CHAPTER 1

INTRODUCTION TO INTEGRATIVE ECOSYSTEMIC FAMILY THERAPY

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> *No man is an island, entire of itself:*
> *every man is a piece of the continent, a*
> *part of the main.*
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> —*John Donne, Devotions*, XVII

Psychology has experienced three distinct phases in its attempt to deal with human beings and their vicissitudes. The beginnings of psychology, of course, lie in the study of the individual. A second phase, family therapy, began in the early 1950s. Accepting the concept that we grow not in isolation but, for the most part, in families, a small band of pioneers began to study and treat families. These theorists focused not on individual pathology but on the structure and communications of families themselves. A third phase, ecosystemic therapy, emerged gradually. This parallel and sometimes intersecting interest, seldom even indexed in early writings about family therapy, concerned the interaction between families and still larger systems. Harry Stack Sullivan (1954), John Elderkin Bell (1975), and Edward Auerswald (1968) were among the first to address ecosystemic concerns. Harry Stack Sullivan (Havens, 1973) was an early American psychoanalyst whose work served as a bridge between individual and systems theory. His "interpersonal psychiatry" taught therapists to examine the individual in the light of familial and social history. Bell (1975) attempted to integrate the intrapsychic, interpersonal, and cultural elements in their attempt to treat people within a larger context. Auerswald (1968) was the first to describe this multileveled work as an "ecological systems approach."

Terms such as *ecology* and *ecosystem* have found their place in such fields of study as biology and sociology over the past century. They derive from the Greek root *oiko-* or *oeco-*, which may be defined as a "home," often in the broadest sense—not an individual dwelling but a "habitat or environment, especially as a factor significantly influencing the mode of life or the course of development" (*Webster's Third New International Dictionary of the English Language*, 1986, p. 720). Like family therapy, ecosystemic therapy is more an attitude than a technique of therapy. A family therapist, whether treating an individual, a couple, or a family group, is collecting information and hypothesizing about treatment while taking into account a growing knowledge of that family's structure. The shift up toward an ecosystemic approach uses a still broader lens (Imber-Black, 1988). Work systems, health care systems, social services and legal systems, gender issues, religion, ethnicity, and culture may all require examination. This broad lens includes the therapy itself and sees the therapist as still another part of the ecosystem. In this chapter we examine what we see as ecosystemic elements in individual, in family, and in larger systems work.

In terms of technique, the ecosystemic approach is integrative or eclectic, in the best sense of the word. The *American Heritage Dictionary* (1991) defines *eclectic* first as "choosing what appears to be best from diverse sources, systems, and styles" (p. 473). The word *eclectic* went out of favor in family therapy circles in the 1970s because it was thought to connote a patchwork rather than a theoretically strong and homogeneous approach. However, by staying close to the actual definition of *eclectic* the

practicing family therapist of the 21st century can create a flexible and effective way of conducting therapy. Such an approach targets the level or levels of the system that most need attention and uses the techniques most appropriate to that level.

We begin this chapter by describing seven principles that are common to most effective systemic therapies but particularly pertinent to integrative ecosystemic family therapy. Each plays some role in the cases presented in this volume, whether major or minor, and so deserves consideration. These principles include family competence, collaboration, neutrality, coaching, confidentiality, the use of power, and the therapist's use of self. After discussing these principles we introduce many of the concepts common to ecosystemic assessment and treatment at the same time we introduce the reader to many of the case studies in the volume that bring these concepts to life.

FAMILY COMPETENCE

Ecosystemic therapy is fundamentally a humanistic therapy. It is founded on the belief that the individual and family are essentially competent systems, if barriers to accessing that competence are removed. Similarly, ecosystemic therapists approach all larger systems as potentially healthy, no matter what their current functioning. This belief helps the therapist approach all parts of the system with respect and optimism while at the same time realistically appraising the barriers, dysfunctions, and difficulties that prevent the person or group from achieving goals. These goals may include dissolution or fundamental restructuring of some part of the system. Anderson, Goolishian, and Winderman (1986) pointed out that many problems are not so much solved as dissolved (or "dis-solved," as Anderson et al. termed it) as people arrive at a narrative on which they can agree.

At the individual level this assumption of competence may be operationalized by a thorough assessment of a patient's strengths as well as his or her psychopathology and intrapsychic struggle. Typically, individuals come to psychotherapy when they are at their worst, and paying attention to strengths provides the therapist with a more accurate overall assessment of the person's functioning. It is also therapeutic for patients to discover this balance; they are usually overfocused on their pain and on the problem that resulted in the need for therapy rather than on their strengths.

A parallel process occurs at the family level. With a couple or family who is in pain and struggling, a group discussion regarding family strengths is an important aspect of a thorough assessment. Hearing about their strengths is, for the family, a therapeutic experience in and of itself. Often, the group members have not recently, or perhaps ever, told each other what it is that they feel their strengths are. This approach opens up meaningful communication on a topic that tends to be less threatening than the subsequent probing of painful issues.

Individuals and families are often taken aback by the assumption of competence and the listing of strengths by the therapist. When eliciting strengths, it is important for therapists to make clear their intent to investigate and listen fully to the patient's and family's concerns. An assumption of competence does not mean a lack of empathy for their pain or a naive approach to problem-solving; rather, it is an attempt to achieve a balanced assessment of strengths and weaknesses. This benefits both therapist and family.

Several traditional family therapy interventions are related to this assumption of competence: reframing, positive connotation, and symptom prescription (Minuchin & Fishman, 1981; Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978; Watzlawick, Weakland, & Fisch, 1974). Although they are not entirely the same, these interventions draw on the assumption that the individual or family has positive intentions, however misguided, and that recognition of positive intentions will help the system to reorient in a more productive way.

