires the power to carry out essential functions. The
### TABLE 2.1. Major Models of Family Therapy: Normality, Dysfunction, and Therapeutic Goals

<table>
<thead>
<tr>
<th>Model of family therapy</th>
<th>View of normal/healthy family functioning</th>
<th>View of dysfunction/symptoms</th>
<th>Goals of therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structural</strong></td>
<td>Generational hierarchy; strong parental authority</td>
<td>Family structural imbalance: Malfunctioning generational hierarchy, boundaries Maladaptive reaction to changing demands</td>
<td>Reorganize family structure: • Strengthen parental/caregiver subsystem • Reinforce clear, flexible boundaries • Mobilize more adaptive patterns</td>
</tr>
<tr>
<td></td>
<td>Clear boundaries, subsystems Flexibility to fit developmental and environmental demands</td>
<td>Symptom is communicative act • Maintained by misguided problem-solving attempts • Rigidity; lack of alternatives • Serving function for family</td>
<td>Resolve presenting problem; specific objectives Interrupt rigid feedback cycle: symptom-maintaining sequence Shift perspective</td>
</tr>
<tr>
<td><strong>Strategic/systemic</strong></td>
<td>Flexibility Large behavioral repertoire for • Problem solving • Life-cycle passage</td>
<td>Problem-saturated narratives constrain options Dominant discourse stigmatizes differences from “norm”</td>
<td>Search for exceptions to problem Envision new possibilities Reauthor, thicken life stories Empower clients</td>
</tr>
<tr>
<td><strong>Postmodern</strong></td>
<td>Normality is socially constructed Many options; flexibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Solution-focused</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Narrative</strong></td>
<td></td>
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<tr>
<td><strong>Behavioral/ cognitive-behavioral</strong></td>
<td>Adaptive behavior is rewarded More positive exchanges than negative (costs); reciprocity Good communication, problem-solving, conflict management Facilitative beliefs</td>
<td>Maladaptive, symptomatic behavior reinforced by: • Family attention and reward • Deficient exchanges (e.g., coercive, skewed) • Constraining beliefs</td>
<td>Concrete behavior goals: • Reward adaptive, not maladaptive, behavior • Communication, problem-solving skills • Adaptive cognitive restructuring</td>
</tr>
<tr>
<td><strong>Psychoeducational</strong></td>
<td>Successful coping and mastery of psychosocial challenges: • Chronic illness demands • Stressful events, transitions</td>
<td>Stress–diathesis in biologically based disorders Normative and non-normative stresses</td>
<td>Multifamily groups provide information, coping skills, and social support to: • Manage demands, master challenges • ↓ Stress and stigma</td>
</tr>
<tr>
<td>Multisystemic</td>
<td>Family, social, larger systems promote healthy child development</td>
<td>Multiple systems influence youth conduct disorder, substance abuse</td>
<td>Family-centered, collaborative involvement of peers, schools, courts, community programs Risk, problem behavior Youth adaptation, family support</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td>Psychodynamic</td>
<td>Relationships based on current realities, not past projections Provide secure base Trust, nurturance for bonding and individuation</td>
<td>Shared projection process Unresolved conflicts, losses, loyalty issues in family of origin • Attachment issues • Unconscious role assignment</td>
<td>Gain insight, resolve family of origin issues ↓ Projection processes Individual and relational growth</td>
</tr>
<tr>
<td>Bowen model</td>
<td>Differentiation of self in relation to others Intellectual/emotional balance</td>
<td>Functioning impaired by family of origin relationships: • Poor differentiation (fusion) • Anxiety (reactivity) • Triangulation • Emotional cutoff/conflicts</td>
<td>Differentiation ↑ Cognitive functioning ↓ Emotional reactivity Change self in relationships: • Repair conflicts, cutoffs • Gain new perspectives</td>
</tr>
<tr>
<td>Experiential</td>
<td>High self-worth Clear, honest communication Flexible rules and roles Open, hopeful social links Evolutionary growth, change Playful interaction, humor</td>
<td>Symptoms are nonverbal messages elicited by current communication dysfunction Old pains are reactivated</td>
<td>Direct, clear communication in immediate experience Genuine relating Individual and relational growth</td>
</tr>
</tbody>
</table>
unquestioned authority of the traditional patriarchal model has given way to the importance of flexible, authoritative parenting. A strong parental subsystem is required for child-rearing tasks, whether the household is headed by two parents or by a single parent, coordinated with involved nonresidential parents or grandparents. Thus, a primary structural objective in family therapy is to strengthen the leadership subsystem.

In the couple/parental subsystem, spouses are seen to support their partners’ better characteristics. At times, spouses in average couples may undermine partners in attempts to improve or rescue them, yet such patterns do not necessarily imply serious pathology. While noting that the spousal subsystem requires complementarity and mutual accommodation, early structural family therapists tended to support the gender-based hierarchy in power and status rooted in patriarchal cultural values (McGoldrick, Anderson, & Walsh, 1987). Therapy was commonly directed to “rebalance” the family by diminishing the mother’s influence, while enhancing the father’s position of authority (Goldner, 1988). More recent therapists work to empower both partners in a mutually respectful, equal partnership (Knudson-Martin & Mahoney, 2005; see Knudson-Martin, Chapter 14, this volume).

Structural family therapists have shown particular sensitivity to the barrage of external pressures and constraints on poor families that contribute to problems in family organization (Aponte, 1994; Falicov, 1998). Minuchin and his colleagues have also directed efforts to change structural patterns in larger systems, such as child welfare and foster care policies and practices that “dismember” poor families and undermine functioning (Minuchin, Colapinto, & Minuchin, 2006; see Engstrom, Chapter 9, this volume).

