CHAPTER TEN

Family Evaluation

The evaluation of a symptomatic family begins with the first contact with a family member. At the outset, in subtle and not so subtle ways, a family automatically attempts to incorporate a therapist into its problems. It is such an automatic process that family members are usually unaware of doing it. An unskilled therapist can be incorporated into a family's emotional problem during a telephone call to arrange the first appointment and never realize what happened, or he can be incorporated during the first encounter with the family in the waiting room by feeling overly sympathetic with a family member who appears helpless and downtrodden. He can be incorporated during the first session by being unduly influenced by a family member's forceful, charming, or theatrical presentation of a viewpoint, or he can be incorporated during a later period in the therapy by gradually getting angry at one family member. A skilled therapist can also be incorporated into a family problem, but he is more likely to recognize it and to know how to get back "outside" the family problem. When a therapist is fused or "stuck" to a family emotionally, he can be part of a family's emotional support system, but he cannot promote differentiation in the family. A therapist who is fused into a family's emotional problem can also be a divisive influence on the family.

An anxious and symptomatic family presents its most "subjective face" to a therapist. Each family member has many subjectively based notions about the nature of the problem in the family and about what "needs" to be done to improve the situation. Blame and self-blame are prominent. Each family member either wants the therapist to be his ally or fears that the therapist will be someone else's ally. As a consequence, each family member has verbal and nonverbal ways of triangling the therapist into his or her point of view. Some

family members are more forceful about this than others. In addition to wanting to influence the thinking of a therapist, an anxious family may also try to get a therapist to take the problem off its shoulders by pressuring him to provide "answers." This pressure may emanate from the family's apparent helplessness, or it may come from overt demands that the therapist fix the problem. These covert and overt maneuvers by a family to involve a therapist emotionally can occur when a therapist is seeing one person, a couple, or an entire nuclear family. The concepts of transference and countertransference describe the emotional interplay between patient and therapist in individual therapy. The concepts of triangles and interlocking triangles describe this emotional interplay in a system of more than two persons.

An anxious individual or family presenting for therapy has a more "objective face" too. The higher the level of differentiation, the greater the capacity for emotional objectivity, even during highly stressful periods. A therapist's ability not to get engulfed by the anxiety and subjectivity of a family can keep him from being incorporated into the emotional process of a clinical family. Although a therapist must be able to listen to the feelings and subjectivity of a family to the extent that family members accept that he knows what is happening in their family, he must also be able to direct his questions to the more thoughtful or less reactive "side" of the family. By doing so, he can be both "in" the system physically and "out" of the system emotionally. A therapist's ability to do this calms a family. Family members may automatically attempt to involve a therapist emotionally, but they are more likely to be calmed by a therapist who can maintain his emotional autonomy than by one who gets reactive to them. If a therapist takes sides (in thoughts, words, or actions), it makes certain family members calmer, but it makes other family members more anxious. It is not necessary for a therapist to have complete emotional autonomy to be effective. He just needs to be more autonomous or less reactive than the family.

When a therapist maintains a reasonable degree of emotional autonomy or differentiation with a family, his functioning can be a stimulus for family members to focus less on others and to be more responsible for themselves. Most family members have notions about what they are doing to create and aggravate family problems, but it is easier to focus on what other family

members are doing or not doing or on what a therapist is doing or not doing than to focus on themselves. If a therapist reacts to a family's anxiety by telling people what to do, the resources of the family will quickly become submerged. If a therapist does not react, but just helps a family define the nature of the problem with which it is confronted (especially the relationship processes that create and reinforce it), the resources of the family will resurface.

To better define the nature of a family problem, people usually require questions to stimulate their thinking. An anxious family is embedded in an intense emotional process that is much easier to react to than to think about. A goal of therapy is for one or more family members to think more objectively about intense emotional processes, that is, for family members to reflect as well as to feel. A therapist who is fairly objective about the emotional process in a clinical family can make the difference between the family's remaining embedded in its problem and the family's getting somewhat free of its problem. A therapist who asks questions about process can help a family member overcome whatever denial or lack of awareness exists about his part in the family process.[1] Getting beyond denial allows a person to be more responsible for his own functioning. Denial may be so strong in some people that a therapist's objectivity and questions about process have little impact. In most families, however, someone is capable of overcoming some of his or her denial and being more of an individual. If one person takes the first step towards being more of an individual, eventually other family members will follow that lead. People get stifled by wanting others to take the lead.

The ability to think systems and to retain that theoretical perspective in an anxious environment makes it possible for a therapist to be in emotional contact with a family and to remain "outside" the family's emotional problem. A therapist is in adequate emotional contact if family members are saying what is important to them emotionally and if they have a sense that the therapist has listened, is interested, and comprehends their respective points of view. A family may interpret this as a "caring" attitude on the part of a therapist, but this is a quite different approach from that of a therapist who tries to show a family that he cares about them or is sympathetic to their discomfort. Sympathy is available in a lot of places, but it eventually wears thin. Emotional

objectivity, which is grounded in a consistent theoretical orientation, is less common and families never grow tired of it. Objectivity and neutrality are always attractive to an anxious family. Objectivity and neutrality are communicated to a family nonverbally as well as verbally. Tone of voice, facial expression, and other nonverbal cues (as well as what a therapist says) convey his attitude and level of reactivity. Therapists can pretend to be neutral for a time, but not indefinitely. Either a therapist is neutral or he is not, and a clinical family will eventually recognize this.

In some families, the intensity of the projection process is so great that the "healthy" family members adamantly insist on getting "help" for the "sick" family member. Such families do not get angry at a therapist who maintains a systems orientation (as long as he does not force it on the family), but the family, at least the dominant person in the family, is not interested in a form of therapy that focuses on relationships. The family will take the "sick one" to another therapist who will give him "the help he needs." An experienced and skilled therapist can get most families sufficiently beyond their projections and denials to keep them in therapy, but there are always some families that will only accept a therapist whose viewpoint agrees with their own.[2]

The characteristics of a therapist's relationship with a family are important from the outset. The more a therapist has worked on differentiation of self in his own family, the more he will be able to get closely involved with a clinical family and still be "outside" the system. When a therapist is "outside" the family emotional system, he thinks for himself. He neither is engulfed by the family's subjectivity nor engulfs the family in his own subjectivity. The processes by which a family's anxiety and subjectivity can "brainwash" a therapist and by which a therapist's anxiety and subjectivity can "brainwash" a family are sufficiently subtle that most therapists require years of clinical experience to recognize them fully. Experience alone, however, guarantees nothing. A therapist can be in practice for years and never realize he is often a pawn of the families he treats or that the families he treats are often pawns of what is needed to make him feel comfortable. Psychoanalytic training addresses this problem by requiring analysts to have a personal analysis. Family systems training addresses the problem by requiring trainees to bridge the cutoff from

their families of origin through differentiation of self.[3] Both psychoanalysis and differentiation of self in one's family of origin enhance a therapist's ability to monitor the effect of his own emotional functioning on his clinical work.