The assumption of competence with regard to the ecosystem is more complex. Each larger system, whether it be a work group, an ethnic group, or an extended family, has infinite possibilities for human error, bureaucratic snafus, interpersonal difficulty, and leadership problems. The job of the ecosystemic therapist is to understand the culture of the larger system as it impinges on the patient and his or her problem. This assessment is conducted in a manner

that is respectful of that system's beliefs, values, and necessary tasks. For example, when a child presents with a school problem, it is very common for the parents to blame the school for the difficulty (e.g., "If you handled my child appropriately, he or she wouldn't have this problem") and for the school to blame the parents (e.g., "If you disciplined and attended to your child appropriately, he or she wouldn't have this problem"). The job of the ecosystemic therapist is to understand both systems' perspectives and, eventually, to build a bridge between the two units that will allow for productive teamwork on the child's behalf. This requires understanding the competence that each system brings to the problem and their differing roles in the child's life, so that slowly both sides come to see the strengths in the child, the family, and the school system in order to more effectively work together.

COLLABORATION

Collaboration is the secret weapon of successful ecosystemic psychotherapy (McDaniel, Hepworth, & Doherty, 1992). What exactly do we mean by the term *collaboration*? We use it to mean respectful partnership and shared power. Power is distributed among patients, families, and professionals as we negotiate mutually acceptable diagnoses and treatment plans. One might think that collaboration is the opposite of assuming the "expert" role. This is an oversimplification. With collaboration, each player may have an area of expertise, whether it is biomedical, psychosocial, or a patient's understanding of his or her own problem. The point is that each person's expertise is respected. The exchange is characterized by a spirit of shared inquiry so that all members, including the patient, the family, and the larger system, participate in what Anderson (1996) called "generative conversation"—people talking *with* each other rather than *to* each other. A more complete definition of collaboration might be the sharing of information, meanings, and decision-making strategies with patients, families, and other professionals.

At the individual level a spirit of collaboration involves understanding and empathizing with each participant's phenomenology—his or her experience of the world. It means establishing a working partnership in which the therapist does not assume that he or she knows what is best. A collaborative relationship is a challenge to the traditional one-up position of professionals and the one-down position of patients. Instead, the therapist's expertise facilitates the exploration of each participant's experience, noticing patterns of coping and stress and arriving at the best decisions possible given the context, each system member's values, and his or her resources.

In ecosystemic family therapy the therapist also forms a partnership with family members whom the patient wishes to involve in treatment and whom the therapist agrees are important to involve. The patient and family are viewed as partners in care rather than treated as objects of care. The family is the first circle of health specialists to respond when a family member is sick or has a problem, and so they are the preferred context of care for many patients who seek help with life stresses, depression and anxiety, interpersonal difficulties, and serious mental illness. Effective collaboration at the family level often rises or falls on the capacity of the therapist not only to engage the family but also to identify, awaken, elicit, and use the patient's and family's own natural resources—their own strengths, competencies, and accomplishments.

In addition to collaborating with patients and families, the ecosystemic therapist also forms collaborative relationships with other professionals involved with the patient and the problem. These can range from attorneys to primary care physicians, from social services workers to ministers. The central skill for collaboration with these professionals, as with all others, involves building relationships. Psychotherapists are experts at building relationships; however, they do not always use that skill with their colleagues, where it is also needed. Professional collaboration requires clear communication and the development of a common mission.

Sometimes professional collaboration is as difficult, or more so, than the collaboration with a patient or family. Professionals may not share a common theoretical framework (such as a physician's biomedical focus vs. a family therapist's psychosocial systems focus). They may have different languages, working styles, practices regarding confidentiality,

and expectations regarding communication with other professionals (McDaniel, Campbell, & Seaburn, 1995). The ecosystemic therapist must become aware of these differences and develop strategies that dissolve any barriers to effective collaboration with relevant professionals.

A joint session between two professionals, or a network session among many professionals, is often a way to bridge important differences. Convening the patient, family, and treatment team in one room allows all parties to state their perspectives and their wishes. It is a powerful vehicle for coordinating care, negotiating difference, and respecting and supporting the patient and his or her family.

NEUTRALITY AND ITS LIMITS

Psychoanalysts have traditionally prized neutrality as an essential principle of therapy. The psychoanalyst was expected to be a blank screen onto whom the patient projected his or her issues. As other theoretical models began to emerge, neutrality remained a highly valued concept, although its definition altered somewhat. *Neutrality* came to mean avoiding the imposition of the therapist's values onto the patient. The goal for the therapist was to facilitate the patient's problem-solving resources toward the patient's own goals, not those of the therapist.

In the 1970s feminist theorists pointed out that true neutrality was unfeasible. They produced evidence that existing theories, research, and practice were conducted through the lens of male experience and were not valid for women and girls. In fact, the unconscious imposition of the male value system on therapy and on research tended to place women and girls in a disadvantaged role (Philpot, Brooks, Lusterman, & Nutt, 1997). Since that time, psychotherapists and social sciences researchers have become aware of their inability to attain the ideal of complete neutrality. Instead, they are encouraged to become sensitized to their own value systems and to consider carefully when to use their values in therapy. For example, a nonjudgmental, accepting attitude on the part of the therapist is generally considered to be the best approach in most cases. However, there are situations in which therapists must openly advocate for change if their patients do not seem to be able to do so for themselves. One such example is a case of physical abuse (Walker, 1984) in which the client's life may depend on the therapist's taking a more active and instructive approach.