In summary, from a structural perspective, no family style is inherently normal or abnormal. Whether organizational patterns are functional or dysfunctional depends largely on their fit with the family’s developmental and social demands. Many varied styles are potentially workable and may meet ordinary challenges. For optimal functioning, a strong generational hierarchy and clear lines of parental authority are considered essential. The strength of the system requires clear yet flexible boundaries and subsystems for the ability to shift organizational patterns to accommodate needed change.

**Strategic/Systemic Approaches**

Early strategic and systemic models were developed at the Mental Research Institute (MRI) in Palo Alto (Weakland, Fisch, Watzlawick, & Bodin, 1974), by Haley (1976) and colleagues, and by the Milan team (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). These approaches viewed healthy families as highly flexible, drawing on a large repertoire of behaviors to cope with problems, in contrast to the rigidity and a paucity of alternatives in a dysfunctional family. Beyond this generalization, they deliberately avoided definitions of normality, with a tolerance for differences and ideosyncracies of families and a conviction that each family must define what is normal or healthy for itself in its situation.
Haley (1976) saw descriptions of family interaction as a way of thinking for purposes of therapy when there is a disturbed child but stressed that it would be an error to deduce from that a model for what normal families should be like. In observations of over 200 normal—average—families, Haley found patterns so diverse that to talk about a “normal” family seemed to him naive:

How to raise children properly, as a normal family should, remains a mystery that awaits observational longitudinal studies with large samples. Thinking about the organization of a family to plan therapy is another issue. As an analogy, if a child breaks a leg, one can set it straight and put it in a plaster cast. But one should not conclude from such therapy that the way to bring about the normal development of children’s legs is to place them in plaster casts. (p. 108)

Assuming that all families confront problems, the MRI model (Weakland et al., 1974) focused on how families attempt to handle or resolve normal problems in living. Symptoms are seen as a communicative act, appearing when individuals are locked into an unworkable interactional pattern and cannot see a way to change it. Families may maintain a problem by the misguided means they are using to handle it. An attempted solution may worsen the problem, or may itself become a problem requiring change. Therapy focuses on problem resolution by altering feedback loops that maintain symptoms. The therapeutic task is to reformulate, or recast, the problem in solvable terms. The therapist’s responsibility is limited to initiating change that will get a family “unstuck” from unworkable interactional patterns.

Haley (1976) selectively focused on key family variables involving power and organization that he considered relevant to therapeutic change. Like Minuchin, he thought a variety of arrangements could be functional if the family deals with hierarchical issues (i.e., authority, nurturance, and discipline) and establishes clear rules to govern the differential between generations.

Implicitly, strategic and systemic therapists assumed an asymptomatic perspective on family normality. They limited therapeutic responsibility to symptom reduction, freeing a family from unworkable patterns to define its own functional alternatives. They contended that most families do what they do because members believe it is the right or best way to approach a problem, or because it is the only way they know. The therapeutic task is to interrupt ways of handling a problem that do not work, that is, patterns that are dysfunctional. The Milan approach (Boscolo, Cecchin, Hoffman, & Penn, 1987) emphasized the importance of observation and inquiry to learn the language and beliefs of each family, to see the problem and relational patterns through various members’ eyes, and to understand the values and expectations influencing their approach to handling a problem and their inability to change.

Through techniques such as relabeling and reframing, these approaches strategically redefine a problem situation to cast it in a new light in order to shift a family’s rigid view or alter a destructive process. Similarly, circular
questioning, positive connotation, and respectful curiosity are used to contextualize symptoms, attribute benign intentions, and generate hope. Therapists also depathologize problems by viewing them as normative life-cycle complications, considering their possible adaptive functions for the family, and acknowledging the helpful, albeit misguided, intentions of caring members trying to help one another. In such reformulations, new solutions can more readily become apparent.

Postmodern Approaches

Solution-focused and narrative approaches are based in constructivist and social constructionist views of reality (Hoffman, 1990). Growing out of strategic/systemic models, yet departing from many earlier tenets, they shift therapeutic focus from problems and the patterns that maintain them to solutions that have worked in the past or might work now, emphasizing future possibilities. They believe that people are constrained by narrow, pessimistic views of problems, limiting the range of alternatives for solution. However, they reject earlier assumptions that problems serve ulterior functions for families. Interventions are oriented toward recognizing and amplifying clients’ positive strengths and potential resources (Berg, 1997; deShazer, 1988).

Postmodern therapists believe there is no single “correct” or “proper” way to live one’s life. What is unacceptable for some may be desirable or necessary for others. Rather than search for structural or psychic flaws in distressed families, they focus on the ways people describe themselves, their problems, and their aims.

Narrative therapists’ avoidance of generalizations about what is normal or abnormal is grounded in Foucault’s observations about the abusive power of dominant discourses:

Too often in human history, judgments made by people in power have been imposed on those who have no voice. Families were judged to be healthy or unhealthy depending on their fit with ideal normative standards. With their bias hidden behind a cloak of science or religion, these conceptions became reified and internalized. One-size-fits-all standards have pathologized differences due to gender, cultural and ethnic background, sexual orientation, and socioeconomic status. (in Nichols & Schwartz, 2008, p. 294)

Postmodern therapists have been especially wary of claims of objectivity, which they regard as unobtainable. They eschew psychiatric labels, family typologies, and evaluation schemas as reductionistic, dehumanizing, and marginalizing of differences from norms. Narrative therapists “situate” themselves with clients and assume a collaborative stance (Freedman & Combs, 1996; White & Epston, 1990). Because clinicians and families are both steeped in the larger cultural discourses, they are adamant that therapists should not impose on clients what they, themselves, think is normal or healthy. In appreciative
inquiry, therapists learn from clients about their predicaments and experience (Anderson, 1997). White (1995) challenged therapists to be transparent: to disclose beliefs that inform their therapy and fully own their ideas as their subjective perspective, biased by race, culture, gender, and class. In short, therapists try not to make assumptions or judge clients in ways that objectify them, so as to honor their unique stories, cultural heritage, and visions for their future.