THE FAMILY EVALUATION INTERVIEW

The evaluation and treatment of a family may include one family member, a husband and wife, an entire nuclear family, or some other combination of nuclear and extended family members. Regardless of the number of family members in the sessions, the basic principles of differentiation apply. Therapy based on systems theory is always guided by the therapist's assumption that an interplay between the life forces of individuality and togetherness is the basic component of family process. Family psychotherapy is family psychotherapy not because of the number of people in a treatment session but because of *how a therapist conceptualizes the problem.* If a therapist's concepts encompass a family relationship process and a connection between that process and individual functioning, a complete course of psychotherapy with just one family member is family psychotherapy.

Thirty years of clinical experience with therapy based on family systems theory very strongly suggests that the most productive approach for increasing basic level of differentiation is family psychotherapy with a person who is motivated to bridge the emotional cutoff from his family of origin. Even if a person is married and has children, the emotional arena of his family of origin seems to be the most productive for increasing the basic level of differentiation. This does not mean that a person ignores his nuclear family relationships and focuses exclusively on the extended family. It means that the extended family is an extremely important component of his effort to work on himself. The ability to function with more differentiation in the family of origin can enhance a person's ability to function with more differentiation in his nuclear family and in other important relationship systems, such as business and community organizations.[4] The ability to *maintain* one's differentiation is as important in the nuclear family as in the extended family and often as important in nonfamily systems as in family systems. The effort to *increase* one's basic level

of differentiation, however, is most productive when directed at one's family, particularly at one's family of origin.

Individual sessions are usually the most helpful to a person who is concentrating on his family of origin. Much of what is "therapeutic" to an individual who is focusing on family of origin actually occurs outside the therapist's office. This is because a person's effort to be more of a self in his family usually requires that he increase his contacts with his family and that he increase the number of family members with whom he is in contact. A primary goal of these contacts is to reactivate as many aspects as possible of the *original* attachments. Attachments to parents are most important because parents usually have had the most influence on the development of an individual's values, attitudes, and emotional makeup. If parents are dead, the people who were closest emotionally to the parents become the most important. Once relationships are more active, an individual then attempts to be more of a self in those relationships. Being more of a self depends on understanding triangles and the process of detriangling. Another goal of having more contact with the family is to learn more about it. Almost everyone is unaware of some important facts about his family. There is no way to learn these facts other than from the family and perhaps from others closely connected to the family. Increasing factual knowledge about one's family is an important component of becoming more of a self.[5]

Sometimes only one family member is motivated for therapy. In such cases, individual sessions are obviously the only option. The entire course of therapy can be with this one motivated person. Family psychotherapy in which only one family member participates can produce an excellent result. The progress of one family member need not be constrained by the attitudes and actions of other family members. An increase in basic level of differentiation in one person who stays in emotional contact with the family can lead to increases in the functioning of other family members. The success of family therapy with one person depends, among other things, on that person's having the attitude that his effort is for himself and not for the family. The person may be motivated initially by a problem in the family, but he must forsake the notion of fixing or changing the family and embrace the notion of changing himself

while in relationship to the family.

If both a husband and wife are motivated for therapy, the sessions can be done with both spouses together, with each spouse seen individually (by the *same* therapist), or with a combination of the two approaches. In the beginning of therapy, both spouses are commonly seen together. After a period of weeks or months, often after one or both are clear that the effort involves working on self and not on the other, most of the sessions may be individual ones. Seeing people together does not preclude their working on themselves. Conjoint sessions are a useful and effective approach to therapy. At times, however, seeing people together impedes the progress of one or both of them. There may be a tendency to cover the same ground over and over. When seen together, it is sometimes difficult for people to escape the notion that "we" are trying to change and to embrace the notion of "I" am trying to change. When it is a "we" endeavor, each one often gets preoccupied with whether the other one is doing his or her part. Another problem that can occur with two people together is that each one is so reactive to the other that neither can think in the sessions. People may be more overwrought at the end of a session than at the start.

When people seek therapy because of a problem in a child, the child and the parents may be included in the initial evaluation period. As therapy progresses, however, most of the time is spent with the parents, either individually or together. The child may have some individual sessions, but he is not the primary focus of therapy. In most instances, even if the presenting symptoms are in a child, it is not necessary to treat him directly.[6]

There are a few instances in which the parents disdain any therapy and the only motivated family member is a dependent child, usually an adolescent. In such cases, the child is seen individually. It is important that a person who comes for therapy has a reason to come *for himself.* A great many children and adolescents are pushed into therapy by someone else, usually the parents. The child or adolescent may comply with his parents' wish that he have therapy, but that does not give him his own reason to be in therapy. A spouse can also be pushed into therapy by his or her mate. There is no "rule" against seeing a spouse or child who is pressured to come for therapy, but if the process is not *recognized and addressed,* the therapist supports the family projection process. A therapist

may have to take a stand and not see a family member unless other family members participate.

Therapy involving an entire nuclear family or some combination of nuclear and extended family members is sometimes requested by a family. Such therapy is generally referred to as family group therapy. Family group therapy conducted by a skilled therapist can be extremely useful for reducing anxiety and relieving symptoms. It is a cumbersome approach, however, for facilitating changes in basic levels of differentiation of self. This is because it is easy for family group therapy to foster a togetherness solution to a problem rather than an individuality solution. In a group under the guidance of a skilled therapist, family members often become calmer by talking openly and achieving a consensus about what to do.[7] Typically, people agree to try to communicate more and to get along with one another better. Such a solution may work well for a time, but it breaks down as soon as one person does not cooperate. In essence, the family consensus is that it will be "all for one and one for all." If one person reneges, the consensus collapses. A togetherness solution makes the integrity of the group dependent on the "weakest link," the first person who gets reactive. An individuality solution is much more durable. If the integrity of a group rests on individuals who have a direction for themselves, a "weak link" can create only minor disturbances.

Most family evaluation interviews are done either with one person or with a husband and wife. Other combinations of people are possible, such as two parents and a child, one parent and a child, an entire nuclear family, or two spouses and members of their extended families. During an evaluation, a therapist addresses ten basic questions:

(1) Who initiated the therapy?
(2) What is the symptom and which family member or family relationship is symptomatic?
(3) What is the immediate relationship system (this usually means the nuclear family) of the symptomatic person?
(4) What are the patterns of emotional functioning in the nuclear family?
(5) What is the intensity of the emotional process in the nuclear family

(6) What influences that intensity – an overload of stressful events and/or a low level of adaptiveness?
(7) What is the nature of the extended family systems, particularly in terms of their stability and availability?
(8) What is the degree of emotional cutoff from each extended family?
(9) What is the prognosis?
(10) What are important directions for therapy?