Neutrality at the systemic level has been described as threefold: (a) neutrality with regard to values and beliefs, (b) neutrality regarding taking sides among family members, and (c) neutrality as to whether the family chooses to change (Tomm, 1984). The issue of taking sides is unique to systems approaches and causes some of the greatest dilemmas. The therapist struggles with the issue of who the client is—the family, or the individuals within the family. Most often the therapist will use multilateral partiality (Boszormenyi-Nagy & Krasner, 1986), connecting with and supporting each family member, empowering each in turn. However, occasionally what may appear to be the best resolution for the family as a whole may be detrimental to one family member; for example, when the mother sacrifices her plans and goals for the good of the family. The therapist must then decide whether to act as an agent of the social system (elevating the good of the family over the needs of the individual) or to act as an advocate for social change. Likewise, in couples work, when one partner, frequently the man, has more power than the other, the therapist must decide whether to balance the system by empowering the weak partner or to maintain neutrality. This dilemma arises often, especially in cases of divorce, extramarital affairs, and physical or mental abuse. The therapist is faced with difficult decisions regarding what to reveal and whom to support.

At the ecosystemic level, *neutrality* can refer to not taking sides among the larger systems but understanding and respecting each. This is certainly the case when one is working with larger systems, such as medical, work, religious, or school ecosystems. It is also usually the case when working with various ethnic groups that might have different value systems or expectations. However, neutrality at the ecosystemic level can mean supporting the status quo, such as acceptance of the role of women as primary caretakers of children regardless of the loss of power into which that position places women worldwide. At this level the therapist must some-

times decide between social action and neutrality. This is an individual decision.

COACHING

One of the most important roles of the ecosystemic therapist is that of coach. The therapist may often need to teach the patient new skills, which can then be practiced and modified both in session and between sessions. Coaching is a combination of psychoeducation, modeling, and role-playing that arms the patient with new techniques to deal with old problems.

At the individual level, the therapist is frequently called on to instruct patients in methods of self-care. For example, patients often suffer from cognitive distortions that interfere with their optimal functioning in life. The individual therapist can use cognitive–behavioral approaches or rational–emotive therapy to help such patients identify the faulty logic and negative self-statements and replace these dysfunctional thoughts with more realistic and positive ones. The therapist can assign self-affirmations to a depressed patient who suffers from feelings of worthlessness. He or she can teach assertiveness skills to a patient who is easily dominated and controlled and ask that patient to demonstrate those skills in a role-play in the session. Most important, the therapist can model self-care for the patient, by setting appropriate boundaries, asserting him- or herself when necessary, and taking care of personal needs for time and relaxation. Coaching at the individual level is like teaching golf or tennis: The therapist is providing the patient with tips on how to improve his or her game regardless of how the other players are doing.

Coaching at the family level, on the other hand, is more like coaching a team. Each player must learn the appropriate skills, but they must also work together toward a common goal. Coaching at this level involves the teaching of interactive skills such as communication, problem-solving, behavior exchange, conflict resolution, negotiation, and so on. Part of the process of coaching at the systemic level is motivating the patients to cooperate for the greater good of the family or couple as a whole. This involves a cognitive shift from "What's in it for me?" to "How can I contribute to the healthy functioning of this family as a whole without losing myself?" Couples must come to adopt a two-winner approach, recognizing the value of a healthy relationship to each individual's personal fulfillment. As when one is coaching a team, the therapist can have all the players in the room at the same time. The patients can practice in session, while the therapist can offer critique of performance, modeling of skills, praise for acquisition of new skills, and constant encouragement.

Coaching at the ecosystemic level requires the therapist to have enough knowledge of the larger system to teach the patient how to act within that system. Furthermore, the therapist will want to impart an attitude of respect, acceptance, and curiosity about the world of the other, which allows for positive and fruitful interaction. This could perhaps be likened to teaching someone how to scuba dive. In addition to providing education regarding the skills needed by the diver, the coach must also teach the student about the ecosystem that the diver will be entering so that the diver will know what to expect and how to behave while swimming with the fish in their undersea world. In a therapeutic situation, the therapist will coach the patient on the expectations, language, behaviors, belief systems, and values of the ecosystem, so that the patient can navigate that world with confidence. For example, a therapist might teach a patient how to talk to his or her doctor in a hospital setting and perhaps model such communication. Or the therapist might sensitize a patient to the differences to be expected and respected in a different culture or ethnic group. The therapist frequently must act as translator between the genders (Philpot et al., 1997) and coach patients in understanding the values, communications styles, and problem-solving approaches of the other gender. At the ecosystemic level, coaching incorporates a philosophical attitude of respect and curiosity with psychoeducation, role-play, and modeling.

LIMITS OF CONFIDENTIALITY

It is difficult to consider the issue of confidentiality without first defining an overarching value: privacy. Privacy and confidentiality are so closely linked that

many authors (Canter, Bennett, Jones, & Nagy, 1994; Koocher, Norcross, & Hill, 1998; Schuchman, Foster, & Nye, 1982) have prefaced their discussions of confidentiality by first defining privacy. For example, Canter et al.(1994) defined *privacy* as "the right of individuals not to have their physical person or mental or emotional process invaded or shared without their consent" (p. 105). The definitions provided by Koocher et al. (1998) and Schuchman et al. (1982) also refer to privacy as an individual right—in fact, one protected by the Fourth, Fifth, and 14th Amendments to the U.S. Constitution. All agree that *confidentiality* guarantees that what is privately revealed will be protected. According to Canter et al., "psychologists are required by the Ethics code and by law to maintain the confidentiality of communications shared with them" (p. 105). For most individual therapists the issue of confidentiality is clear cut and is well defined by ethical codes. Only with informed consent may one, on a carefully defined and limited basis, share information, except where required by law.