Narrative therapy is guided by a few basic assumptions: that people have good intentions and neither want nor need problems; and that they can develop empowering stories when separated from their problems and constraining cultural beliefs. The therapist redirects focus from family causal assumptions of dysfunction to appreciate the toxic effects of many dominant discourses in the social world. For instance, eating disorders are seen as largely influenced by internalization of cultural obsession with thinness and beauty for women. Contending that therapeutic neutrality is not possible and can perpetuate harmful patterns, clinicians are encouraged to challenge culturally based injustices, such as men over women, rich over poor, and whites over people of color.

Therapeutic goals extend beyond problem solving to a collaborative effort to help people reauthor their life stories and their futures. Through conversation, problematic narratives are thickened and perspectives expanded to incorporate new possibilities for more empowering constructions, problem resolution, and positive growth. Respectful inquiry aims to free clients from constraining or oppressive personal or cultural assumptions, enlarge and enrich their stories, and encourage them to take active charge of their lives.

Behavioral and Cognitive-Behavioral Family Approaches

Behavioral approaches to family therapy, developed from behavior modification and social learning traditions, view families as critical learning contexts, created and responded to by members (Alexander & Sexton, 2002; Patterson, Reid, Jones, & Conger, 1975). Interventions attend to the ongoing interactions and conditions under which social behavior is learned, influenced, and changed, with focus on family rules and communication processes. Therapists specify problems and goals in concrete, observable behavioral terms, guiding family members to learn more effective ways to deal with one another and to enhance positive interactions.

Behavioral approaches view a healthy family in terms of its adaptive, functional transactional processes. Because relationships involve a wide range of possibilities, there are many opportunities for rewarding exchanges. In well-functioning families, adaptive behavior is rewarded through attention, acknowledgment, and approval, whereas maladaptive behavior is not reinforced. Problematic relationship problems tend to have deficient reward exchanges, with reliance on coercive control and punishment (Patterson et al., 1975).
In couples, Gottman (1994; see Driver, Tabares, Shapiro, & Gottman, Chapter 3, this volume) identified specific interactional processes that predict the long-term success or failure of relationships. Of note, happy couples have five positive interactional exchanges for every negative exchange. Couples and families may be helped to change the interpersonal consequences of behavior (contingencies of reinforcement) for more positive acknowledgment and approval of desired behavior. All behavioral researchers emphasize flexibility and adaptability as partners evolve together and cope with the many challenges and external forces in their lives. Also important is long-term reciprocity and trust that the give and take will be balanced out over time. In contrast, dysfunctional relationships are more rigid and skewed, lack mutual accommodation, and are restricted by short-term tit-for-tat exchanges. Communication skills—particularly clear, direct expression of feelings, affection, and opinions; negotiation; and problem solving—are considered key to functional couple and family processes and can be learned. Relationship success is predicted not by the absence of conflict but by acceptance of differences (Jacobson & Christensen, 1996) and conflict management (Halford, Markman, Kling, & Stanley, 2007). For effective problem solving, difficult issues are controlled, escalating conflicts are slowed down, and arguments are kept constructive. Repair of hurts and misunderstandings is crucial.

Cognitive-behavioral couple and family therapy (CBCFT; Dattilio, 2005, 2010) addresses the subjective meanings and emotional experiences of family members that contribute to the persistence of rigid family rules and dysfunctional behavioral patterns. Therapists focus on five types of cognitions influencing relational problems: (1) selective perception of others and the relationship; (2) causal attributions for events in the family; (3) expectancies, or future predictions; (4) assumptions about others and relationships; and (5) standards—beliefs about what characteristics couples and families should have. Cultural, religious, or societal norms and ideals are explored as they influence individual and shared family beliefs, or schemas, and related relational patterns. Clinicians coach members in devising their own more benign alternative meanings for distressing events and distorted or constraining cognitions to contribute to enhanced functioning and relational well-being.

Psychoeducational Approaches

The family psychoeducational model, based on solid empirical evidence, was developed for family intervention with schizophrenia and other persistent mental illnesses (e.g., Anderson, Reiss, & Hogarty, 1986; Lefley, 2009). This approach corrects the pathologizing tendency in traditional treatments to blame a “schizophrenogenic mother” or a “toxic” family for causing mental illness. Research has established that mental disorders are influenced by the interaction of a core biological vulnerability and environmental stresses. Families are engaged respectfully as valued and essential collaborators in treatment, serving as vital resources for their loved one’s long-term functioning and well-being in the community. Attention is given to their caregiving
challenges as they struggle the best they know how in managing severe cognitive, emotional, and behavioral symptoms.

Multifamily group interventions (McFarlane, 2002) are designed to reduce family stress and provide support through practical information and management guidelines for predictably stressful periods in the course of a chronic mental illness. Families are helped to develop coping skills and to plan how to handle future crises. The group format provides social support, sharing of problem-solving experiences, and reduction of stigma and isolation of families. Brief psychoeducational “modules” timed for critical phases of an illness (Rolland, 1994) support families in digesting manageable portions of a long-term coping process and in handling periodic flare-ups.

Psychoeducational multifamily, couple, and single-parent group approaches are finding application in a wide range of problem situations faced by normal (i.e., average) families, such as family psychosocial demands of chronic physical illness (Rolland, 1994; Steinglass, 1998; see Rolland, Chapter 19, this volume), and stressful family transitions, such as job loss (Walsh, 2002, 2006). By identifying common challenges associated with stressful situations, family distress is normalized and contextualized, and therapy is focused on mastering adaptational challenges.