Beginning answers to all of these questions come from information gathered during a family evaluation interview.

FORMAT OF THE FAMILY EVALUATION INTERVIEW

History of the Presenting Problem

The family evaluation interview begins with a history of the presenting problem. This part of the interview focuses largely on the symptoms and on the symptomatic person or relationship. Here it is important simply to let the family tell its story and to listen carefully to each family member's perception of the problem. Fairly exact dates of when symptoms developed or recurred are important. These dates may be found to correlate with information that is gathered later in the interview. For example, a wife's first diagnosis of rheumatoid arthritis may be found to have occurred three months after her husband's mother died. Such a correlation does not establish a relationship, but is suggestive of one. Are the symptoms for which the family is seeking help a product of a gradual buildup of intensity or have they developed rather abruptly? The latter suggests an association with recent events inside or outside the family. People may be so "close" to a problem that they do not think of events being connected with symptoms. When a therapist simply asks questions about events, associations may suddenly dawn on people. The associations can provide perspective, and there is usually something calming about perspective.

Each family member's view of what created and sustains the presenting problem is important. These views can range from ones that are totally subjective and reactive to ones that are more thoughtful. An example of a

totally subjective view is the following: "The problem is that my wife is crazy and she needs a doctor to make her well." The person who says this is denying that he has a part in creating his wife's symptoms. An example of a more objective view is the following: "My daughter is rebelling, but I believe she is reacting to things occurring in our family." Therapy begins with the perceptions of the family. These are what family members believe about the nature of the problem. Even people who claim to "have no idea" what the problem is about usually have some ideas they are not expressing. People who insist the doctor or therapist is the expert and should be telling them what creates the problem must be addressed at the outset. If a therapist falls into the trap of being set up as an expert who can tell the family what its problem is and what is needed to fix it, he may never get out of that trap. He may be forever prescribing techniques for change. Family members always make some assumptions about the "cause" of their problems. Successful therapy depends on getting these assumptions out in the open so they can be examined.

There may be more than one symptom in a family. The wife may have a chronic psychosis and the husband a history of medical problems. Obtaining precise details about all symptoms in a family is important. What are the exact dates of the wife's psychiatric hospitalizations? How long was she in the hospital each time? How was she treated? There is quite a difference between someone who has been perpetually dysfunctional and someone who has had two psychotic reactions, who recovered from each one within three weeks, and who has functioned very effectively between hospitalizations. What is the nature of the husband's medical problems? When did they develop? What has been the impact of his illnesses on the marriage and the family? Have the problems affected the husband's functioning significantly?

It is important to know if the wife is still in some form of therapy for her psychiatric problems at the time she and her husband come for family therapy. The wife may say that she had always felt that their marital relationship significantly influenced her psychiatric condition, but she could never get her husband to come for therapy. He finally agreed and she wants to stop individual therapy. Another husband may say that he wants family therapy because he thinks his wife is too dependent on her individual therapist. He thinks the therapist has too much influence on her and that he is the outsider.

At times, a therapist doing individual therapy with a patient makes the referral for "family therapy." An individual therapist may do this thoughtfully or reactively. A reactive referral is one in which the therapist is at an impasse with the patient and wants to bring in reinforcements. He wants to continue the individual therapy as well as have his patient and her spouse get "family therapy."[8] If a family therapist accepts such a referral, it is prudent for him to consider the individual therapist to be a member of the family. A multiple therapist arrangement may significantly interfere with individuals' work on differentiation of self, however.

One of the most constructive attitudes a therapist can have when he approaches a clinical family is to regard the family as a tremendous resource for the therapist's learning. The therapist knows something about family process, but he always has more to learn. A clinical family can teach him if the therapist will ask questions and listen to what the family has to say. Many of the questions therapists ask are really opinions disguised as questions. If a therapist can ask questions that do not express an opinion or assume an answer, then he can learn about the family and in the process the family can learn about itself. When a therapist gets anxious about "fixing" a problem in a family, he usually stops learning about the family. He is so preoccupied with what he is "supposed" to be doing that he is unable to inquire carefully into what actually happens in the family. If a therapist's anxiety inclines him to get distant from a family and to act if he has no responsibility for helping the family see its options, the family will likely go elsewhere for help – and it should.[9]

At the conclusion of this part of the family interview, the therapist should know which family member is the force behind seeking therapy and his or her reasons for doing it at this particular time. The therapist should also know which family member is symptomatic, whether the symptoms are physical, emotional, or social, when the symptoms first developed, what the complete clinical course of the symptoms has been, and what the degree of dysfunction associated with the symptoms has been. The therapist should also know how each family member present in the interview views the nature of the problem and what each one's particular reasons for being at the session are. If a wife says, "I am here to do anything I can to help my husband with his drinking

problem," or an adolescent says, "I am here because my parents insisted I come," or a father says, "We are here to get advice on how to help our son with *his* emotional problem," or another wife says, "I want to work on changing me; to heck with these others," the therapist knows immediately what his initial approach to each of these people must be.[10]

History of the Nuclear Family

The history of the nuclear family begins at the point the husband and wife first met. Information is gathered about what each person was doing before they met as well as what each was doing when they met. When and where was each person born? How much education had they had? What had been their work histories? Had either had any significant physical, emotional, or social symptoms prior to their meeting? Had either been married previously and, if so, when were those marriages and were there children from them? If there are previous spouses and children, where are they now and what is the current relationship with them? In terms of the present marriage, what were the respective life circumstances of each spouse when they met? What attracted them to each other? What was the early period of their relationship like? What was courtship like? When did they get engaged? Were there any serious problems during that period? When and where did they get married? Did anyone boycott the wedding or was anyone excluded from it? What was the early period of the marriage like? Any serious problems or symptoms? It is always important to get both viewpoints. One spouse may have been miserable and the other may have been quite content.

When was the first child born and how did each spouse adapt to the new circumstances? Any serious problems or symptoms associated with that period? When were subsequent children born and how did the family adapt to those changes? Any serious problems or symptoms? Where has the nuclear family lived and what are the dates of any geographical moves? What were the reasons for the moves? Has either spouse continued to go to school or gone back to school since they met? What degrees have been obtained or not obtained? What has been the occupational history of each spouse since they met? If jobs have been lost, under what circumstances? What have been the school and

social adjustments of each of the children? Has any child had or does any child currently have significant physical, emotional, or social symptoms other than those in the presenting problems? Has anyone moved out of the home, such as a child, or moved into the home, such as a spouse's parent? When did these moves occur? If one or more of the children are no longer living at home, where are they now and what are they doing? Have any of the children gotten married and had children of their own? Are any planning to get married? What is the nature of the contact with the children who are living on their own?