A third concept, privilege, further enlarges one's understanding of confidentiality. Koocher et al. (1998) stated that "privilege and confidentiality are oft-confused concepts." He defined *privilege* (or *privileged communication*) as "a legal term . . . for certain specific types of relationships that enjoy protection from disclosure in legal proceedings" (pp. 463–464). Privilege belongs to the client, not the treating person. For this reason, if the client decides to waive the privilege, the treating person may be forced to testify.

With the introduction of film recordings of therapeutic sessions, such as the early work of Nathan Ackerman and Carl Whitaker and, later, the use of one-way mirrors and videotape in family and couples therapy training, the issues of both privacy and confidentiality required re-examination. If one refers back to the definition of privacy one will note that it is a privilege granted to the *individual*. From the moment that one begins to deal with couples and families, the private becomes public. Couples or families are invited to share their privacy with one another in the presence of one or more professionals.

As we consider confidentiality in the larger context of couple and family work, all sources cite the increased complexity of ethical issues, particularly of confidentiality. Gottlieb (1995) reviewed the ethical issues that surface as one moves from the individual to couples or family therapy, with particular attention to the issue of change of format. Gottlieb asked readers to examine the question "who is the client?" A therapist begins, for example, by seeing a woman alone, because the husband has refused therapy. After a certain number of sessions, the husband agrees to come. The therapist is now faced with a series of questions: Is the client now the couple? If so, how are the therapist's responsibilities to the couple best achieved? What, then, are the therapist's obligations to each member of the couple? In compliance with the current ethical guidelines of the American Psychological Association, Gottlieb noted, the therapist would have obtained a release from the woman at the outset of therapy that would permit him or her to share revealed information. He then pointed out that such an agreement might inhibit the initial patient from revealing important information to the therapist. Would the therapist better serve the system by knowing information and struggling with issues of confidentiality or by creating a situation that may almost guarantee that important information will be withheld?

Lusterman (1995) suggested one approach to this dilemma. He reminded readers that a systems-oriented practitioner never views a presenting problem as existing solely within the psyche of the "identified patient." Given this, he suggested that the presenting patient be told, "At some point others may join us. . . . Anything that is discussed in an individual session will be regarded as confidential. If you wish to discuss it with others, you may, but I will not." This often permits very important material, such as an adult's affair or a student's school truancy, to surface quickly. The therapist must, of course, point out that in certain circumstances there is a legal duty to report. Any time there is a further change of format, the question of confidentiality must once again be raised and a record made of the informing.

Live supervision is a juncture between family theory and treatment and larger systems interventions. Because it introduces an entirely new (and of-

ten unanticipated) element into treatment, the definition of who the client is, and the question of what the client's privileges and protections are, need to be addressed. Gottlieb (1995) concluded his discussion of change-of-format issues by stating that

> *With adequate preparation of client systems for both change of format and live supervision, the systemic therapist may avoid a variety of potential problems. Treatment decisions cannot be totally driven by existing ethical principles; sound clinical judgment must also be used. (pp. 567–568)*

Change-of-format issues multiply as therapists work with still larger systems. Therapists must work to define to each subsystem what will be considered confidential and how to protect that confidentiality. For example, a family therapist may be working with a family and a school in regard to the issue of a troubled child. The family requests that, because of economic danger, it is very important that the school not be informed that the father may have to close his currently shaky business. The school's principal, in turn, may ask the therapist to guard the information that a teacher who has acted inappropriately toward the family is soon to be fired. What can the therapist do at the very beginning of therapy to set the stage for dealing with such issues? Until guidelines are more clearly drawn, perhaps the best one can do is to be clear within oneself about how one views change-of-format issues and to routinely inform one's clients as one undertakes each new relationship.

USE OF POWER

What is *power*, and who has it? Neither question yields an easy answer. Simon, Stierlin, and Wynne (1985, p. 263) described the muddle surrounding power: "All authors on family therapy are of the opinion that questions of power are an essential aspect of family dynamics, and 'everyone knows what power is, until you ask them' (Cromwell & Olson, 1975, p. 3)." Individual-centered theories are no clearer. In general, when individually oriented theories touch on power they are dealing with the psychodynamics of power or with how the power "drive," "need," or "motive" develops. Harry Stack Sullivan (1953), for example, described a "power motive," by which he meant the infant's struggle to develop increasing competence in handling his or her physical and social development. Sullivan compared this "normal" developmental event with its neurotic counterpart, the power *drive* (see Munroe, 1955, p. 360). In some individuals the self can achieve safety only in a hostile and insecure manner. When this happens, he explained, the power *motive* is replaced by the power drive, by which the individual "tends toward fulfillment at the expense of others" (Munroe, 1955, p. 360). Adler "saw man's problem as a struggle for power in an attempt to overcome a feeling of inferiority" (Thompson, 1950, p. 11). Freud placed the origins of the developing feeling of power in the struggle over bowel control, with its possible resolutions of either defiance or submission (Thompson, 1950, p. 31). Thompson (1950) noted that Freud, "in fact if not in intention," was describing "much more than the possible erotic pleasures connected with the anal zone." Rather, she noted, he was describing "a complex interpersonal situation."

