Families can have a significant influence on a child’s mental health. Family therapy is a treatment modality that can be used alone or in combination with other treatment modalities. Family therapy strategies include psychodynamic, structural, strategic, and cognitive-behavioral schools. In this article the different schools are described and a case of a depressed teenager is used to illustrate how each type of family therapy is implemented.

INTRODUCTION

Family relationships can positively or negatively impact child development. This influence also occurs in the reverse manner: families influence the overall health of the child and the child influences the overall health of the family. This bidirectional influence is greater when the child has a psychiatric disorder.¹ When treating children, family interventions are commonly incorporated to a greater or lesser extent. In fact, child treatment has been referred to as *de facto* family therapy.² A psychiatrist or therapist doing family therapy utilizes the connection that exists between child and family with the goal of improving the overall functioning of the family. When a family functions better, the child functions better.³

Family therapy is a form of psychotherapy that directly involves all family members in addition to the “identified patient”—and explicitly attends to the interactions among all family members. If the focus is on the set of relationships in which the person is intertwined, family work can be done regardless of who is initially involved.⁴ Family therapy focuses on the relational and communication processes of families in order to work through clinical problems, even though the child may be the only family member with overt psychiatric...
INTRODUCTION TO THE CASE: A 15-YEAR-OLD BOY AND HIS FAMILY

J was a 15-year-old boy who first encountered mental health treatment after he admitted to his parents that he had thoughts of harming himself. He had been caught smoking cigarettes in his room at home by his stepfather and in the verbal altercation that followed J told his mother and stepfather that he “didn’t care anymore and wanted to die.” J’s stepfather became very angry and threw him out of the house for being disrespectful and untrustworthy. The mother then became enraged at her husband and told her husband that if he kicks out J, she is going, too.

J admitted to feeling depressed for several months prior to this episode. He wanted to be an actor and said that he did not see the point of studying or going to school. Although he did well academically in the 9th and 10th grade, his grades declined significantly in 11th grade to the point that he was ineligible going to school. Although he did well academically in the 9th and 10th grade, his grades declined significantly in 11th grade to the point that he was ineligible to participate in extracurricular activities like the drama club. He admitted to having difficulty fitting in and was associating with the kids who skipped class and took drugs. J’s depressive symptoms included sad mood, decreased motivation, decreased energy, decreased concentration, and sleep difficulty. After breaking up with his girlfriend, he cut himself superficially on his forearm with a razor and had fleeting thoughts of suicide.

THE INFLUENCE OF FAMILY: THE “BIOPSYCHOSOCIAL MODEL”

The biopsychosocial model attempts to understand the whole person by elucidating the interactions between the biological, psychological, and social aspects of an individual. Using this model in relation to a child, the family environment would be the most important social factor. It is easy to understand how this family environment substantially impacts a child.1 Normal child development is associated with the positive family processes of secure attachment relationships, effective parenting practices, and emotionally nurturing environments. On the other hand, risk factors for childhood psychiatric disorders include the negative family processes of parental pathology, family and marital conflict, coercive parenting practices, and persistent negative affect.2

Research using twin and adoption studies has been conducted to investigate the impact of both genetic and family factors. One study found that adopted children with a high genetic risk for schizophrenia were more sensitive to adverse rearing practices in their adoptive family than were adopted children with low genetic risk.3 There was a clear association between the diagnosis of schizophrenia and disordered rearing in the children with high genetic risk, which was not seen in the children with low genetic risk. The characteristics of family functioning associated with disordered rearing included a tendency to be critical, to be constricted, and to have boundary problems. The conclusion was that both genetic risk and rearing environment were interactive in promoting either the protection against or the emergence of schizophrenia in the adoptive child.4 Another study looked at how family dysfunction affected recovery from a major depressive episode. Inpatients who viewed their family functioning as being “healthy” were more likely to recover within 12 months, then those who rated their family functioning as “poor.” Family dysfunction in this study was characterized by poor communication, poor problem solving, and criticalness.4

Although it may at first seem intuitive that family processes that precipitate childhood psychiatric disorders place all children in a family at equal risk, findings from the behavioral genetic literature make a convincing argument that this is not the case.5 Shared environmental influences, although the same for all children in a home, are experienced and interpreted differently by each child, so that these events become different for each individual child based on the child’s own temperament. In addition, children’s individual characteristics affect parenting behavior. Even siblings, who are similar due to their genetic makeup, are different based on their individual temperaments.6 Individual temperaments have an impact on how children’s parents relate to them, such that each child in a family may experience a different parenting style.