**Multisystemic Models**

Several evidence-based, multisystemic, and multidimensional models offer highly effective intervention approaches with high-risk and troubled youth by involving families and larger community systems (Henggeler, Clingempeel, Brondino, & Pickrel, 2002; Liddle, Santisteban, Levant, & Bray, 2002; Santisteban et al., 2003; Sexton & Alexander, 2005). These family-centered approaches with adolescent conduct disorder and substance abuse also yield improvements in family functioning, including increased cohesion, communication, and parenting practices, which are significantly linked to more positive youth behavioral outcomes than in standard youth service. Multisystemic interventions adapt structural, strategic, and behavioral approaches; may take a variety of forms; and involve school counselors, teachers, coaches, and peer groups, and may work with the police, probation officers, and judges to address adolescent and family legal issues. They might help a youth and family access vocational services, youth development organizations, social support networks, and religious group resources.

These approaches engage families that are often seen as unready, unwilling, or unmotivated for therapy, in a strengths-oriented collaborative alliance. They develop a shared atmosphere of hope, expectation for change, and a sense of responsibility (active agency) and empowerment. Rather than seeing troubled youth and their families as “resistant” to change, attempts are made to identify and overcome barriers to success in the therapeutic, family, and social contexts. Therapeutic contacts emphasize the positive and draw out systemic strengths and competencies for change. Clinicians maintain and communicate an optimistic perspective throughout assessment and intervention processes.
Intergenerational Approaches

Early in the field of family therapy, several growth-oriented intergenerational approaches to family therapy were developed.

Psychodynamically Influenced Approaches

Several intergenerational approaches bridged psychodynamic, object relations, and family systems theories, broadening focus from early childhood maternal influences to ongoing dynamic processes in the family network of relationships. In core tenets, parents—individually and through couple/parental bonds—promote attachment, separation, and individuation processes considered essential for healthy development. Attachment theory was expanded to consider how an optimally functioning family system provides a secure base for members and a context of security, trust, and nurturance (Bowlby, 1988; Byng-Hall, 1995).

Healthy functioning as a spouse or parent is seen as largely influenced by family-of-origin experiences. In theory, a shared projection process, based on complementarity of needs, influences mate choice and ongoing parent—child transactions. In healthy couples, partners are capable of intimacy and commitment, and are relatively well-differentiated, with mutual acceptance despite differences and disappointments. In a healthy family, parents are aware of and free enough from intrapsychic conflicts, projections, and unfulfilled needs to invest in parenting and be responsive to their children’s developmental priorities.

Couple and family dysfunction are thought to arise from unresolved past conflicts or losses, interfering with realistic appraisal and response to others. Current situations are interpreted in light of one’s inner object world, contributing to distortion, scapegoating, and irrational role assignment. Symptoms can result from attempts to reenact, externalize, or master intrapsychic issues through current relationships. A significant trauma or loss may reverberate through the entire family system, with emotional upheaval fueling distress in other members and relationships.

Assessment and treatment explore the connection of multigenerational family dynamics to disturbances in current functioning and relationships. The therapist facilitates awareness of covert emotional processes, encouraging members to deal directly with each other to work through unresolved issues and to alter negative patterns from the past (Framo, 1992). The conjoint process serves to build mutual empathy in couple and family bonds. Extended family members may be included in sessions, or individuals may work on changing relationships between sessions.

The contextual approach of Boszormenyi-Nagy (1987) emphasized the ethical dimension of relationships in intergenerational legacies of accountability and loyalty. Families are thought to be strengthened by actions toward trustworthiness and relational equitability, considering all members’ interests for growth, autonomy, and relatedness. Ideally, family members openly
negotiate transitions and commitments with flexibility, fairness, and reciprocity. Covert but powerful loyalty issues can fuel conflict and dysfunction. Therapy aims to resolve grievances for reconciliation of relationships.

In summary, these approaches hold a model of ideal, or optimal, functioning toward which therapeutic growth is encouraged. Therapy aims to reduce pathological family dynamics through insight, facilitation of direct communication, and efforts toward relational repair. Assumptions about healthy family processes were extrapolated from clinical theory and dysfunctional cases. Little was said about average families, extrafamilial influences, or family and cultural diversity. The pathological bent has been strong: Consideration of intergenerational dynamics are focused on negative influences to be contained or resolved, with scant attention to positive experiences and relationships in the family of origin or current bonds that might contribute to healthy functioning.

Bowen Model

Bowen (1978) developed a theory of the family emotional system and a method of therapy from observation of a wide range of families, viewing them on a continuum from the most impaired, to normal (i.e., average), to optimally functioning. He accounted for the variability in functioning by the degree of anxiety and differentiation in a family. When anxiety is low, most relationship systems appear normal, or symptom-free. When anxiety increases, tensions develop in the system, blocking differentiation and producing symptoms. Most families were thought to function in the moderate range, with variable cognitive and emotional balance and some reactivity to others in needs for closeness and approval. In families with “moderate to good differentiation of self,” couples are able to enjoy a full range of emotional intimacy without losing their individual autonomy. Parents can encourage their children’s differentiation without undue anxiety or attempts to mold them. Family members take responsibility for their own behavior and do not blame others. They can function well alone and together. Their lives are more orderly, they can cope with a broad range of situations, and when stressed into dysfunction, they use a variety of adaptive coping mechanisms to recover rapidly.