All of the conceptualizations of power so far described deal with the patient's power issues and, to some extent, the family's as well. With rare exceptions, individually oriented therapists have placed little attention on the influence that the therapist has over the patient. The belief system of most individual therapies suggests that therapy, when properly carried out, enables the patient to change—it is the process, not the therapist, that motivates the change. Where there were problems, supervision often focused on the therapist's countertransference—defensive attitudes that interfere with the therapeutic process. It is ironic that one of the first psychologists to directly focus on the therapist's power was B. F. Skinner who, in a debate with Carol Rogers, pointed out that Rogers's so-called "nondirective" therapy was, in truth, very directive, although not by the therapist's conscious choice. Skinner insisted that the famous Rogerian response–"hmm hmm"–had strong value as a verbal reinforcer, as did the therapist's nods of assent and even changes of posture (Rogers & Skinner, 1956).

Early family therapists also paid scant attention to the therapist as a locus of power in the therapeutic process, but by making the process public, through film, video, and live demonstrations, it became impossible to ignore the powerful impact of the therapist's presence. For example, when one reads Nathan Ackerman's (1958) classic, *The Psychodynamics of Family Life*, one sees the workings of an "objective" thinker struggling to present the dynamics of family development and the impact of the therapeutic process. When one sees a film of Ackerman at work, however, one is immediately struck by the power of his presence and the use to which he puts this presence as he attempts to disrupt the family system. The same can be said for all the early masters: Satir, Whitaker, Minuchin, Haley, and others of great stature.

Although the masters seldom indexed the word, *power* is an ever-present force in much of their theorizing. For example, Minuchin (1974) wrote,

> *The therapist's skill at producing stresses in different parts of the family system will give him, and sometimes the family members themselves, an inkling of the family's capability to restructure when circumstances change. His input and his expert prodding produce new context, or changed circumstances, to which the family must adapt under his eye. (p. 147)*

(A note on gender and power: It was men who were seen as powerful therapists in 1974.) Hoffman examined the issue of power (and powerlessness) in an article entitled "Beyond Power and Control" (1985). After reviewing many family systems approaches to power, she proposed a "second-order" family systems therapy. Labeling it not so much a method of therapy as a stance, she suggested a cybernetic epistemology with the following characteristics:

1. an "observing system" stance and inclusion of the therapist's own context
2. a collaborative rather than hierarchical structure
3. goals that emphasize setting a context for change, not specifying change
4. a "circular" assessment of the problem
5. a nonpejorative, nonjudgmental view.

These principles provide a bridge from older, more "reparative" or "corrective" notions of family systems therapy to an approach that is inclusive, one in which the helping system has no "stars." "It is up to us," concluded Hoffman, "to find a noninterfering, nonpurposive vocabulary for change that respects this way of being organized" (p. 395). This bridge provides an elegant path to what might then be called a "second-order ecosystemic therapy."

McDaniel and Hepworth (in press) described a well-functioning system that includes the family and the helping professionals collaborating with them:

> *With regard to power and dependency, we want to suggest that the most effective way of using one's power . . . is to give it away —that is, to recognize the power of the patient and the power of the family as partners with us in healthcare.*

They then explained that "such a process encourages a functional interdependency between patients, families, and the healthcare team."

Let us return to Hoffman's examination of power. She noted (1981, p. 191) that many family theorists "posit power issues as the basis for family difficulties." "But power," she avers, "is never an absolute item; it always has to be 'power for what?'" What families can provide, she answered, is

> *an orderly access to intimacy. . . . It may also be related to an invisible systole and diastole of connecting and withdrawing shared by all the social animals. This unconscious but orderly arrangement can be a function of the nuclear family, but it can also extend to the borders of the face-to-face community in which the family lives. (p. 191)*

It is to this community and its interaction with families that ecosystemic theory and practice devote their attention. Within this context, it becomes increasingly clear that the belief that we, as therapists, possess power is more illusion than a reality. Pediatrician Ellen Perrin (1999) pointed out that "The dif-

ference between 'collaboration' and 'help' is that in a collaboration the participants have the same goal, relatively equal status and power, but different skills and knowledge that contribute to attaining the goal" (p. 58). As we move closer to a fully realized ecosystemic theory and practice the issue of power is replaced by the power inherent in the act of collaboration.

THERAPIST'S USE OF SELF

Therapist use of self has been an important component of therapy from the inception of psychoanalysis and Freud's concept of countertransference. Exactly what is meant by *use of self* differs depending on the theorist and the frame of reference the therapist uses to conceptualize a case. Thus, use of self is different for a therapist doing individual therapy than it is for a systemic therapist. Furthermore, use of self takes on even greater complexity when an ecosystemic paradigm is incorporated in the conceptualization.

For an individual therapist, use of self usually entails an awareness of one's own reaction to a patient in the moment, separation of that response from one's personal issues, and appropriate reflection of that reaction to the patient in order to help the patient gain insight into the effect his or her behavior might have on others. It might also mean the sharing of personal experience that could teach or model suitable behavior for the patient or offer the patient insight into motivations. At all times it is important for the therapist to understand his or her own countertransferential issues so as not to confuse personal concerns with those of the patient.

At the systemic level the therapist must be aware of the family-of-origin and marital issues that could color his or her perception and expectations in the therapeutic relationship. For example, a therapist who holds the position of oldest child in his or her family of origin may at times have difficulty supporting and empathizing with a youngest child who appears, to the therapist's standards, to be irresponsible. A therapist whose life experiences have taught him or her to value marriage more highly than individual fulfillment might work extra hard to save a marriage long after the couple has given up. A male therapist might find himself siding with the male in the couple more often, whereas a female therapist may have more empathy for the female partner. Also, the expectations that a therapist brings to the case regarding a healthy family or marriage can influence the direction therapy takes, for better or worse.