J’s family dynamics. J’s family consisted of his mother, stepfather, 18-year-old older sister, and 11-year-old sister. J’s biological parents divorced when he was two years old and his mother remarried when he was six. His mother reported that his biological father was abusive toward her, but not the children. She left him after an incident where he struck her while she was holding J when he was an infant, and she felt J’s safety was being seriously threatened. J had little contact with his biological father since the divorce, but contacted him recently because he wanted to leave his current family and live with him in another state. To J’s disappointment, his biological father’s response was noncommittal.

J’s mother reported symptoms of posttraumatic stress disorder (PTSD) from the abuse she suffered from J’s biological father as well as from a sexual assault in her adolescent years. She also experienced chronic headaches and fatigue, which sometimes limited her involvement with her children. She revealed that her family of origin was unstructured and that she had “too much freedom,” which she felt contributed to the sexual assault she suffered. She believed that she was allowed to “run wild” and became involved with alcohol at a young age. Of her children, she felt most similar in temperament to J. She
feared that without more parental supervision he could end up like her and put himself in dangerous situations.

J always had a distant relationship with his stepfather. J’s stepfather was a retired police officer who highly valued order and discipline. He did not agree with J’s long hairstyle or passion for acting. He forced J to cut his hair and change his style of clothes after he was caught smoking. J admitted that sometimes he feared him when his temper ignited. The stepfather was generally suspicious of mental health providers and viewed psychiatric symptoms as an excuse or a weakness. This caused marital problems in relation to the mother’s PTSD symptoms as well as J’s depressive symptoms.

J’s older sister had bipolar disorder and although she had been stable for the last two years, she had a difficult time for several years and was unable to attend a regular school. J felt his older sister was not held to the same standard as he was because of her psychiatric illness, and he felt this was unfair. J felt that the expectations for success were all the more potent for him due to his sister’s illness. His sister also smoked cigarettes and, as far as J could remember, had never been reprimanded for this behavior. J’s younger sister had no mental health diagnosis, but did have exaggerated separation anxiety when she was a young child, some of which was still evident. She got along well with her siblings, but spent most of her time with her mother at the exclusion of peers. Several times a year she would complain of a stomachache until she was allowed to stay home from school. This was more frequent following the altercation between J and his stepfather, which raised the stress level for everyone in the home.

**PSYCHODYNAMIC FAMILY THERAPY**

Family therapy can be divided into several different schools of thought: psychodynamic, structural, strategic, and cognitive behavioral. Although the goals of each school are similar, the techniques and strategies each employs are unique. A combination of these approaches is used in contemporary family therapy.

The psychodynamic approach to family therapy is based on psychoanalytic theory. From this viewpoint family psychopathology is based on the intrapsychic processes of individual members. These intrapsychic processes shape one’s interactions with others, most prominently in intense emotional relationships like those among family members. The collective processes of all members merge into the “family neurosis.”

According to psychoanalytic theory, prominent intrapsychic processes take place in the unconscious. These include repression, projective identification, some aspects of unresolved grief, and transference. An important concept that involves these processes is “psychic determinism.” Psychic determinism refers to the idea that mental events do not occur at random and that every behavior has a cause or source embedded in the individual’s history. Transference occurs when one’s feelings, thoughts, and wishes are projected on another person who has come to represent a person from an individual’s past. One feels about and treats the other person (the “object”) as though he or she were that important person from the past. In individual psychoanalytic psychotherapy, transference occurs within the therapeutic relationship and refers to projections of the patient onto his or her psychiatrist. By contrast, when speaking of family transference, the emphasis is on intrafamily projections and not those projections focused on the psychiatrist or family therapist.