Bowen related individual and family dysfunction to several processes: (1) high emotional reactivity and poor differentiation in the family emotional system; (2) triangles formed when two members (e.g., parents), avoiding conflict, embroil a vulnerable third person (e.g., child); (3) family projection processes focusing parental anxiety on a child; and (4) emotional cutoff of highly charged relationships by distancing. Stresses on the family system, especially with death and loss, reduce differentiation and heighten reactivity, commonly producing triangulation or cutoffs. With extreme anxiety and fusion, reactive emotional processes seriously impair functioning and relationships.

The Bowen model values exploration and change beyond symptom reduction. The therapist, as coach, guides client efforts to gather information,
gain new perspectives on key family members and patterns, and redevelop relationships by repairing cutoffs, detriangling from conflicts, and changing one’s own part in vicious cycles. Carter and McGoldrick (2001) expanded the therapeutic lens to address the impact of larger cultural forces, such as sexism and racism. They clarify that contrary to criticism that Bowen therapy stresses cognitive processes and autonomy (traditional masculine values), the main objective in Bowen therapy is differentiation of self in relation to others to achieve richer, deeper relationships not blocked by emotional reactivity, fusion, or distancing.

Experiential Approaches

Innovative experiential approaches developed by Satir and Whitaker were highly intuitive and relatively atheoretical. Yet both held strong views on essential elements of healthy family functioning. Satir (1988) blended a communications approach with a humanistic orientation. She observed a consistent pattern in her experience with optimally functioning families—described as untroubled, vital, and nurturing.

1. Family members have high self-worth.
2. Their communication is direct, clear, specific, and honest.
3. Family rules are flexible, human, and appropriate.
4. Family links to their social world are open and hopeful.

By contrast, in troubled families, self-worth is low; communication is indirect, vague, and dishonest; rules are rigid and non-negotiable; and social interactions are fearful, placating, and blaming. Regardless of the specific problem bringing a family to therapy, Satir believed that changing those key processes relieves family pain and enhances family vitality. She regarded those four aspects of family life as the basic forces operating in all families, whether an intact, one-parent, blended, or institutional family, and in the growing variety and complexity of families. She was ahead of her time in attending to the spiritual dimension of healing and growth.

Whitaker believed that all families are essentially normal but can become abnormal in the process of pain caused by trying to be normal. He distinguished healthy families by attributes similar to those noted by other early systems therapists (Whitaker, 1992). He emphasized the value of humor to diffuse tensions and playfulness for creative fantasy and experimental problem solving. Whitaker also saw healthy families as having an evolutionary sense of time and becoming: a continual process of growth and change across the life cycle and the generations, facilitated by family rituals and a guiding mythology or belief system.

Symptoms are thought to result when old pains from life experience are aroused in current interaction. To change behavior, key elements in family process are addressed; all are believed to be modifiable. Therapists facilitate
awareness and mutual appreciation through a shared affective experience, with open communication of feelings and differences. Therapists follow and reflect the immediate experience, catalyzing exploration and spontaneity to stimulate genuine, nondefensive relating. These ideas and methods have been applied in many family and couple enrichment programs.

**Summary of Clinical Models**

This brief survey of family therapy models reveals varied, yet overlapping, perspectives on family normality, health, and dysfunction. All approaches, grounded in a systemic orientation, view normality in terms of ongoing transactional processes, and most attend to social and developmental contexts. Their differences reflect more a selective emphasis on specific aspects of functioning: structural patterns, communication and problem-solving processes, and meaning systems (Sluzki, 1983). Components of family functioning in each domain are mutually interactive. For example, emotional differentiation facilitates and is facilitated by firm boundaries and clear communication.

Family therapists have increasingly integrated elements of various models into practice with a broad range of families, couples, and problem situations (Lebow, 1997; Walsh, 2011b), as in emotionally focused therapy combining attachment theory and behavioral approaches (Johnson, 2004).

In brief therapy approaches that focus on immediate problem solving, therapists should be mindful of contextual influences, such as a recent job loss and financial strains that may not be mentioned by the family focused on child behavior problems. Conflict between a daughter and stepmother may involve interlocking triangles from an unresolved parental divorce. Growth-oriented therapists need to be cautious not to reinforce a family’s sense of deficiency by setting unrealistic goals of ideal functioning or value-laden visions of family health reflecting clinician or cultural standards.

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**FROM A DEFICITS TO A STRENGTHS PERSPECTIVE**

Over recent decades, family therapists have rebalanced the skewed perspective that long dominated the clinical field. In the many, varied approaches, therapeutic focus has shifted from deficits, limitations, and pathology to a competency-based, health-oriented paradigm, recognizing and amplifying family strengths and resources (Walsh, 2011b). This positive, future-oriented stance shifts the emphasis of therapy from how families have failed to how they can succeed—envisioning positive goals and options that fit each family’s values and situation, and that are reachable through collaborative efforts.

Family therapy approaches have also become more respectful, with awareness that the very language of therapy can pathologize the family. We have become more sensitive to the blame, shame, and guilt implicit in pejorative labels with attributions of family causality. We have turned away from
earlier models emphasizing a hierarchical therapist-as-expert stance and adversarial strategies to reduce family pathology. The therapeutic relationship has become more collaborative and empowering of clients, recognizing that effective interventions depend more on drawing out family resources than on therapist change techniques. Interventions aim to reduce stress, enhance positive interactions, support coping efforts, and mobilize kin and community resources to foster loving relationships and effective family functioning.

Strength-oriented approaches are widely used in community settings with “nonclinical” families impacted by acute or chronic stress conditions, such as home- and school-based approaches with low-income underserved families (Boyd-Franklin & Bry, 2000) and collaborative practices with multistressed families (Madsen, 2006) and homeless families (Fraenkel, Hameline, & Shannon, 2009). Family therapists are increasingly addressing the impact of major trauma, such as war-related suffering in military families (MacDermid, Samper, Schwarz, Nishida, & Nyaronga, 2008), and recovery from traumatic loss and community disasters (Rowe & Liddle, 2008; Walsh, 2007).