Therapists can cautiously share familial or marital experiences that might offer suggestions for change or hope for successful outcome. For example, one exercise frequently used by couples therapists involves the generation of a list of nice little things a couple can do for one another to change the atmosphere of their marriage from negative to positive. A couple who is having difficulty thinking of these microbehaviors might find it helpful if the therapist says, "I like my spouse to bring me a cup of coffee while I'm putting on my makeup. Would that be something you would like?" When a couple feels discouraged regarding a commonly seen problem, the therapist can offer hope by acknowledging that in his or her experience, many couples have had similar problems and have been able to overcome them in different ways. Self-disclosure is a delicate issue that is hotly debated in therapeutic circles. When and how much should be disclosed must be carefully considered. The therapist must judge whether the personal disclosure will facilitate the therapeutic process and be certain that the disclosure is not the therapist's own attempt to resolve a personal struggle. This probably means that self-disclosure occurs only when issues are long resolved and no longer cause emotional responses. If unsure, the therapist should seek supervision or share his or her concerns with a trusted colleague. As in individual work, the therapist must be aware of the personal systemic issues that can affect the progress of therapy and allow the patients to come up with their own solutions.

At the ecosystemic level the therapist must be cognizant of the fact that perceptions, values, and expectations are influenced by the ecosystem in which the therapist is immersed, whether it be ethnicity; religion; gender; nationality; or the consequence of a smaller ecosystem, such as a profession or work setting. For example, female therapists will be less able to empathize with the dilemmas of manhood than will male therapists, unless they have

learned to expand the female lens through which they have been socialized to see the world. White middle-class therapists will not be as attuned to signs of discrimination against minorities as will African American therapists, unless they have been thoroughly sensitized to these issues. In other words, the therapist must be aware of the effect of the ecosystem on his or her thinking and be trained to approach members of other ecosystems with curiosity and acceptance. On the other hand, a therapist cannot assume that just because he or she shares the same ecosystem with the patient that the patient's experience and solutions to problems will be the same as the therapist's. For example, a therapist who has suffered chronic illness will be more understanding of the issues involved in that existence than one who has not, but he or she must also be careful not to impose his or her method of dealing with illness on the patient. Nevertheless, the therapist can use his or her empathic knowledge of the ecosystem to facilitate the patient's movement toward healthy resolution. A therapist who sees that a patient is stuck in his or her gender role journey at the angry stage, for instance, can use personal knowledge of that stage to connect with the patient and move him or her toward change and integration. In order to sensitize themselves to the ecosystemic issues that affect their perceptions, therapists can take advantage of courses and continuing-education workshops on multicultural issues, gender, multisystemic approaches, and so on. Self-awareness is always vital to effective therapy.

At all three levels—individual, systemic, and ecosystemic—therapist use of self is a vital and integral part of therapy. It simply takes different forms depending on the size of the system.

ECOSYSTEMIC ASSESSMENT

Ecosystemic assessment, which by its nature is eclectic, can lead therapists to the "wise choosing" that is likely to produce theoretically sound and integrative treatment. At the individual level, the ecosystemic therapist may or may not explicitly consider the intrapsychic makeup and personality of the patient and relevant family members. Most ecosystemic therapists appraise individuals' strengths and weaknesses in the context of a systemic evaluation. As we meet the individuals who compose the system, we seek information about each participant that will move the therapeutic process forward: What is the person's coping style? What are his or her strengths? What are his or her patterns of difficulty? Is the current problem one that has occurred before, or is it a new turn of events? What is the temperament of the patient? How does this temperament fit with the temperaments of the rest of the family? Have there been any serious illnesses, accidents, or disabilities in the family that may have had a profound effect on the intrapsychic and interpersonal processes of a system? A biopsychosocial history is an essential part of any comprehensive family assessment (McDaniel et al., 1992). Chapter 4, by David Schnarch, and chapter 8, by Mary-Joan Gerson, make particular reference to the intrapsychic lives of their clients even as they consider the role each plays in the couple system. In chapter 22 Becky Butler describes her treatment of an individual client by carefully examining the client's family and her gender systems and then connecting her to other systems in the 12-step community.

Depending on the therapist, the family assessment may be highly structured or relatively loose. Chapter 3, by Douglas K. Snyder, Jebber J. Cozzi, Jami G. Stevens, and Michael C. Luebbert, presents a fairly structured approach, as does chapter 32 by Catherine Weigel Foy and Douglas C. Breunlin. At the other end of the spectrum is chapter 9, by Harlene Anderson, who eschews any attempt to create an agenda for assessment and favors a conversation-generating approach to determine the direction of exploration.

ECOSYSTEMIC FAMILY TREATMENT

For many therapists the developmental stage of the family is of primary importance in both assessment and treatment. Indeed, it is at developmental transition points that families often present for treatment. In chapter 8 Mary-Joan Gerson describes a young couple faced with the decision as to whether to have a child. In chapter 19 Ronald F. Levant and Louise B. Silverstein describe a couple having difficulty renegotiating their previously egalitarian roles after

their child is born. At the opposite end of the life cycle, in chapters 11 and 12, respectively, Timothy T. Weber and Deborah A. King describe two families, each dealing with an elderly widowed parent, under different but highly stressful circumstances. Gay individuals and couples have an additional developmental issue to negotiate: that of "coming out" to their families. As Thomas Russell illustrates in chapter 5, this coming-out process can precipitate a significant disruption in relationships. James H. Bray's research and clinical work show that the development life cycle of stepfamilies is different than that of first-marriage nuclear families; his case study in chapter 10 of a stepfamily with grown children nicely illustrates this. In chapter 2 Jay Lebow describes a family who visits and revisits therapy at various stages of the family life cycle, a phenomenon seen often in the practices of exosystemic family therapists.