The process of dynamic family therapy involves bringing unconscious conflicts between family members into consciousness using techniques like interpretation. Change is facilitated by “working through” the unconscious transference distortions of each family member. Through this process, parents become aware of how conflicts in the present family system are related to their unconscious attempts to master old conflicts arising from their family of origin.

**Treating J and his family using psychodynamic family therapy.**

When the psychodynamic family therapist viewed J’s family through a psychodynamic lens, the conflict between J and his stepfather was rooted in past relationships: The stepfather was predictably resistant to engaging in treatment based on his suspiciousness of the mental healthcare system, but with time and the nonjudgmental acceptance offered by the therapist, all members, including the stepfather, began to see treatment as a safe environment.

It is revealed that the stepfather also was harshly disciplined by his own father and at times physically reprimanded for not being masculine enough. J’s long hair and interest in acting threatened his stepfather because his stepfather was unconsciously projecting his own fears and memories of punishment onto his stepson.

The mother’s conflict with J was also embedded in her past. Her overidentification with J could be understood as projective identification of herself as a struggling adolescent. She was unable to enforce limits on him due to her own unresolved conflict with her mother for not providing this for her as an adolescent. The mother’s unconscious anger toward her parents for not stepping in and protecting her was likely being internalized into her somatic symptoms of headaches and fatigue. These physical symptoms also served the subconscious purpose of giving her a way out of difficult parenting decisions and leaving them up to the stepfather.

J’s symptoms of depression also served an unconscious purpose. J spent the majority of his formative years with his mother and his siblings. Ever since she had married his stepfather, J perceived that the stepfather took the attention and love of his mother away from him. This created an “oedipal” conflict where J felt unconscious aggression toward his stepfather. This unresolved conflict manifested itself through J’s current psychiatric symptoms.

The psychodynamic family therapist used interpretation of selected material
to increase the family’s insight into how the past was continuing to affect the present. With this insight, as well as an expanded repertoire of emotional expression, the family could solve its present conflicts effectively without being weighed down by the past.

**STRUCTURAL FAMILY THERAPY**

The structural family therapist views symptoms that occur in a particular family member, often the identified patient, to be directly linked to the organizational context of the family. Family structure can be defined as the organization of the family unit that dictates how family members relate and how various family functions are carried out. The family structure involves a set of functional demands that organize the way in which family members interact. This structure is invisible to the members themselves. It is the therapist’s goal to understand this structure and ultimately to facilitate transformation of the structure as a means of solving problems.

Important elements of family structure include boundaries, hierarchies, alliances, and coalitions. The clarity of boundaries within a family is vitally important to the overall functioning of the family and can range from disengaged to enmeshed. Members of a disengaged family have no contact with each other. An enmeshed family has too much contact and how various family functions are carried out. The family structure involves a set of functional demands that organize the way in which family members interact. This structure is invisible to the members themselves. It is the therapist’s goal to understand this structure and ultimately to facilitate transformation of the structure as a means of solving problems.

The seating arrangement in the room was shifted to represent the desired changes in the hierarchy and in the alliances of the family. The mother and the stepfather were placed together and on equal footing and the children were placed together as well, separated from the mother. To tackle the boundary problems of the family, behavioral assignments were employed to bring J and his stepfather closer together and also to create space between Mother and both J and his younger sister. J and his stepfather were assigned to take up a hobby together once a week and the mother was assigned to join an activity outside of the home to allow both J and his younger sister some time and space of their own.

**TREATMENT OF J’s FAMILY USING STRUCTURAL FAMILY THERAPY.** Through careful observation of J’s family in the consulting room, a structural family therapist would uncover a dysfunctional structure of his family and work to transform it into a functional one. The boundaries of this family were a complex combination of enmeshment and disengagement. The mother and younger sister characterized an enmeshed relationship and, to a lesser extent, the same held true for the boundary between J and his mother. On the other hand, J and his stepfather characterized a disengaged relationship.

The hieratical structure of the family was also skewed because the stepfather was at the top, but then a large gap existed between him and the mother. This placed the mother closer to the children than to the over-dominant stepfather. Another dysfunctional element was the palpable alliance between J and his mother against his stepfather.

