Psychodynamic Influences on Contemporary Family Therapy

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KEYWORDS

• Family therapy • Psychodynamic theory • Family systems

KEY POINTS

- Family therapy has roots in early psychodynamic theories and ideas, particularly theories of attachment, object relations, self-psychology, and mentalization.
- Many theoretic therapy models focus on the treatment of an individual and individual psychopathology; however, family systems theory supports working systemically with patients in the context of their families.
- Family therapy is often the most efficient and effective therapy modality, particularly when working with children and adolescents.

BACKGROUND

The goal of psychiatric treatment, particularly in working with children and adolescents, is the return to healthy functioning and a normative developmental trajectory. The advent of family therapy arose from the recognition that the return to healthy development for an individual was unsustainable without intervention within the family system. People of any age experience wellness or illness in the context of their lived environments and family systems.

To understand how the transformation in treatment occurs, it is important to recall the lineage of psychodynamic theories and how they contribute to contemporary family and parent therapy. Psychodynamic and accompanying developmental theories provide us with a map to aid patients in their return to healthy development. Family therapy departs from individual therapy by using psychodynamic theories to facilitate change within the family system rather than within an individual. The evolution and development of family therapy as a distinct modality came about in the 1950s in the

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context of more systemic ideas around living systems and "cybernetics" emerging in multiple disciplines at the time. Family therapy was also born from recognizing that some clinical situations did not respond to psychodynamic treatments (nor necessarily to behavioral ones) as they were applied directly to an individual.

Sigmund Freud is often a starting point for psychoanalytic theoretic development. Freud believed that the patient's development of insight was the vehicle of change that allowed one to be freed from unconscious repetition.[1–7] Certain of Freud's theories limited their usefulness in family work such as the emphasis on instincts that demand gratification or management, as it did not account for the importance of parent/infant attachment and family relationships.[1]

Family therapy draws heavily from Melanie Klein's Object Relations, John Bowlby, and other members of the middle group's theoretic contributions of attachment theory, and Heinz Kohut's self-psychological concepts of empathy, self-object, mirroring, idealizing, and twinship. Many of these concepts, when applied to dynamic relationships between people, rather to the intrapsychic world of one person, are highly applicable in the practice of contemporary family therapy today.

Melanie Klein's theories of the paranoid-schizoid position and depressive positions were organizing states for locating oneself in relation to various types of 'others'.[8] These theories of organizing states in relation to 'other' are an important theoretic underlay for family therapy. Conceptualizing a child or adolescent's symptoms as stemming from their relationships *within* their family system is the key to understanding how to restore healthy development. Healthy development is often restored not by focusing on targeting change within the child alone but by targeting change within the family system.

The Middle Group, whose major figures include W. R. D. Fairbairn, D. W. Winnicott, Michael Balint, John Bowlby, and Harry Guntrip expanded upon Melanie Klein's vision of an infant that was wired for human connection. They departed from Klein's proposition that all infants contend with constitutional aggression, deriving from the death instinct, and instead theorize that infants are wired for nontraumatic development, but may be thwarted by inadequate parenting.[9] Winnicott pioneered the concepts of holding environment, transitional object, and good enough mothering. Ronald Fairbairn's relational theory of psychic structure focused on interpersonal relationships in the development of one's psychic structure.[10] All of these theoretic developments contribute to the understanding of how contemporary family therapists localize pathology and where to focus treatment. The belief that humans are wired for healthy development and that parents' own traumatic experiences and attachment histories contribute to pathology in their children is an important starting point for family therapists to recognize the roots of pathology and how to restore a family system to a healthy developmental trajectory.