A family resilience framework has been developed to focus strengths-based practice on highly stressful situations of adversity (Walsh, 2003, 2006; see Walsh, Chapter 17, this volume). Grounded in research on resilience and well-functioning families, this practice approach identifies and facilitates family processes that foster effective coping, adaptation, and positive growth in response to serious life challenges. A family resilience framework has useful application in recovering from crisis, trauma, or loss (e.g., complicated grief, major disasters, refugee experience); in weathering persistent multistress conditions (e.g., chronic illness); in navigating disruptive transitions (e.g., divorce, job loss); in overcoming barriers of poverty or discrimination; in supporting the success of at-risk youth (family–school partnerships); and in enabling vulnerable families to thrive.

Collaborative family health care, a rapidly growing practice area, espouses an interdisciplinary team approach with health care providers, patients, and their families to foster optimal biopsychosocial care based on research showing that preventive and integrative approaches to mental health and health care are most effective when supported by families (McDaniel, Hepworth, & Doherty, 2007; Rolland, 1994). A systems approach expands the customary model of caregiving from one designated, individual caregiver, whose overload can compromise health and well-being, to a mutually supportive caregiving team involving siblings and other key family members (Walsh, 2011a).

Current systems approaches include varied intervention formats with individuals, couples, and families, from consultation and brief therapy to multisystemic approaches, multifamily groups, and more intensive family therapy. Families may also be linked with local support groups, online resources, and organizations that advocate for families. A family systems approach is distinguished less by who is in the therapy room and more by the clinician’s attention to relationships and systemic patterns in assessment and intervention. Regardless of the source of problems, family therapists involve key family members
who can contribute to needed changes. Individuals may be seen separately or brought together for some sessions in different combinations, depending on therapeutic aims. Therapists consider (1) how family members may contribute to and are affected by problem situations; (2) how members can be resources in solving problems; and (3) how family functioning and relational bonds can be strengthened for greater well-being and positive growth.

CHALLENGES AND OPPORTUNITIES FOR CLINICAL PRACTICE, TRAINING, AND RESEARCH

Clinicians’ Views of Family Normality and Health

Postmodern perspectives have heightened awareness that clinicians—as well as researchers—co-construct the dysfunctional patterns they “discover” in families, as well as therapeutic goals tied to beliefs about family health. Even unintentionally, one’s subjectivity and partiality enter into assessment questions and their framing, the questions not asked, issues considered salient to pursue, and those that are not. Therapists cannot avoid normative thinking at some level. Noticing what we are trained to see, we may be blind to strengths and too readily ascribe pathology. Clinical sensitivity to normative (typical) family challenges and judgments about optimal family functioning reflect therapists’ values and beliefs rooted in cultural, professional, and personal orientations. It is essential for clinical training programs to examine social constructions of family normality and explore how such basic premises influence family assessment and intervention.

Beliefs about family normality from clinicians’ own cultural backgrounds, life experiences, and professional orientation influence family evaluation and intervention goals. In a survey of family therapists (Walsh, 1987), nearly half viewed their own families of origin as not having been “normal.” Yet being “abnormal” held quite different meanings. Some saw their own families as very dysfunctional. Others saw theirs as atypical, not conforming to average families in their community. Many felt their families failed to live up to ideal family standards in the dominant society or their cultural or religious norms. Clinicians’ perceptions were also influenced by their practice models and their own experiences in therapy. Those in systems-oriented approaches were less blaming and more hopeful about change. It is important for clinicians to reflect on their own perspectives on normality and how these influence their views of families in therapy and the goals they set.

Training Experience with “Nonclinical” Families

Clinical training benefits immeasurably from observations and interviews in the community with normal “nonclinical” families, those whose members are not in therapy. The format might include (1) family life narrative interviews (separate and conjoint) to gather different family members’ perspectives
on their family identity, history, current relationships, and future hopes and dreams; (2) reflection on a problem or crisis faced, and the strategies and resources drawn on for coping and resilience; and (3) direct observation of family interaction on a brief structured task, such as planning a special trip together. A family genogram (McGoldrick, Gerson, & Petry, 2008), as well as a family resilience framework and family functioning assessment tools (see Walsh, Chapter 17, and Lebow & Stroud, Chapter 21, this volume), can be useful to identify strengths and vulnerabilities in family functioning, taking into consideration family members’ life challenges, resources, and aspirations.

Interviews with nonclinical families attune students to the diversity of family perspectives and salient issues relative to their life-cycle phase, family form, gender, cultural/religious values, and socioeconomic influences. Discussion of the wide range of “normal” families encountered by classmates provides an opportunity to deconstruct stereotypes, myths, and faulty assumptions. Pathologizing tendencies inherent in the problem focus of clinical training can be examined. In assessing strengths and resources, as well as vulnerabilities, students gain awareness of family competencies and potential. It also becomes apparent that all families are challenged in one way or another over their life course, and most are remarkably resilient.

Multiple-observer perspectives are afforded by having students team up to conduct the interview and later discuss their observations and assessments, and also to note similarities and differences related to their own sociocultural background, gender and sexual orientation, and current developmental phase. Awareness is heightened that each clinician is part of every evaluation and influences what is observed, emerging information, and functional or dysfunctional judgments ascribed to individuals and relational patterns. In expanding perspectives on normality, the experience more importantly can depathologize views of clinical families in distress and humanize the process of therapy.