To begin to shift this structure, the therapist recreated the family dialogue that transpired when J’s stepfather caught him smoking. The therapist was careful to ensure that each family member talked to the other person and not about the other person or the event.

**Psychiatrist:** J, can you tell me what you remember about the time you were caught smoking?

**J:** I was in my room and I thought my parents were still at work when my dad bursts open my door and starting yelling. I was afraid he was going to hit me I looked so mad.

**Psychiatrist:** Can you look at your dad and tell that story again to him?

**J:** I guess….. Dad, I was really scared by you when you were yelling. I know I did something wrong but….  

**Stepfather:** (Looking at psychiatrist) I didn’t mean to scare him.

**Psychiatrist:** Dad, can you say that to J.

**Stepfather:** I didn’t mean to scare you, but I know you are really a good kid at heart and it hurts me to see you making stupid decisions.
how families can behave differently, not why families behave the way they do. The past is largely ignored, while the importance is placed on the present and the current, repetitive family processes.12

Change is brought about by formulating clear goals that target changing relational and communication processes within the family.13 The strategic family therapist views the problem as the family’s unsuccessful attempt at a solution. The therapist recognizes that this unsuccessful attempt exacerbates the problem and plans a successful solution using innovative problem solving strategies. These strategies include such tactics as reframing, restraining the system, positioning, and prescribing the symptom.4

Reframing challenges the way in which family members perceive the family reality based on their individual perspectives. This challenge reframes the symptom or situation in a less conflicted way and often with a more positive spin. This helps family members see the problem differently and ultimately behave differently.5 Restraining the system is when the therapist discourages change or emphasizes the risks of change in an attempt to propel the family toward change as a reaction against the therapist’s advice. Positioning is a tactic where the therapist chooses one family member’s position and agrees with it, but exaggerates the position in a way that makes it distasteful. Positioning is often used when two family members hold opposing positions. The goal of this exaggerated and somewhat unpleasant position supported by the therapist is to motivate the family member into change. Prescribing the symptom follows the same logic, but must be used with caution. For this strategy to be successful, the strategic family therapist must encourage the very symptom he or she is trying to extinguish. This is done by using a plausible rationale to try to convince the family members that they need to continue the symptom or problematic behavior to study its effects or even that they need to increase the symptom’s frequency. One must be careful not to seem insincere or manipulative when using this intervention. If done appropriately, the family’s perception of the symptom is changed from something that is out of its control to something within its control. Once family members perceive they have the power to change or manipulate the symptom, the elusive quality of the symptom is gone and replaced by a feeling of control. The therapist hopes to unite the family against the therapist’s advice and cause them to rebel and, therefore, stop the problematic behavior on their own.

Treatment using strategic family therapy. Using the strategic approach, the family therapist viewed that the family’s unsuccessful attempts to solve the presenting problem actually became the problem. The therapist devised a solution that replaced the unsuccessful attempts with a successful one. A possible approach to creating a “success” for the family’s problem-solving attempts was to explain that the stepfather’s reaction to J’s smoking was due to the stepfather’s obvious concern about the wellbeing and future of J. The stepfather’s extreme reaction was evidence of just how much he cares. This tactic admitted that the stepfather’s reaction may have gone too far, but emphasized the love he had for his stepson and not the bad behavior on either family member’s part.

Psychiatrist: There are often multiple ways to view a situation. For example, Dad’s reaction to catching J smoking was to become angry. Although there may have been a better and less hurtful way of handling the situation, the level of his anger shows just how much he really cares for J. After all, if he didn’t care much at all for J or his future, he would not care or get angry if J were smoking. J is actually very lucky to have a dad who cares so much about him, even if Dad does have a difficult time showing it sometimes. J: Well, it doesn’t feel like he cares most of the time.

Stepfather: I hope you know that I do love you and I just want what is best for you. I am quick to anger, I’ll admit that.

Mother: I agree. We both love you so much. Maybe we need to say that more.

J: Ok, ok, I get it. You care about me and that is why you care so much when I do bad stuff.