Has either spouse had any physical, emotional, or social symptoms other than those mentioned already? Has there been any significant medical treatment or psychotherapy not mentioned already? Have the husband and wife had any periods of separation, either enforced or voluntary? What was the adjustment to those periods like? Have there been other periods of major stress on the family? What were the circumstances? Have there been any financial upheavals? Is any family member currently being affected emotionally due to circumstances related to his or her work situation? Is either spouse retired or planning to retire in the near future? Are there situations in the family's neighborhood that are presently affecting them emotionally? Are there situations in other social networks that are affecting the family?

Depending on the specific issues that are brought out during the history of a nuclear family, other questions may need to be asked. Information gathered from all of these questions provides clues about several important areas: (1) the nature of the patterns of emotional functioning in a nuclear family; (2) the level of anxiety a family has experienced in the past and the level it is presently experiencing; and (3) the amount of stress a family has experienced and is experiencing. Evidence that one spouse's functioning has improved significantly and the other spouse's functioning has declined significantly during the course of their relationship is an indication that the spouse whose functioning has declined has been the more adaptive or "de-selfed" one in the marriage. When some people talk about their early relationship they are very specific about what attracted them to each other. One wife said, "I needed to be needed and he was in need. We were a perfect match." She added, "I don't need him like I used to and it has created a lot of conflict in our marriage." Another husband said, "I married her because I wanted to take care of her. She

seemed helpless and lost. I never thought she would become this dependent on me." This husband's part in promoting underfunctioning in his wife is evident in the statements about his early attraction.

Previous marriages are important to be aware of, especially when there are children from those marriages. Ongoing battles with an ex-spouse, custody fights, and children from a previous marriage who are living in the present couple's household all have important effects on a family. If a previous spouse died, the surviving spouse's residual reactions may affect his present family. Many people who have been divorced have a firm determination to keep a subsequent marriage intact. This is important to be aware of because it could increase the tendency to vent anxieties on a child rather than on the marriage. A stepfather may react negatively to his wife's overinvolvement with a child from her previous marriage. A stepmother may encounter many obstacles in trying to be "a mother" to the children from her husband's previous marriage. A child may react intensely to his mother's or father's remarriage. The opposite reactions may also occur. Parents and children alike may function considerably better after a remarriage.

A marked difference in the ages of two spouses occurs much less frequently in well differentiated people than in poorly differentiated people. Very short or very long courtships occur much less frequently in well differentiated people than in poorly differentiated people. People who had a comfortable relationship while they lived together, but who experienced a marked deterioration in the relationship soon after marriage, are usually people who had managed the undifferentiation in their relationship by not getting married. Children are born out of wedlock more frequently to poorly differentiated people than to well differentiated people. If people elope, this is usually a reactive rather than a thoughtful decision. When one side of a family is excluded from or boycotts a wedding, this provides clues to the level of emotional intensity that exists between that spouse and his extended family. If either spouse has a significant physical, emotional, or social dysfunction early in the marriage and it disappears when the wife gets pregnant, this is a clue about a basic pattern of emotional functioning in the nuclear family. This pattern may be obscured later by symptoms in a child. It is only by asking about the early years that a basic pattern of emotional functioning in the marriage is revealed.

When a first pregnancy seriously disturbs the emotional equilibrium in a marriage, the disturbance may have important long-term repercussions. A husband may have had a psychotic reaction after the birth of his first child and it may have so threatened his wife that she made numerous adjustments after that hoping to avert another breakdown. She might have wanted a second child, but did not press the issue out of fear that her husband could not cope. The husband did not push either. If this is picked up in the history of a family that has come for therapy for another reason, the issue may turn out to be much more important than the issue for which the family actually sought therapy. The family has been governed for years by fear of what might happen, but the family may be capable of overcoming that fear.

The history of symptoms in each family member gives clues to where the various pressures in the system have been expressed. In some families, the expression of tensions shifts around frequently; it is important for a therapist to be aware of these shifts. A family evaluation is intended to give a therapist some clear ideas about the nature of the emotional process in the family he is addressing. A history that includes only recent events in the family and vague references to the past is not enough to provide this sort of perspective. This is part of the reason so much information about symptoms and events in the past is collected. Geographical moves are another important area to inquire about because moves may correlate with the development of symptoms in a member of the nuclear or extended family.[11] People move for a lot of different reasons. People may say they moved because of "a good job offer," but there are often other incentives. The most attractive feature of a move to a husband might be getting his wife away from the demands of her family or getting himself away from the demands of his family. Families may be very different emotionally after a move.[12]

The impact of a geographical move on nuclear family emotional process is illustrated in the following clinical case. A schizophrenic son lived with his two parents in Baltimore, Maryland. The son was 24 years old and had been markedly dysfunctional since high school. The mother was very involved with her son, but she also had a group of friends and relatives in the Baltimore area with whom she was quite involved. The father was fairly busy with his work

and rather passive in his approach to his wife and son. The father succeeded in convincing the mother to move to an area about three hours from Baltimore, where the father intended eventually to retire. The mother did not want to move, but gave in to pressure from the father. Soon after the move, the mother collapsed into depression and heavy drinking. The father became helpless in face of his wife's collapse and drank heavily too. The functioning of the schizophrenic son improved significantly. He obtained and held a job, met people socially, did the shopping, and drove his mother to and from her doctor's appointments. The mother's isolation was an important factor in her collapse.

When a spouse goes back to school or work this may herald shifts in the patterns of emotional functioning in a marriage. It may trigger a lot of anxiety in a family, which eventually gets expressed as a symptom in some family member. The problem is not the spouse's going back to school; the problem is the family's inability to adapt to that event. By the same token, a person who cannot finish a degree is often reacting to a relationship process in his nuclear and/or extended family. Occupational history can be another important indicator of emotional process. When a family member loses a job and cannot motivate himself to get another one, this is almost always a symptom that is reinforced by a family relationship process. Emotional turmoil in one family member's work environment can threaten or "infect" a nuclear family system. Turmoil in neighborhood or other social networks can be an important influence too. Even anxiety stirred by a national or international event, for example the assassination of President Kennedy, can significantly affect the emotional functioning of a nuclear family. Poorly differentiated families are the most vulnerable to responding to anxiety in the social environment.

