I was in the USA with the aim of broadening my perspective on the opportunities and challenges facing our Centre and more broadly family therapy when I received Sophie’s text inviting me to write something about a simple, obvious, mundane and yet intriguingly complex topic for the AAFT newsletter: *What is the difference between individual therapy and family therapy?* Whilst frustratingly general, the question excited me partly because I was on the M15 bus at the time, traveling up 1st Ave to meet Lois Braverman, President of what is for The Bouverie Centre the mecca of family therapy, a centre that had a huge impact on how Bouverie was structured in the early years - The Ackerman Institute for the Family. About to move from midtown (149 East 48th Street) to downtown (936, 2nd floor, Broadway) I was grateful the shift had been delayed for a week so that had I got to discuss the status of family therapy with Lois in the old building, where many of my predecessors had made a similar pilgrimage.

Scribbling some ideas in my diary as I headed north through the Manhattan traffic I was immediately drawn to how the theory, practice and philosophy of family therapy invites, encourages or demands a pluralistic view of the world. Of course there are the obvious differences between an individual and family therapist: that the latter is more likely to invite more than one person into the room or at least be more comfortable with multiple stake holders, that a family therapist is likely to be more interested in the space between people and in the power of relationships to heal. However, I kept coming back to the holding and balancing of simultaneous multiple realities and perspectives, whether emerging from the day-in-day-out practice reality of a family therapist or from the theoretical, conceptual or philosophical stance that underlies this work, as the essential difference between individual and family therapies.

In practice the daily grind of considering multiple realities and perspectives leads family therapists to genuinely appreciate that there are different views about what is the problem, how the problem is described, or if a problem even exists, the individual experience of the problem, what’s led to the to it and why it developed, what has been done about it and what a solution would look like or if one exists, and the challenges or areas of competency and resilience that exist near or around the problem.

In conceptual terms, family therapy's acceptance of multiple perspectives leads to the emphasis on context, whether family, relational, personal style, socioeconomic, gendered, cultural, historical or educational and more recently brain chemistry context, just to name a few. Appreciating the context of each person’s behaviour, views and attitude leads the family therapist to more easily act from a post-modern stance that there is genuinely more than one way to skin a cat or to live one’s life.
From a theoretical perspective the valuing of multiple perspectives means that explicit explanation principles and objective statements about cause, effect and outcome are not easy and hence the family therapist is forced to emphasise or to be satisfied with theories about process. This means that family therapy theories focus on the processes and structures rather than a specific objective explanation. I remember my frustration as a young clinical psychologist working in an adult psychiatric hospital at how the medicos could make simple and convincingly clear predictions based on a diagnostic assessment while I could only say it depends on the context of the individual family. Gradually I learnt to sound convincing even though I was still saying ‘it depends’. Traditional family therapy theories provide only one element of the structure, the relational, the transgenerational, the social or political context and efforts to create theories of cause and effect, such as Mara Selvini’s attempt to explain how anorexia nervosa developed and her invariant prescription never amounted to much. We will need to ensure that our current interest in trauma theory does not tempt or seduce us into an objective explanatory model of everything.

Philosophically, the exploration of different perspectives leads to a position of what I call ‘contextual compassion’ - a name I have given to my personal process of appreciating a person, even a person behaving badly, once I understand his or her context. It is not a condescending ‘niceness’ but an appreciation of why the person is ‘naturally’ behaving in this way, given their context. Contextual compassion is a powerful position from which to challenge a client’s unproductive or destructive behaviour, whether it is self- or other-directed. Assuming that clients (like us all) are simply trying to survive and wanting to do their best is an attitude I think held by many family therapists and leads those therapists to a practice approach of progressively stepping into the shoes of everyone involved whether they are other family members or other workers. This creates a non-blaming and non-pathologising approach to the work. This approach is why the skills of family therapists translate well to working with complex systems of any kind.

I am aware that I have not said much about individual therapy or therapists – this is deliberate. I am cautious about commenting on such a large and diverse group of people and a complex array of ideas. Instead I have tried to comment more on what family therapy may invite, encourage, push or demand of its adherents, with the caution that any idea, theory, concept or philosophy can be corrupted in the wrong hands.

Whilst a frustration to me very early in my career, family therapy’s emphasis on process rather than explicit static explanations has the advantage that the approach is always growing as basic ideas are translated into different contexts, or applied to work with different clients or communities. Family therapy by its nature tends to be inclusive, evidenced most recently in Glen Larner, Tom Strong and Robbie Busch’s editorial in the latest ANZJFT edition entitled, *Family Therapy and the Spectre of DSM-5*, which could be seen as another, more learned discussion of the points I make here. In response to the dilemma for family therapy inherent in the editorial title of this themed edition, they state:
A best possible stratagem may be to adopt an ‘ethic of hospitality’ towards an inhospitable language of diagnosis, one which takes it on board yet at the same time challenges, enriches, thickens, extends or even ‘dances’ with DSM-5 ... 

*Larner, Strong & Busch (2013, p.87)*

Whilst a culture of inclusiveness may challenge our identity (what specifically do family therapists stand for?), it also allows family therapy to be constantly transformative as a model and profession. And that’s good enough for me!

Given I was meeting with Lois Braverman I took the opportunity to pose Sophie’s question to her. Lois emphasised that family therapy is a way of thinking no matter what you do. The person telling you their story always has a relational context which influences their thinking and this thinking is influenced by their family context. Lois went on to argue that individual therapy, especially psychoanalytic therapy (which I learnt is still the dominant therapeutic model in New York), conceptualises problems internally. Lois was keen to point out that it is not how many people are in the room, she is always thinking of their context. Pragmatically she believes family therapy ideas and techniques work and that problems are solved more quickly using a non-pathologising family perspective.

It seems Lois and I share an interest in context and in non-pathologising approaches, funny how the two seem to go hand-in-hand.

Dr. Jeff Young, Director 

The Bouverie Centre: Victoria’s Family Institute.

Reference


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