John Bowlby recognized the dilemma of families' difficulty with adjusting to the changes in their child as a result of individual therapies and hospitalizations. Bolby's attachment theory is noted to have offered a bridge between psychodynamic theories and family system theories. Children have attachment and psychological needs and the ways in which parents respond to these needs shapes their working internal models of relationships. In this sense, looking at intergenerational attachment histories was an early offshoot of applying attachment theory to family systems. Bolby believed that the negative relational experiences that some children had led to the development of dismissive or preoccupied attachment styles which shaped their working models of themselves.[10] Key negative core beliefs that children with unhealthy attachment styles may develop are ideas around being incompetent and unlovable and the belief that others are untrustworthy.[11–14]

Heinz Kohut's work with narcissism led to important theoretic contributions pertaining to early infantile and child development. Kohut proposed that infantile vitality is lost when one grows up in a milieu which lacks certain necessary experiences. Kohut identified 3 different types of self-object transferences: the mirroring transference, the idealizing transference, and the twinship transference, that relate to self-object experiences which are developmentally necessary to achieve vitality and a healthy sense of self.[15–18] Kohut described the evolution of mental life related to real-life experiences with parents. He argued that the pathology in the individual is born from the pathology existing in a parent or caregiver. Kohut's theoretic orientation that pathology evolved from the absence of certain necessary experiences within the family adds to family therapy's understanding that pathology within the family system must be addressed to promote healthy development within the patient.

Ideas of cybernetics, as mentioned earlier, were in vogue at the time in fields of engineering, medicine, psychology, sociology, and beyond. The idea of an interconnected family system, which favors equilibrium and is resistant to change (much like the thermostat system in your home) was applied to psychological theory at the time. Though the patient with schizophrenia may have made great strides in individual psychodynamic treatment in the hospital, the return to an unchanged system at home meant that there was systemic pressure for the family system to return to the old equilibrium and dynamics.

The limitation of individual treatments was thus realized and it was recognized that in order to maintain lasting change and recovery for the individual patient, the pathology within the family system required direct interventions with the family system. Many members of the family system must make changes or accommodations to create a new equilibrium or homeostasis in the family system.

The location of pathology is one important shift in the development of more contemporary family therapy models. The shift in focus from intrapsychic pathology, or the premise that the "problem" lies within the individual and that insight and exploration lead to healing, gave way to the idea that pathology or problems lie in the context of the systems and lived experiences of any given individual. Problems in life are sustained, maintained, or worsened based on the quality of relationships and communication patterns and dynamics between people. If the location of pathology is within the context of relationships (attachments), then the focus of intervention shifts from working with an individual to working with a family system.

This shift in thinking about pathology and the location of effective treatment, also led to the challenging of some previously supported psychodynamic concepts. For example, in Steve De Shazer's 1984 paper "The Death of Resistance," he argued that when closed family systems, which favored homeostasis and lack of change, became more open family systems with some encouragement for change (perhaps in the context of psychotherapy) that that there was less resistance to change. Thus, homeostasis gave way to what was coined "morphogenesis" or the idea that open systems are more flexible to change over time. Resistance historically may have referred to the unconscious defense mechanisms of an individual which made psychological change and improvement unavailable.[19] For some, this was seen as "patient blaming" rather than acknowledging that the therapist themselves becomes part of the system around the patient and thus partially responsible for change, or lack thereof, in the patient or family system.

Narrative family therapy arose in the 1990s recognizing that it is the narrative or story that one tells about oneself which may become a focus of exploration and treatment. The co-creation of a richer narrative between the therapist and patient or therapist and family, may help in the improvement of symptoms. It is common narrative practice to

"externalize" the problem explicitly. The therapist helps the patient see that they are not the problem, per se, but that their problems (and also the potential solutions) are in the context of their relationships, their communication styles, and their interpersonal dynamics. Externalization, or creating an alternate more complex story about the problem, can help mitigate shame and blame when people feel themselves to be defective or broken or have told themselves the narrative that they are the problem.

THE FAMILY THERAPIST STANCE

Expectations around change in the context of more open family systems considerably shifted the "stance" of the therapist in the context of family therapy. The recognition that the therapist is not a distant and uninvolved expert, aiding in the development of insight in the patient, but rather is a cooperative and collaborative ally, in the necessary change led to what Milton H. Erickson described as the "present and future stance." He noted that "the sina qua non of psychotherapy should be the present and the future adjustment of the patient." Jay Haley described Erickson as a therapist with "an attitude of confidence as if it would surprise him if change did not occur."[20] The shift in the therapist holding hope and the expectation for change has been an important evolution in the stance held in family therapy.