Data about the adjustments and symptoms of each child provide information about the family projection process, about which child is least separate from the parents emotionally. That a firstborn daughter had symptoms that completely disappeared when her younger brother was born and that the brother grew up to have significant emotional problems of his own is a strong indicator of a shift in the emotional process of the family after the birth of the second child. For whatever reason, the family projection process shifted from the first child to the second one. Data that the functioning of all the children

has been fairly stable in most aspects indicate the parents have contained many of their emotional problems within or between themselves.

The temporary or permanent moves of people into and out of a nuclear family can also have major effects. If an adolescent's behavior problems disappeared soon after his aged paternal grandmother moved into their home, and the grandmother's "forgetfulness" soon became a focus of the family, this may indicate that the family emotional process had shifted. The grandmother rather than the adolescent became a repository of family anxiety. Symptoms may be associated with a grown child's moving out of the house. If a child has moved out and is having difficulty or has cut off from his parents, this may influence the family. If the children have moved out and scattered to the four winds, this is a different situation than if they had moved out and stayed in the same geographical area as the parents. If an adult son or daughter moves back into the home, this could trigger anxiety in the family to the point of symptoms. If one of the children is planning to get married or is married and is now pregnant, this may be having an important influence. Again, these are all associations between events and symptoms that the family may not have reflected on.[13]

If a therapist does not do a detailed history of a nuclear family, associations that can help people gain perspective on a problem may be overlooked. Important events, such as a husband's cancer surgery two years earlier, may not even be mentioned by a family, at least initially, unless a therapist asks. One spouse may have been seeing a therapist for years and not consider it important enough to mention. "What does the therapist have to do with my son's problem," a father might ask. The father's funneling of his anxieties into the relationship with his counselor may have a lot to do with his son's problems. For example, it may have been easier for the father to talk to a supportive therapist than to deal with his wife on important emotional issues.

At the conclusion of this part of the evaluation, a therapist should be aware of the important changes that have occurred in the nuclear family since its inception. He should have an impression about the degree of stress the nuclear family has been under (past and present) and about how well the family has adapted to the stress. The therapist should now be aware of the immediate

relationship system of the symptomatic person and be aware of the predominant patterns of emotional functioning in that system. He should also be aware of how those patterns may have changed over time. The therapist should have an impression about the intensity of the emotional process or level of chronic anxiety in the nuclear family, both in the past and in the present. He should be aware of whether that intensity is linked more to an overload of difficult life events or more to a low degree of adaptiveness in the family. So at this point in the evaluation, the focus has been expanded from the symptom and the symptomatic person to the immediate relationship network of which that person is a part. The last part of the evaluation is to gather information about each extended family system and to broaden the perspective on the presenting problems even further.[14]

History of Extended Family Systems

The goal of this final part of the evaluation is to place the nuclear family in the context of the maternal and paternal extended family systems. The characteristics of the emotional process in the nuclear family are significantly influenced by the characteristics of the emotional process in each spouse's family of origin. In addition, the nature of each spouse's current relationships with members of the extended family and recent events in both extended families can affect the level of chronic anxiety in the nuclear family. The nuclear families that comprise an extended family system can be conceptualized as interlocking emotional fields. Each nuclear family is a self-contained emotional unit in some respects, but each nuclear family also responds to problems that occur in the other nuclear families.[15] The response can range from reactive to thoughtful. Reactive responses can result in an escalation of anxiety and its spread through most of the extended system. Thoughtful responses can reduce the anxiety and keep it reasonably contained in the nuclear family where it was generated originally.

The basic information collected about each extended family is similar to the information collected about the nuclear family. Usually, however, a therapist collects a little less detail about the extended family system than about the

nuclear family system. If a family member is motivated, however, to define more of a self in his family of origin, he will eventually assemble a great deal of data about his multigenerational family. Unless a therapist has a specific research interest in a clinical family, it is not necessary for him to be aware of all this information. A therapist provides general principles and guidelines for approach to the extended family and he helps a family member recognize when he is "caught" in the system emotionally, but the family member is on his own in the project in many respects. The information the family member gathers is more important to him than to the therapist. Knowing more facts about one's multigenerational family and knowing the people in the family better can change how a person thinks about his family and about himself. The change does not result from what a therapist says, but from the thinking the family member does about what he has learned about his family.

Data gathered in the extended family survey include the following: birth date, death date, cause of death, educational background, occupational history, health history (includes physical, emotional, and social symptoms), marital history (includes dates of marriages and divorces), and geographical locations (past and present). The data are collected on both spouses' parents, siblings, and children of siblings. If there are stepparents, stepbrothers, stepsisters, half-brothers, or half-sisters, the information is collected on them too. After the information has been gathered on the immediate family of origin of each spouse, similar data are collected on the previous generation. This includes data on each spouse's grandparents, aunts and uncles, and first cousins. It is often not possible or even necessary to get the same amount of data on everyone in the extended family. It is often obvious which parts of the family are most significant to the nuclear family being evaluated, and more detail is usually obtained on those segments of family. It is important to obtain some data on the great-grandparents of each spouse and others who seem to be important in that generation. A great-aunt or great-uncle may be an especially important figure in the family.

Initial impressions can be formed about a nuclear family's relationship with the extended families from how much information spouses know about their families and from their attitudes towards them. Attitudes range from, "I don't know what I would do without my family," to, "I've got a sick family and the

more I stay away from them the better." In an initial evaluation interview, some people acknowledge that they are unhappy with the character of the relationship with their family and wish they could improve it. They have been unsure of how to approach the family and welcome any ideas a therapist has. The amount of knowledge people have about their extended families varies tremendously. When a person knows very little about his grandparents or about his grandparents' families, this usually means that the person's parents were fairly cut off from those families. In general, the people who minimize the influence of the past on the present are the least motivated to bridge emotional cutoffs with the family of origin. The people who believe the past has a major influence on the present are usually more motivated to bridge emotional cutoffs with the past.

Assessing the degree of emotional cutoff of each spouse is sometimes simple and sometimes difficult. If a person says, "I do not see my family very often, nor do I tell them much about my life," it is safe to assume a significant degree of cutoff. If a person says, "I have wonderful parents and I wish I could spend more time with them than I do," this does not necessarily mean that the person is not cut off. Such a person may have an idealized view of his parents and feel guilty that he has not been a "better son." When he is with his parents, he may try to present an image to them that he thinks will make them comfortable and, as a consequence, make him comfortable. Pretending to be something one is not in order to avoid tensions in a relationship is part of what creates emotional cutoff. If a person says, "I am close to my mother, but have little relationship with my father," such a statement must be interpreted in the context of triangles. The apparent "closeness" with mother and apparent cutoff from father may reflect the father's being in the outside position between his wife and child. The "closeness" with mother is based on a harmonious emotional fusion and the cutoff with father is exaggerated by that fusion. So assessment of cutoff is not a simple matter of asking if a relationship is harmonious or if people see one another frequently.