A major decision that must be made at the beginning of treatment is who is to be seen, and when. Which individuals are most relevant to what Anderson et al. (1986) called the "problem-determined system?" Should the therapist work with the couple, the nuclear family, the friends, or include the extended family? What about the in-laws or a significant boyfriend, school personnel, religious advisors, and so on? Each of the cases described in this book reveals how the therapist went about deciding whom to see and why.

As we determine the treatment system, another question must often be answered: Are the identified patient and the "customer for treatment" the same person? The "customer" may be defined as the person who most desires change. If the patient is not the customer—the person most motivated for change—then it is useful during the assessment session to know that, and to know who is. For example, a parent or parents may be the customers seeking treatment for an unmotivated child. In chapter 24 Thomas C. Todd describes the identified patient in his case as an adolescent diabetic girl with an eating disorder but often finds himself thinking of her father as his customer. Carl D. Schneider and Dana E. O'Brien describe in chapter 7 the negative results that can occur when one assumes that both individuals in a couple are "customers" (in this case, in divorce mediation) when in fact only one person has really bought into the working relationship. A school or court may require that a child or adolescent be seen when really the family is in need of services. In a case that reveals important racial and power issues, Barry Jacobs courageously reveals in chapter 13 his naivete as a new therapist in first excluding the sociocultural aspects of work with an adolescent who was court-ordered into treatment and his family. The active buy-in of social agency staff may greatly enhance the effectiveness of family intervention. In chapter 14 Wendy Greenspun shows how sensitive involvement of foster care and protective-services staff actually enhanced family intervention and paved the way for successful resolution of a potentially explosive child sexual abuse case. This case, like many others in this volume, illustrates that the ecosystemic therapist must work strategically to involve customers, patients, and any others who are significant in the problem-determined system so that the therapeutic process has the best chance of succeeding.

In actually working with a couple, whether in couples therapy or as part of family therapy, the ecosystemic therapist must consider the history of the couple and their repetitive patterns of interaction (e.g., communication, problem-solving, conflict resolution, intimacy). This includes their patterns of interactions with previous therapists, as David Schnarch aptly shows in chapter 4. What works well, and what may contribute to the ongoing problem? How strong is the marital subsystem? the parenting subsystem? What are their strengths and weaknesses as mates? As coparents? How can these be utilized to resolve the presenting problem?

At the family level, how does each significant subsystem work? the sibling subsystem? the grandparents or extended family? Are the boundaries between generations clear, appropriate, and functional? Are there significant cutoffs? Are certain members of the family routinely left out of communications? Would bringing these members back in be helpful in resolving the problem, or would it add more stress to an already-burdened system? Are there triangles that create problems in the family?

In terms of technique, most ecosystemic therapists now draw from the schools of family therapy

that have evolved since the 1950s, whether they be structural, strategic, transgenerational, psychodynamic, cognitive–behavioral, or narrative, to name a few. Each of these approaches tends to emphasize certain aspects of content or process over others. For example, structural approaches tend to focus on family structure, boundaries, and hierarchy and favor here-and-now interventions such as blocking and reframing. Transgenerational approaches look for patterns of cutoff, triangulation, and unresolved grief and favor the use of genograms to trace how patterns have been passed on from one generation to the next. Cognitive–behavioral interventions focus on skills building in several areas, including communication, problem-solving, conflict management, and structured homework as core components of treatment.

How these approaches are combined depends on the particular therapist and presenting problem. For example, in chapter 12 Deborah A. King combines a transgenerational life review process with problem-solving and communications skills training in working with a widowed elderly depressed man and his grown children. Douglas K. Snyder and his colleagues describe in chapter 3 how they worked sequentially with a couple to strengthen boundaries between the couples and their families of origin (structural), improve communication and conflict-resolution skills (cognitive–behavioral), and examine the roots of their emotional reactivity in their families of origin (trangenerational) in order to begin to reduce their overreactions to one another. These integrated approaches are typical of most cases described in this volume. Some presenting problems, however, seem to lend themselves to a more focused approach. For example, family psychoeducational approaches to serious mental illness have been found to be highly effective and highly valued by families, as the cases described in chapter 29, by David A. Moltz, and chapter 30, by Teresa L. Simoneau and David J. Miklowitz, clearly show.

At the larger systems level, the ecosystemic therapist should consider many factors, including gender, race, ethnicity, culture, class, work, physical health, and religion. Because these issues are underrepresented in most general casebooks, we have chosen to include a number of cases in these areas.

In the area of gender, Gary R. Brooks examines in chapter 21 how he slowly came to appreciate the role of gender as a major organizing variable in families by reviewing the blunders he made in working with a family organized with traditional gender roles. He then was given a second chance to work with the family when he was more gender aware. In chapter 19 Ronald F. Levant and Louise B. Silverstein describe a structured approach to couples work that combines sharing an in-depth understanding of gender socialization with the couple with family-of-origin work. In chapter 20 Carol L. Philpot combines individual and couples therapy and a women's group to help women examine the gender messages they have internalized that are limiting their lives and their relationships.

Religion, another underrepresented variable, is explored by Don-David Lusterman in chapter 17, in which he describes his work with a Jewish family. Although his work with this family involved joining on many levels, his willingness to share the evolution of his own religious identity appeared to be a turning point in the therapy. In chapter 33 Nancy Boyd-Franklin describes her work supervising a young White therapist working with an African American family and emphasizes the role of spirituality as a resource in family therapy.