Contemporary family therapists may lean historically on psychodynamic principles, again primarily concepts from attachment theory, and also find meaningful theoretic concepts in other forms of family therapy. These include structural family therapy, developed by Salvador Minuchin in the 1960s which paid particular attention to interpersonal boundaries, hierarchies of power in family systems, and how family members reacted to major life changes, such as welcoming a child into the family or become empty nesters. Strategic family therapy was developed by Jay Haley and Cloé Madanes in the 1970s and helps identify problematic patterns, reframe behaviors, and restructure interactions between family members. This form of therapy requires the therapist to be quite active including using paradoxic interventions in sessions and suggesting tasks outside of sessions. Solution-focused therapy was developed by Insoo Kim Berg, Steve de Shazer, and colleagues in the 1970s. Solution-focused therapy is hopeful, future-focused, and helps patients and families identify exceptions to problems as well as to work to identify potential solutions. Michael White, David Epston, and others developed narrative family therapy in the 1970s and 1980s which incorporates social justice ideals in a narrative practice in which the therapist helps the family co-author a new narrative about themselves and each other. Many contemporary family therapy theories are based on the assumption that people can and do have the capacity to change and the therapist can play a role in supporting this process. The therapeutic stance of more contemporary models of family therapy is hopeful, collaborative, and the therapist defers expertise about the family to the family themselves. Harlene Anderson coined the term "not knowing" to refer to the process of the therapist deferring expertise about the family to the family themselves. This stance differs from earlier psychodynamic models where the therapist is the expert and offers interpretations of behavior to the patient with the understanding that new insight will be therapeutic.[21]

CONTEMPORARY INDICATIONS FOR FAMILY THERAPY

Clinicians who work with children and adolescents are likely to find that a high percentage of their patients respond best to family therapy interventions, given the developmental age of their identified patients. One of the author's colleagues, John Stewart, PhD, a long-practicing attachment focused family therapist, often uses the

analogy of the "canary in the mine." It was common practice at one point for mine workers to bring a canary deep into the mine as a crude measure of the air quality. The canary would succumb to rising carbon monoxide in the mine, giving the miners time to exit safely before they became victims of the toxic air in the environment. Stewart applies this analogy to working clinically with children and families. Many of our mental health theories and therapies are directed at the individual. Treating the ill canary would be fruitless if we did not consider the toxic environment that surrounds him. Treating the child in the absence of involving the family system can be similarly misguided at times. We are not arguing there is no role for individual theories or treatment modalities, but that often, in our clinical experience, the most effective and efficient way to heal is by working with the system around a child.

We also note that in our experience, the person with the least power and autonomy in a family system, who may often be a child, maybe the first to succumb or become symptomatic when the family relationships or dynamics are problematic.

LIMITATIONS OF FAMILY THERAPY AND BARRIERS TO FAMILY THERAPY

Just as John Bowlby and psychoanalytic practitioners treating schizophrenia reckoned with the limitations of individual treatments, family therapy has its limitations as well. In some situations, direct intervention in the family system may not be preferable to work with an individual. However, an informed family therapy approach will be valuable even when the individual treatment is deemed to be the most beneficial treatment modality. Starting with individual treatment may be best for patients with active substance use disorders, complex personality disorders, or family systems with active or ongoing abuse or violence.

There are some practical limitations to family therapy as well. Many clinicians have limited training in family systems theory and practice and are overwhelmed or uncomfortable with providing treatment in settings with multiple family members present. Unfortunately, we have often seen a patient present to our practice and we learn that every member of the family is in individual outpatient therapy, often without collateral information sought or collaboration around treatment goals. What is frequently missing, in our experience, is one clinician working systemically with the family. This tends to lead to a quicker resolution of the problems and conflicts within the family system. In our experience, when family dynamics are contributing to the symptoms of the family member presenting for mental health treatment, individual therapy modalities are not the treatment of choice. It is not to say that there is never an indication for individual treatment, for there often is. However, family therapy may improve or resolve symptoms in a shorter period of time than individual therapy on its own, particularly with younger children. It can misguided to think that an hour a week of individual therapy with a child or adolescent will be adequate, if the dynamics in the family (where the child spends the majority of their time) are part of the underlying problem. We would advocate for training programs for all mental health clinicians in family systems theory and practice, so clinicians feel comfortable with this modality when indicated.