**Normalizing Family Distress**

Ordinary families often worry about their own normality: Are they doing well? Are they doing it “right”? Differences from either average or ideal norms are often experienced as stigmatized deviance: deficient and shame-laden. The overwhelming challenges and changes in contemporary life can compound feelings of inadequacy, especially for multistressed families with limited resources. In a culture that readily blames families and touts the virtue of self-reliance, parents often feel doubly deficient: for having a problem, and for being unable to solve it on their own. In my experience, much of what is labeled as family “resistance” to therapy stems from concerns of being judged dysfunctional and blamed for their problems. Nonengagement is often taken as further evidence of their dysfunction or insufficient caring and motivation for change. Many families have felt prejudged and blamed in contacts with schools, mental health or human service providers, welfare agencies, or justice systems. Expecting a therapist to judge them negatively, they may mistake a clinician’s neutral stance or well-intentioned silence as confirmation
that they are deficient or fail to fit a cultural ideal of the family. It can be helpful to explore families’ concerns and the models and myths they hold as ideal. It is crucial to disengage assumptions of pathology from participation in therapy, taking care not to present—or imply—family deficits as the rationale for family therapy. It is essential to understand every family’s challenges, affirm members’ caring and efforts, and involve them as valued collaborators in therapeutic goals.

The aim of normalizing family members’ distress is to depathologize and contextualize their feelings and experience. For instance, intense emotional reactions are common and understandable in crisis situations and are normal reactions to abnormal conditions, such as war-related trauma. Normalizing is not intended to reduce all problems and families to a common denominator; it should neither trivialize clients’ suffering, struggle, or plight, nor normalize or condone harmful and destructive behavior patterns.

**Errors in Pathologizing Normal Processes**

Two types of errors can be made in regard to questions of normality. The first is to overpathologize families by mistakenly judging normal processes as dysfunctional, or difference (deviance) as abnormal (pathological). Clinicians should be aware of their own value-laden assumptions and keep informed by current research on family and couple functioning. Family distress is common and expectable under stressful conditions, such as the challenge of chronic illness or in response to a devastating loss. Members may be coping as well as can be reasonably expected in such adverse situations.

Clinicians may also err in conflating relational style variance with pathology when it reflects personal preferences or cultural differences from dominant North American norms. For instance, the overused label “enmeshment” pathologizes families whose high cohesion is culturally normative, such as Latino families (Falicov, 1998; see Falicov, Chapter 13, this volume). In many cases, high connectedness and caretaking may be both functional and desirable in couples and families, without being intrusive (Green & Werner, 1996).

Clinicians should also be careful not to label a family by an individual member’s disorder or substance abuse problem (e.g., an alcoholic family) or by a single family trait or stylistic feature (e.g., “This is a chaotic family”). Given multiple influences, clinicians must not presume a family causal role in individual disturbances. Moreover, the complex texture of family life should not be reduced to a one-dimensional—and pejorative—label. As family systems researchers have documented, individual and family functioning involve multiple family processes intertwined with biological and environmental influences (see Lebow & Stroud, Chapter 21; Spotts, Chapter 22; Fishbane, Chapter 23, this volume).

The structural concept of parentification has too often pathologized common patterns as inherently damaging. It is normative in most cultures to expect children to carry a share of family responsibilities, particularly household chores and care of younger siblings. In large families, in situations of parental
absence or incapacitation, and in multistressed and underresourced families, such as overburdened single-parent households, delegation of responsibilities to older children may be essential for family functioning. It can work well so long as generational boundaries and lines of authority are clearly drawn. It can also hold benefits for children in gaining competencies, as long as they are not overburdened, abused, or required to sacrifice developmental priorities, such as education and peer relations. What is considered “age-appropriate” is to some extent culture-based, and each family’s situation, constraints, and resources must be considered.

Errors in Normalizing Dysfunction

Clinicians may also err by not recognizing and dealing with harmful family processes by assuming them to be normal. Family therapists have recognized that the early systems concept of circular causality, or a therapeutic stance of neutrality, reinforces the status quo and accepted norms and practices. Gender-based, demeaning treatment, violence, or abuse should never be normalized, despite its common occurrence or its rationalization as sanctioned by cultural or religious beliefs. Acceptance of diversity is not the same as “anything goes” when family practices harm any member.

Family Diversity and Complexity: Meeting the Challenges

The cultural ideal of the white, middle-class, intact nuclear family of the mid-20th century long remained an implicit standard in clinical practice, training, and research, lagging behind the changing family structures and challenges of most Americans over recent decades. The generation of family therapists that has come to the forefront has broadened our attention to the multiple ways of being a family, and the impact of larger systems and sociocultural influences on family well-being and dysfunction (e.g., Boyd-Franklin, 2006; Breunlin, Schwartz, & MacKune-Karrer, 1992; Falicov, 2007; Hardy & Laszloffy, 1995; Imber-Black, 1988; McGoldrick & Hardy, 2008).

Family, Social, and Community Connections

Clinical practice can be informed by the burgeoning research and clinical literature addressing the common adaptive challenges and strengths associated with varied family forms and transitions (see Part II, this volume). Research with community samples, especially longitudinal studies, can support efforts to identify predictable strains and facilitate effective family processes. For instance, the research on significant variables in divorce and stepfamily adaptation (see Greene et al., Chapter 5; Pasley & Garneau, Chapter 7, this volume) illuminates key processes that family practitioners can target to help families buffer expectable stresses and facilitate optimal adjustment for children and their parents.
We have moved beyond the myth of the self-reliant nuclear family household to expand attention to the multiple relationships and powerful connections among extended and informal kin living together or separately, and even at great distance. Genograms and time lines (McGoldrick et al., 2008) are valuable tools to diagram complex family structures and note the concurrence of stressful events and transition with symptoms of distress. Postdivorce, remarriage, and adoptive families may need assistance in dealing with normal challenges (i.e., common and expectable in their situation), balancing needs for a cohesive family unit with children’s vital connections with noncustodial parents and extended family. Gay communities provide strong bonds in the face of family, cultural, or religious nonacceptance. Close friendships, social networks, faith congregations, and community supports can be invaluable resources. New technologies, from cell phones to the Internet and social networks, offer opportunities for connection and information, as we navigate myriad challenges in today’s complex world.