After basic data have been collected on each extended family, the influence of recent events in either the wife's or the husband's families can be discussed. Recent illnesses, accidents, deaths, divorces, marriages, geographical relocations, or financial setbacks in key members of either extended family merit some

exploration. Sometimes a nuclear family's reaction to such events has been an undercurrent in the family but not discussed openly. A family evaluation interview may be a forum that allows people to say things they had not said at home. An "emotional shock wave" occasionally occurs in an extended family. A death of a very important family member is followed by significant symptoms appearing in many of the nuclear families that comprise the extended family system. An "emotional shock wave" appears to reflect the spread of anxiety through the system. The development of each new symptom or problem adds, of course, to the anxiety. It can last from several months to more than a year. An "emotional shock wave" can be triggered by an event other than a death; for example, the bankruptcy of a family business may ripple out among several nuclear families.

When gathering data on the extended families, the therapist needs to get an impression about which members of the extended family are most involved with the nuclear family being evaluated. A relationship between the wife in a nuclear family and her mother may be a frequent source of distress for the wife. The wife's relationship with her mother's sister, however, may be very supportive. If this aunt has recently developed a serious illness or has retired and moved away, it may be having a major effect on the wife. A business relationship between the husband in a nuclear family and his brother may be injecting considerable anxiety into the husband's nuclear family. The husband's wife may think her brother-in-law takes advantage of her husband in the business. The wife may frequently pressure her husband to "stand up" to his brother. This may result in periods of tense distance in the marriage. The tension may affect their child's bed-wetting. If the parents seek help for the child's bed-wetting, they may not mention the husband-brother-wife triangle. A therapist must inquire systematically into the extended family relationships in order to be sure he gets a reasonably complete picture of all the emotional forces affecting a nuclear family.

In addition to recognizing which extended family members are involved with a nuclear family, it is important to recognize which extended family members are not involved. A family "black sheep" whom everyone has ostracized, an uncle who has been in a state hospital for many years and been "forgotten," an "alcoholic" grandfather who "left" his wife and married another

woman and as a consequence has been blamed for many family problems, an aunt whom everyone is certain "cheated" the family out of grandmother's estate, and a brother who "disappeared" can be important people to contact if a person wants to be more of a self in his family of origin. People with whom emotional contact has been lost can be more of a source of anxiety to a nuclear family than people with whom emotional contact has been maintained. If one makes emotional contact with a schizophrenic relative in a state hospital, it can contribute as much to the person who makes the contact as it does to the relative. Sometimes people are afraid that highly dysfunctional family members will become dependent on them if they contact them. Such problems can be managed if the focus is kept on one's own functioning and not on the other's functioning.

Data on the extended family can be used to form impressions about the basic patterns of emotional functioning that prevailed and prevail in each spouse's immediate family of origin.[16] Has the undifferentiation in the family of origin been managed primarily through marital conflict, dysfunction in a spouse, or dysfunction in a child? What has been each spouse's functioning position in his or her family of origin? Is the husband an oldest son who appears to have fled the expectations of his family? Did the husband become a substitute husband for his mother after his father died? Is the wife the person her siblings expect to take care of their parents? Is she the one who usually gets called about problems? Is the wife or husband a person the family has always regarded as a "child"? To what extent has that perception carried over into the nuclear family?

Some exploration of the characteristics of the principal triangles in which each spouse grew up is important. In the early exploration of these processes, only fairly gross patterns may be evident. There are many subtle aspects of triangles of which people may be unaware. These subtle aspects are learned about over time. Discussion of the gross aspects early in therapy can stimulate a family's interest in learning more. Does a mother's relationship with her symptomatic son have any parallels to her mother's relationship with her brother? The mother grew up in the triangle with her mother and her brother. She may have been fused with her mother's worry about her brother and

transferred those unresolved feelings into the relationship with her son. Until she is asked about it, she may have just worried about it. Conceptualizing it as a triangle is often very helpful to people. Does a husband's relationship with his wife have any parallels to his parents' relationship? The husband may have grown up feeling angry at his mother and sympathetic toward his father. He may now feel angry at his wife and sure that the anger is justified. His wife, of course, plays out the opposite side of the relationship process.

The composite of data on the extended families provides an impression about the stability and intactness of those systems. The stability and intactness of a family relationship system roughly parallel the average basic level of differentiation in that system. The parallel is not exact because of the distinction between functional and basic levels of differentiation. A family can be kept fairly stable and intact for several generations based on a rigidly held system of beliefs, for example. The belief system may help the family function above its basic level. The belief system could originate primarily from within the family or it could be incorporated from outside. Whether it originated inside or outside the family, it is often promulgated by one or a few key family members. When those people die, the functioning of the system may decline. At the other extreme is a family whose stability and intactness are undermined by a disastrous series of unfortunate life events. Such a family may function below its basic level of differentiation for several generations. In general, however, an impression about the stability and intactness of an extended family system can be used as a rough indicator of the average basic level of differentiation in that family system.

The stability of a family is assessed on the basis of information that is assumed to be linked, at least in part, to emotional functioning. Longevity, health history, occupational and educational performance, and marital and reproductive history are assumed to bear a relationship to emotional functioning. It is the composite of these data coupled with an awareness of a particular individual's and a particular nuclear family's life circumstances that is used to assess differentiation in a multigenerational family.[17] Does the nuclear family being evaluated reflect the outcome of a rapid downward multigenerational trend in functioning? Is the nuclear family a fairly unstable

unit in the midst of other fairly unstable units in the extended system? Does the nuclear family appear to be more stable than most of the extended system of which it is a part? It is important for therapeutic planning that a therapist form an impression about the stability of the emotional process in the nuclear family being evaluated and the stability of the emotional process in the extended system that surrounds the nuclear family.

The intactness of a family is assessed from impressions about the number of people in an extended family system who are alive and reasonably available to the nuclear family being evaluated. At one extreme are extended family systems that are fragmented. Many family members are dead and those still alive are out of contact with one another. Such systems are usually characterized by very unstable relationships. At the other extreme are extended family systems in which family members are still alive and they are in excellent emotional contact with one another. Such systems are characterized by remarkably stable relationships. It is important to remember, however, that highly unstable systems have their more stable members and highly fragmented families have people in them who manage to stay in contact with one another. The more intact an extended family system, the more a potential resource it is to a nuclear family. Highly motivated people, however, can sometimes reestablish emotional contact in a family that appears irretrievably fragmented.