There are insurance and payment limitations as well. Despite the complexity and challenges of family therapy, many insurance companies reimburse family therapy sessions at rates even lower than individual therapy sessions. Due to insurance and revenue pressures, health care systems in the United States increasingly hire psychiatrists for "medication management," "evaluation and management," or short-term consultative services and delegate ongoing regular psychotherapy to other types of mental health providers. It is essential for psychiatrists to advocate for continued training in psychotherapy modalities, including in family therapy.

CLINICAL VIGNETTE

Jack, a 13-year-old Caucasian male, was brought by his mother, Tammy, to an initial assessment with a child and adolescent psychiatrist due to concerns about his mood and behavior. Always a spirited and active child, he became sullen, withdrawn, and explosive at home in the last year and given a family history of depression, she worried he was depressed. There were no major concerns at school or other parts of Jack's life. After exploring his symptoms and better understanding family dynamics, the psychiatrist suggested family therapy as the starting point for treatment. Jack did not meet criteria for a mood or other mental health disorder and the issue appeared to one mostly limited to the home setting in the context of the parent-child relationships. This suggested to the psychiatrist that individual therapy may not be the treatment modality of choice. Though family therapy can be an unexpected recommendation for some parents, who may be expecting medication and/or individual therapy recommendations, Tammy was open-minded to the idea that family patterns were contributing to Jack's symptoms and felt that all members of the family would be amenable to participating in treatment.

The psychiatrist scheduled several sessions with Tammy and her husband, John, to better understand the nuclear family. Exploring the attachment histories of the parents revealed that John, a lawyer, had grown up in a working class Irish Catholic family in Philadelphia with parents who struggled with alcoholism. John's father was a plumber and he financially provided for the family; however, there was not much warmth or affection from either parent toward John or toward each other. John was an only child and often felt lonely at home. John's parents divorced when he was 14 and he lived primarily with his mother during high school. She tended to be relatively passive and anxious and had a series of boyfriends, leaving little time for him. John's father died of alcohol-related liver disease when he was 19. John was ambivalent about the loss, noting that he always wished his father would "sober up and be the father I needed." He recalled thinking he would do better as a father should he have the chance. John's respite was at school. He was deemed a talented student by middle school. He was the first in his family to go to college, and then he went on to law school. He was a stoic "pull yourself up by your bootstraps" kind of guy who was quite intellectualized and distant from his own affective states.

John was immediately attracted to Tammy when they met through a mutual friend when he was in law school. Tammy was pursuing her Master's degree in Education at the time and he saw her as confident and funny. Tammy also had a difficult childhood, something which they bonded over during their courtship. Tammy grew up in a middle-class family in a suburb of Cleveland. Her mother was disabled by anxiety and essentially housebound for much of Tammy's childhood. This left Tammy, the eldest of 4 siblings, a caretaker from an early age. Her father worked in insurance sales and was reportedly mercurial and often angry at home, leaving her feeling "on eggshells" in his presence. For Tammy, her education was similarly a path to a different life, one of independence and self-sufficiency. She deeply resented her parents for what she felt was the "loss of my childhood" due to caretaking demands. She had distant relationships with her younger siblings who were scattered across the country with their own families.

The couple married and moved to a suburb of a city far from both their families for John's first job at a law firm. Tammy taught elementary school for several years. They had their son Jack followed 2 years later by his sister Sarah. Tammy found the stress of teaching and raising children difficult, as John worked long hours, so she decided to be a stay-at-home parent. She was somewhat conflicted by this decision though she

and John decided it made sense for the family. Tammy expressed resentment toward John as she again felt overwhelmed with the caretaking needs, this time of her own young children.

The psychiatrist helped them identify and explore a common dynamic in couples, one of a pursuer and withdrawer. John reported feeling "nagged" and "attacked" when he walked in the door with a variety of demands from Tammy. Tammy felt abandoned and invalidated when her pleas for support and affection were met with John retreating to the basement to wrap up his work day on his computer. Furthermore, she noted John made her feel "crazy" and "emotional," reminiscent of her own mother, when John was emotionally unavailable and distant.