**Addressing Varied Life Cycle Challenges**

Family therapy training and family process research have tended to focus on couples rearing children and adolescents. With growing diversity in developmental pathways, greater attention is needed to address the full and varied course of individuals and their families (see McGoldrick & Shibusawa, Chapter 16, this volume). We need to recognize the many relational and generative options of those who remain single or without children, whose lives have often been stigmatized as incomplete. With the aging of societies, we need, above all, to attend to family challenges of caregiving and the opportunities for positive change and growth in later life (Walsh, 2011a).

**Addressing Culture, Race, Class, Gender, and Spirituality**

The intersection of sociocultural influences in family functioning needs to be better integrated into clinical training and research designs, and not marginalized as “special issues.” Falicov (1995; Chapter 13, this volume) offers a useful multidimensional framework that views each family as occupying a complex ecological niche, sharing borders and common ground with other families, as well as differing positions (e.g., race/ethnicity, gender, social class, life stage, rural vs. urban). A holistic assessment includes the varied contexts a family inhabits, aiming to understand values, constraints, and resources.

Greater attention is needed to the corrosive effects on couples and families of sexism, racism, heterosexism, ageism, classism, stigma of disabling conditions, and institutionalized forms of discrimination (see McGoldrick & Ashton, Chapter 11, this volume). Systems-oriented therapists have increasingly assumed an affirmative responsibility to advocate for social justice and for changes in larger systems, such as health care disparities, to support strong families and the well-being of all members.
The role of religion and spirituality in couples and families is receiving increasing attention (Walsh, 2009; see Walsh, Chapter 15, this volume). In family therapy, multifaith and multicultural perspectives can guide respectful inquiry to understand spiritual sources of distress and identify potential spiritual resources that fit client belief systems and preferences. Incorporating the spiritual dimension of human experience in theory, research, and practice expands the systemic lens to a biopsychosocial–spiritual orientation.

**Progress and Priorities in Family Process Research**

Family research and funding priorities must be rebalanced from psychopathology to health and prevention if we are to move beyond the rhetoric of “family strengths” and “healthy families” to clearer understanding of key processes and social supports for families to thrive. Over recent decades, a number of family systems research teams have made important contributions in mapping multidimensional components of well-functioning families (see Lebow & Stroud, Chapter 21, this volume, for a review of major models and assessment tools). Whereas early studies focused on white, middle-class, intact families, researchers have increasingly expanded their studies to a broader diversity.

The contributions of mixed methods, including quantitative and qualitative studies and using observational, interview, and questionnaire approaches, yield valuable insider perspectives (by family members) and outsider perspectives (by researchers or clinicians) (Sprenkle & Piercy, 2005). Quantitative research has tended to focus on behavioral and communication patterns that can be readily measured through direct observation, rating scales, and self-report questionnaires. Qualitative methods, such as narrative interviews, are especially useful to understand belief systems, perceptions, and other subjectivities of family experience. Advances in biobehavioral research are finding physiological, genetic, and neurological interactions with couple and family processes (see Spotts, Chapter 22, and Fishbane, Chapter 23, this volume). Computerized genogram programs (McGoldrick et al., 2007) hold untapped potential for tracking patterns in multigenerational family research.

Multidisciplinary dialogue and collaboration should be more strongly encouraged in conferences, journals, and research projects. The chasm between clinicians and researchers needs to be bridged through mutual exchange of perspectives: We have much to offer one another toward our common aim to understand and promote healthy family functioning. In future research and theory construction, our challenge is to become more knowledgeable about family functioning in its diversity. First, we need to better understand the normal (i.e., typical, expectable) patterns of living, strains, and resilience in families with varying forms, social contexts, and life challenges. Second, we need to identify key processes and mediating variables that foster effective family functioning, adaptation, and the well-being of members. We have much to learn from families that succeed—to inform clinical practice with families in distress and prevention efforts with those who are vulnerable.
CONCLUSION

The diversity and complexity of contemporary family life have heightened recognition that no single model of family functioning should be touted as normal or ideal for all families to emulate or for therapies to promote. It is imperative to examine the social constructions of normality that powerfully influence all clinical theory, research, training, and practice. Therapeutic neutrality is impossible, because we can never be value-free. Thus, it is naive—and ethically questionable—to adopt a neutral position toward normality, dismissing it from consideration, maintaining a stance of “anything goes,” or adhering to a “one size fits all” model of intervention. We need to be aware of the implicit assumptions about normality we bring to our work with families from our own worldviews, including cultural standards, clinical/research paradigms, and personal/family experience. We must challenge the stigmatization of differences as pathological and work toward more inclusive social policies and attitudes.

Finally, families today face unprecedented challenges in our highly stressful, rapidly changing society and uncertain world. Many are confused and concerned about how to build and sustain strong, loving relationships; to raise children well; and to care for loved ones in need. Our challenge as therapists is to enable families with diverse values, structures, resources, and life challenges to forge their own varied pathways in coping, adaptation, and resilience. It is important to explore each family’s constraining views of normality and support family members’ values and preferences for healthy functioning, if we are to be attuned and responsive to the broad spectrum of families in our times.

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PART II

VARYING FAMILY FORMS AND CHALLENGES