Work is another ubiquitous variable in ecosystemic work. Sylvia Shellenberger presents in chapter 6 a case of couples therapy in which the wife initially presents in crisis, her job threatened because of spotty performance in the context of a company in the process of downsizing. Although the case primarily focuses on the couple in terms of communication and support, the work nicely illustrates multiple levels of intervention, including work with the employee assistance counselor and the union representative and consultation with an organizational psychologist.

Culture and ethnicity are explored in several ways in this volume. In chapter 16 Susan H. Horwitz describes how a mother and her adult daughter had to negotiate three cultural transitions while negotiating unresolved grief from the past and the daughter's current marital crisis. Jaime E. Inclan describes in chapter 18 how the immigration experience affects relationship patterns and belief systems

and explains how it is necessary to create a "cultural bridge" if family therapy is to be effective. In chapter 15 Robert Q. Pollard, Jr., and Natalie C. Rinker describe a different sort of culture, the culture of the deaf, and provide unique insights from their work with a deaf adolescent and her family. These principles are generalizable to families that are bilingual, those with intracultural differences, and families with different types of disabilities.

Perhaps nowhere is the ecosystemic model of family intervention more relevant than in cases of physical illness, where multiple systems are, by the very nature of the problem, involved. In this volume, seven chapters, each involving very different illnesses and stages of couple or family life, illustrate the various ways therapists work creatively with these systems to help patients and their families adjust to their illnesses and the illnesses' effects. In chapter 23 Anne E. Kazak describes the treatment of a couple with two young children (ages 2 and 8), the younger of which had just completed a long but successful treatment for cancer. Although the 8-year-old is initially referred for treatment, the therapist initially focuses on the overburdened couple, helping them strengthen their marriage before tackling parenting concerns. Thomas C. Todd describes in chapter 24 the family treatment of an adolescent diabetic girl who developed a life-threatening eating disorder, which forced him to add creatively to the structural model of working with families in which he had been trained.

In chapter 28 Robert Bor and Riva Miller present two case studies: In the first they describe how they set up a free-standing hospital-based HIV/AIDS counseling service, and in the second they tell of how they handled the ambivalence of a 33-year-old man to both tell and not tell his family he was dying of AIDS. In chapter 26 Jeri Hepworth shares how her individual and couples work with a chronic-pain patient changed radically once she herself experienced a stress-related health problem. David B. Seaburn, too, describes, in chapter 25, couples work with a chronic-pain patient, describing how the patient's change in attitude toward her own pain expanded his own understanding of treating illness. Susan H. McDaniel, Jennifer L. Harkness, and Ronald M. Epstein describe in chapter 27 how they worked as a team to provide truly integrative family care to a 53-year-old man and his 82-year-old mother, who suffered from Crohn's disease and severe depression.

Self-of-the-therapist issues are vital for inclusion in an ecosystemic approach. Second-order cybernetics (Maruyama, 1963) resulted in systems psychologists' recognition that therapists are part of the system to be assessed. The therapist cannot be a distant figure, acting on a problem, a patient, or a system. He or she is a part of, not apart from, the systems they treat. As Don-David Lusterman is fond of saying to his supervisees, "You are your own violin. Make sure to be in tune, and know where you are in the orchestra." Each therapist must monitor his or her own individual and systemic issues and be aware of them and use them as part of ecosystemic treatment. This includes both what is currently happening for the therapist personally (e.g., a failing marriage, a sick child, own depression) as well as his or her own personal family history (e.g., an alcoholic father, an immigrant grandparent). It also includes the therapist's professional history—not just successes, but what he or she may consider real blunders as well.

Many of the chapter authors in this volume were willing to personally self-disclose in order to illustrate what this means in actual practice, so that others might learn how to do the same. In chapter 31 Nadine J. Kaslow and Sari Gilman Aronson describe a patient they treated as cotherapists, who later committed suicide. The description of their personal reactions provides a poignant example of such therapeutic use of self. Rather than suppress their feelings about the case, they courageously decided, 18 months after the patient's death, to visit her grave and to have a session with her family. In their chapter they candidly reflect about how this loss, early in their careers, affected them personally and professionally.

Although technique and content issues are presented in the cases in this volume, we want to stress that we believe that most of the therapist's effectiveness results from being an expert on the process, rather than the content, of ecosystemic therapy and from being open to continuous learning both from patients and from colleagues. This process focus in-

cludes making space for each relevant voice to be heard and recognizes that individuals are embedded in ever-evolving ecosystems that must be understood and valued by the therapist. The successful therapist is curious about each relevant subgroup and system and their interactions with one another and with the problem.

CONCLUDING WORDS

Readers familiar with the companion to this volume, *Integrating Family Therapy: Handbook of Family Psychology and Systems Theory*, are aware of the theoretical interests of many of the authors also represented in this book. In this chapter we have tried to examine the ecosystemic perspective from various points of view, taking into account each level of consideration, from that of the individuals, couples, and families; to the larger systems, such as schools, health care systems, social services agencies; and within the surrounding cultural context that encompasses distinctions such as gender, social class, ethnicity, and religion.

Because this volume is a casebook, the reader is allowed to go deeper into the therapist's experience of therapy as it unfolds. The reader is permitted to sit with the authors as they struggle to integrate theory with practice, self with system, ideals with realities. The reader will see the complexity of clinical work come alive as he or she faces, together with the authors, the many decisions that must be made about the direction that the therapy will take and the times that the therapist must surrender to the process of therapy itself. We invite you to join our authors now, as they take you on the journeys they have traveled.

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