Much of the data collected about the nuclear and extended family systems can be organized in the form of a family diagram.

THE FAMILY DIAGRAM

The family diagram is an outgrowth of family systems theory. The information contained on a family diagram is meaningless without a thorough understanding of the principles that govern emotional systems. The diagram reflects the ebb and flow of emotional process through the generations. It defines the vicissitudes of a living organism, the multigenerational family.

The data collected in a family evaluation interview are collected because these data are assumed to be influenced by the emotional process in the family. The data vary from family to family, and this variation is assumed to be the result of differences in emotional intensity in families and differences in the

way anxiety is managed in families. When these data are placed on a family diagram, they provide a picture of the underlying emotional process in the family from which they were gathered. The connection between the data on a family and the family's emotional process can be illustrated by an oversimplified case example.

In the case example, the principal way in which the anxiety generated by the undifferentiation in the husband's immediate family of origin was managed was dysfunction in one spouse. This was the principal mechanism while the husband was growing up and after he left home. Marital conflict and impairment of a child were not prominent anxiety-binding mechanisms in his family of origin. The principal way in which anxiety generated by the undifferentiation in the wife's immediate family of origin was managed was marital conflict. This was the principal mechanism while the wife was growing up and after she left home. Dysfunction in a spouse and impairment of a child were not prominent anxiety-binding mechanisms in her family. The principal way in which the anxiety generated by the undifferentiation in the husband and wife's nuclear family is managed is impairment of a child. Dysfunction in a spouse and marital conflict are not prominent anxiety-binding mechanisms in their nuclear family. The emotional process in these three family emotional fields (husband's family of origin, wife's family of origin, and nuclear family) can be diagrammed as in Figure 14.

The data on the diagram of this family would reflect the patterns of emotional functioning in each family emotional field. In the husband's family of origin, the data would show some degree of clinical dysfunction in his mother and no dysfunction in himself or in his father. The husband's parents' marriage would be described as harmonious. In the wife's family of origin, the data would show no significant clinical dysfunction in any family member, but the marriage would be described as conflictual. It may have ended in a divorce. In the nuclear family of this husband and wife, the data would show symptoms in the son, but the functioning of the husband and wife would be unimpaired and their marital relationship would be described as harmonious. The degree of dysfunction is influenced by the basic level of differentiation and by the degree of stress each family emotional field has experienced and is experiencing. Differences in the degree of dysfunction or conflict in a particular family are

also reflected in the data. If the wife in family A had been in a mental institution since the birth of her son, that would reflect a more intense process than if she had been hospitalized briefly after the birth of her son and had been in individual psychotherapy intermittently since that time.

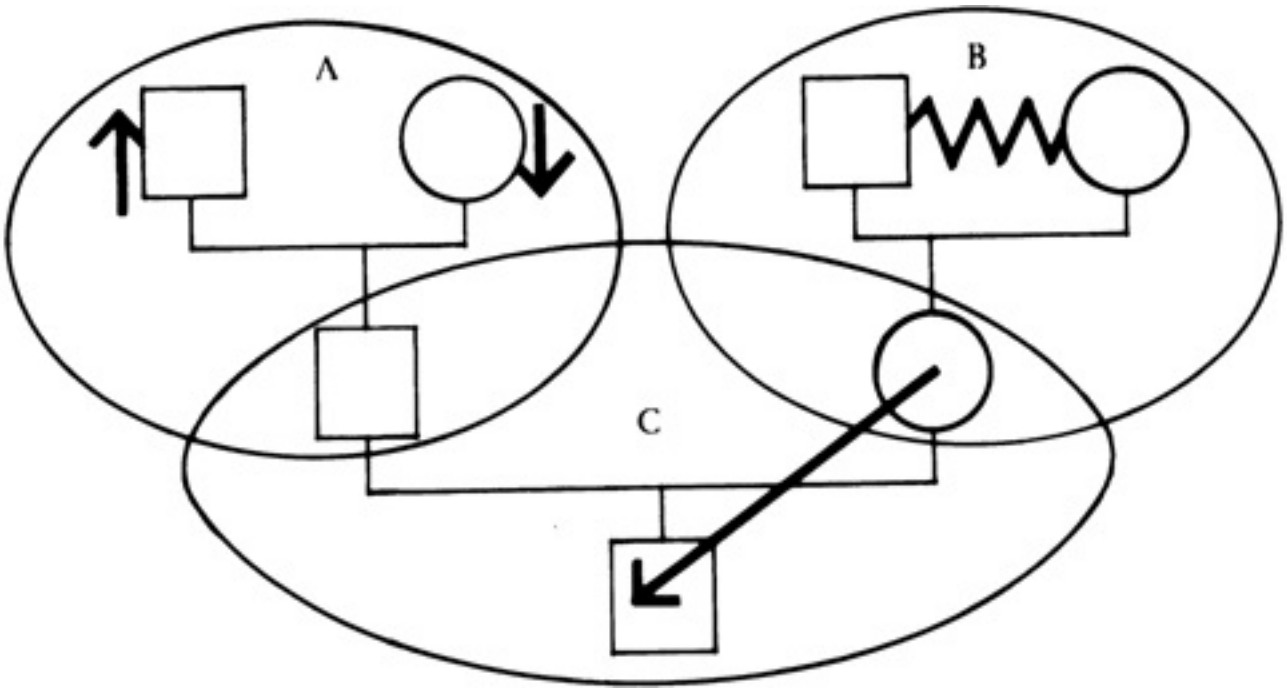


Figure 14. Family A is the husband's family of origin. The principal pattern of emotional functioning in his family was underfunctioning by his mother (indicated by the arrow pointing downward) and overfunctioning by his father (indicated by the arrow pointing upward). Family B is the wife's family of origin. The principal pattern of emotional functioning in her family was conflict between her parents (indicated by the jagged line between the parents). Family C is the nuclear family of this husband and wife. The principal pattern of emotional functioning in their family is the family projection process (indicated by the arrow from the mother to the son). These are highly simplified ways of diagramming the various patterns of emotional functioning, but they are a useful shorthand.

Family diagrams are always more complicated than this one. There are usually more people and more generations. In addition, in a nuclear family emotional field there may be more than one pattern of emotional functioning that contributes to clinical symptoms. No matter how complicated a diagram is, however, the data still reflect basic patterns of emotional functioning and basic intensities of emotional process present in a multigenerational family. This makes it possible to reconstruct the basic patterns of emotional functioning and the degree of intensity of emotional process in nuclear families

that existed four or five generations ago. The information about functioning that is available for people who died 100 or 125 years ago is usually less than for people in recent generations, but a large amount of information is not required to develop some impressions about the past. Information that a great-great-grandfather spent much of his life in mental institutions or in prisons is not difficult to obtain.[18] In addition to the recollections of family members, various records can provide information. When that great-great-grandfather's functioning is compared to the functioning of his contemporary relatives, some conclusions can be drawn about the patterns of emotional functioning in his nuclear family.