A positioning tactic could be to play off the disagreement between the mother and the stepfather on how to deal with J’s behavior. The therapist could exaggerate The mother’s position and in the process make it a bit distasteful by explaining that the mother should stick by her son at the expense of her relationship with her husband because it is obvious that trying to be both a wife and a mother is too overwhelming for her in her fragile, physical condition.

Finally, a way to prescribe the symptom would be to rationalize with J that it is important to continue to remain depressed to make sure everyone in the family can experience with him what is it like to feel true depression. This will help the family understand and empathize with him so that they will no longer be angry about his behaviors.

This technique worked to unite the family against the therapist, with the goals of empowering the mother to balance her relationship with her husband and her children and helping the stepfather to “back off” and make joint decisions with the mother. This strategy ultimately motivated J to move beyond his depression.

COGNITIVE-BEHAVIORAL FAMILY THERAPY

Cognitive-behavioral family therapy applies many of the basic principles of individual cognitive-behavioral therapy. In addition, it also relies heavily on family psychoeducation. Just as strategic family therapy can be understood by how it differs from the psychodynamic approach, so can cognitive-behavioral therapy. While the psychodynamic therapist emphasizes the importance of intrapsychic forces, the cognitive-behavioral therapist emphasizes the importance of external social forces.8 In this orientation, all
behavior is learning-based and can be unlearned using basic principles of behavior modification. In fact, this type of family therapy grew out of behavioral modification programs for young children with deviant behavioral problems. The cognitive-behavioral family therapist plays the role of a teacher or coach and brings about change by understanding the influence of positive and negative reinforcements.

Techniques employed include operant conditioning, contingency contracting, thought diaries, communication training, and psychoeducation. Operant-conditioning strategies attempt to shape behavior through positive and negative reinforcements and may use time-out procedures with younger family members. Contingency contracts are behavioral plans family members agree to perform that replace destructive patterns related to the presenting problem. Thought diaries are homework assignments given to family members that track thought patterns with the goal of uncovering and then correcting common cognitive distortions like catastrophic thinking or overgeneralization. The cognitive-behavioral family therapist also coaches families in fundamental communication skills, such as how to listen empathically, express positive feelings, and convey negative communications respectfully. Psychoeducation also is a fundamental part of the cognitive-behavioral approach to family therapy and can be tailored to each individual family’s needs. Psychoeducation can include a broad range of topics from general principles of learning theory to specific information about a family member’s psychiatric diagnosis.

**Treatment using cognitive behavioral family therapy.** One of the fundamental components of cognitive-behavioral family therapy is operant conditioning, and this can be used in several ways. Positive reinforcements like time to play his favorite video game or an allowance toward his first car were used to reward J for making good grades in school. On the other hand, negative reinforcements were used like not increasing J’s allowance if he is caught smoking or skipping class. The younger sister’s behavior was also modified using operant conditioning. If she stayed home due to a stomachache, the stepfather would stay home with her instead of the mother in order to remove the perceived reward of staying close to her mother. She also received a prize, her favorite dessert, or a movie night out if she did not miss any school for one month.

Communication skills training also was incorporated. With the therapist as the coach, the skills of listening and sharing feelings and ideas respectfully was practiced in session and then at home. This would improve many intrafamily relationships.

Psychoeducation is a wise use of the cognitive behaviorist’s resources in this case, especially in light of the stepfather’s belief that psychiatric symptoms were a sign of weakness. The therapist discussed important topics, such as normal adolescent development, signs and symptoms of depression, and anger management.

**CONCLUSION**

Family therapy shifts the focus of the psychiatrist’s attention away from the child and onto the family as both the source of pathology and the target for treatment. It is clear that a child’s mental health stems both from genetic factors and from family dynamics. Although a child’s genetics cannot, at this time, be modified, the family dynamics are at our disposal.

The historical backdrop and subsequent outgrowth of the different schools of thought about family therapy are similar to the schools of thought about individual therapy. They arose from the theoretical orientations in the broader mental health community and sometimes from reactions against earlier orientations. Although several different schools of family therapy exist and strategies of recommended treatment differ, contemporary family therapy that utilizes a multimodal approach incorporates insights and techniques from each school of thought based on an individual family’s needs and the therapist’s style.

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