The psychiatrist had sessions with Jack and Sarah alone and then the siblings together. Jack reported feeling loved by both parents but feeling enormous pressure from them to "be perfect." Though bright, Jack was more motivated by sports and peer relationships than academics, and his average performance in school was frustrating to his parents. He similarly felt attacked by his mother when he returned home from school and would spend most of the evening in his room, playing video games or chatting online with friends. He denied feeling depressed but did agree that he was irritable with his parents as he felt he could not "catch a break." He sometimes admitted he would "explode" with frustration when he felt he could not escape parental demands. His sister Sarah meanwhile did well at school which came more easily to her than to Jack. She was quiet and introverted; though, she had a few close friends at school. She reported trying to "stay out of it" at home when either her mother and Jack or her parents were arguing with each other. Jack and Sarah generally got along well with typical sibling bickering at times.

The turning point for the family occurred about a year prior when John had a significant episode of major depression requiring a medical leave from work and a psychiatric admission. This terrified Tammy who felt the family's financial stability was in peril. She also felt resentment for John's helplessness and impairment which required her caretaking of him, in addition to their children. John and Tammy had each sought their own individual therapy at that time; however, this had further entrenched them each in their beliefs that they were the "victim" and the other the "villain" in their marital relationship. Though John's depression was in remission and he had since returned to work, there was little affection in the couple's relationship.

The treatment involved helping the parents understand their own and each other's attachment histories and their own vulnerabilities which led them to their pursue/withdraw dynamic which also played out between Tammy and Jack. Both parents ultimately had deep unmet attachment needs, feeling abandoned by the other, and the psychiatrist facilitated open exploration of these more vulnerable and self-reflective feelings, which at home were masked with anger, resentment, and defensiveness. Sessions with the whole family identified the deep need for connection that all family members felt and helped the children understand their parent's underlying good intentions, which were often lost to the children. Jack learned more about his parents' difficult childhoods which created more empathy and understanding. He understood that his irritability and aggression was particularly difficult for his mother due to her own childhood experiences and agreed to work with the psychiatrist on more effective ways to manage his frustration. For John, being more present during family time helped Tammy feel less alone in caretaking for the children. Throughout the treatment, the psychiatrist helped the family hold hope that they could once again find more loving and connected family relationships, something each member longed for. The assigned homework between sessions focused on the family enjoying each other's company by revisiting a prior love of family bowling nights as one way to reconnect.

John and Tammy also resumed semiregular "date nights" as Jack and Sarah could stay home alone for a few hours. Working flexibly with different members and subunits of the family over time, with a clear focus on attachment, helped co-create a more nuanced and empathic family narrative and more robust connections among all members.

SUMMARY

Family therapy has deep roots in psychodynamic theories, particularly in theories of attachment, object-relations, self-psychology, and mentalization. The realization that patients improved in the context of an inpatient hospitalization only to relapse again when discharged back to their home environment prompted a rethinking of psychodynamic and behavioral treatment models targeting individual psychopathology to include more systemic thinking and therapeutic techniques. Considering interpersonal dynamics, family attachment histories, and the communication patterns that arise in the context of family systems led to the development of various theoretic models of family therapy.

The stance of a contemporary family therapist is one of an "appreciative ally," holding hope and supporting the family in a transparent and collaborative manner, recognizing that the therapist can become part of the family system.[20] While there are pressures against family therapy models including reimbursement limitations and lack of clinical training in family therapy among many mental health clinicians, family therapy is often the most efficient treatment model, particularly when working with children and adolescents.

CLINICS CARE POINTS

- Family therapy has roots in psychodynamic theories including attachment theory, object-relations theory, self-psychology, and mentalization.
- Systemic ideas about psychopathology occurring within the context of family systems led to the development of family therapy theories and practice.
- Though there are some practical barriers to family therapy, including limited clinical training for many mental health providers and insurance reimbursement limitations, family therapy is often the most efficient and effective treatment, particularly when working with children and adolescents.

DISCLOSURES

The authors have nothing to disclose.

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