Researching one's own family sufficiently to formulate impressions about the multigenerational emotional process makes it possible to see the emotional "script" in one's multigenerational family and, as a consequence, to be less preoccupied with the actions and inactions of any one family member. Knowledge about multigenerational emotional process gets the focus off specific individuals in one's past, particularly off one's parents, and in so doing provides a unique perspective on one's own family and on one's own life.

Some people believe their parents are at fault for not having been "better" parents. They should have been "more loving" or "less rigid" or "more available" or "less critical." The basic viewpoint is "My family is the cause of the problems in my life." An alternative to this viewpoint is that every family member, including one's parents, is embedded in a multigenerational emotional process and everyone, including oneself, has a responsibility to grow up as much as possible within that process. If people hold their parents or others responsible for their growing up, they may go through an entire lifetime faulting their parents and looking for someone who can finally give them what they have always "needed." If people relinquish the notion that parents were "supposed" to have done it "right," they have many options for "growing up themselves." Learning enough about the multigenerational emotional history of one's family to change the way one thinks about the family and about oneself probably contributes more to the effort to "grow up" than anything else a person can do. A change in how one thinks about oneself and others is the key to tempering the influence of subjective notions about how oneself or others

"should" be and to tempering the influence of emotional reactivity on one's functioning.[19]

The recording of the information a therapist gathers about a clinical family or about his own family follows a basic format and uses standard symbols. The basic format and symbols used to record information about each nuclear family in a multigenerational family system are shown in Figure 15.

Due to deaths, divorces, and remarriages, nuclear families change over time. The formats and symbols used to record these events are shown in Figure 16. When a person has children from more than one marriage, this is diagrammed as in Figure 17. Adoptions, miscarriages (spontaneous abortions), induced abortions, and stillbirths are shown in Figure 18.

When much of the data collected in a family evaluation interview is included on a family diagram, the diagram can get very complex. If the goal is research, then all the data must be included. In doing family psychotherapy, however, it is usually not necessary for a therapist to put so much information on his or her diagram. An example of how a family diagram might appear after one or two interviews with a clinical family is presented in Figure 19.

Here is the basic information collected during the family evaluation, hypothetically dated September 1983: The nuclear family lived in Washington, D.C. The parents sought therapy because of school and social problems in their 12-year-old younger daughter. The background of the father in this nuclear family is as follows: He is the youngest of three children in his family of origin. He grew up in New York City. His father died of a heart attack (acute myocardial infarction) at age 46 in 1956. His mother, now 70 years old and in good health, remarried fours years later to a widower. The widower has an older son and younger daughter from his previous marriage. The mother and stepfather moved to Florida in 1974. The father in the nuclear family being evaluated has an older brother who appears to be the most unstable functioner of the three siblings. The father's older sister and her family live on Long Island and are doing well. Several relatives in the father's grandparents' families, at least on the maternal side, are alive. The father's maternal grandmother, now 95 years old, is in a nursing home in Florida near her oldest child and only daughter, this father's mother.

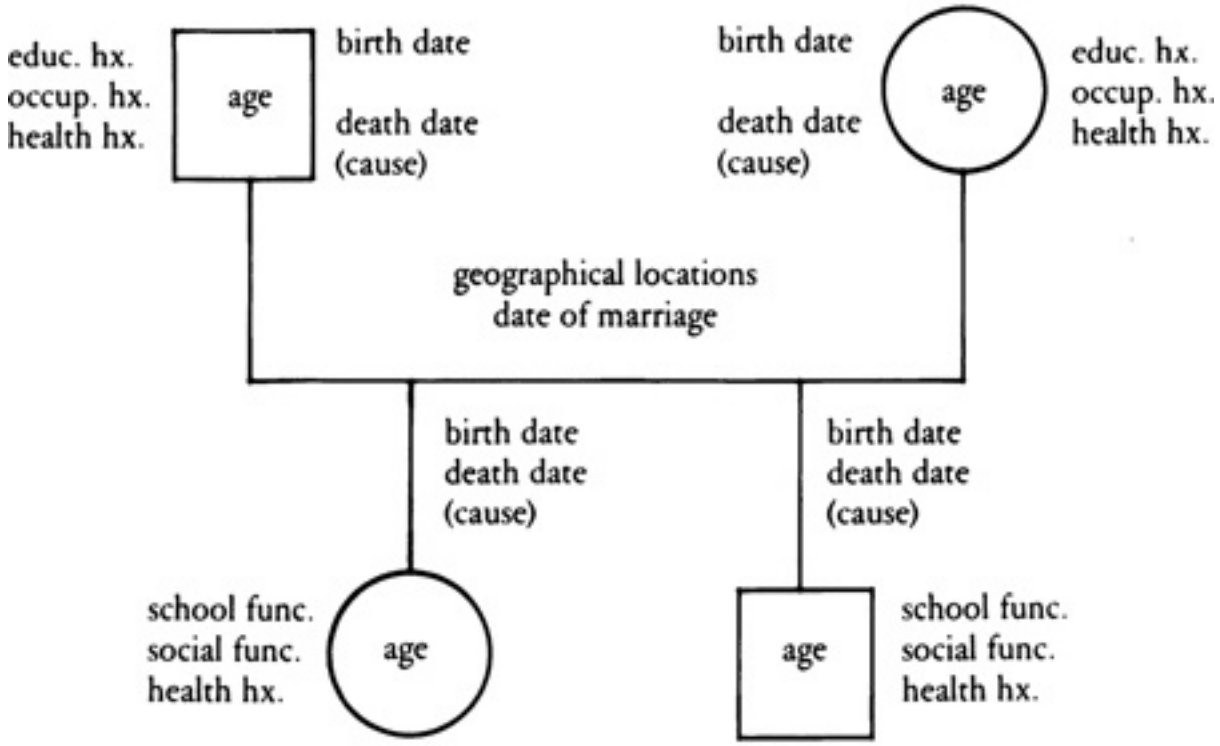


Figure 15. The husband (males on the left when symbolizing a marriage) and wife are at the top and their two children below. Children are shown from left to right in the order of their births. Data on the marriage may also include when the couple met and the date they were engaged. The data on the children in this diagram are for dependent children. Geographical information includes all the places a nuclear family has lived and the dates they lived there.

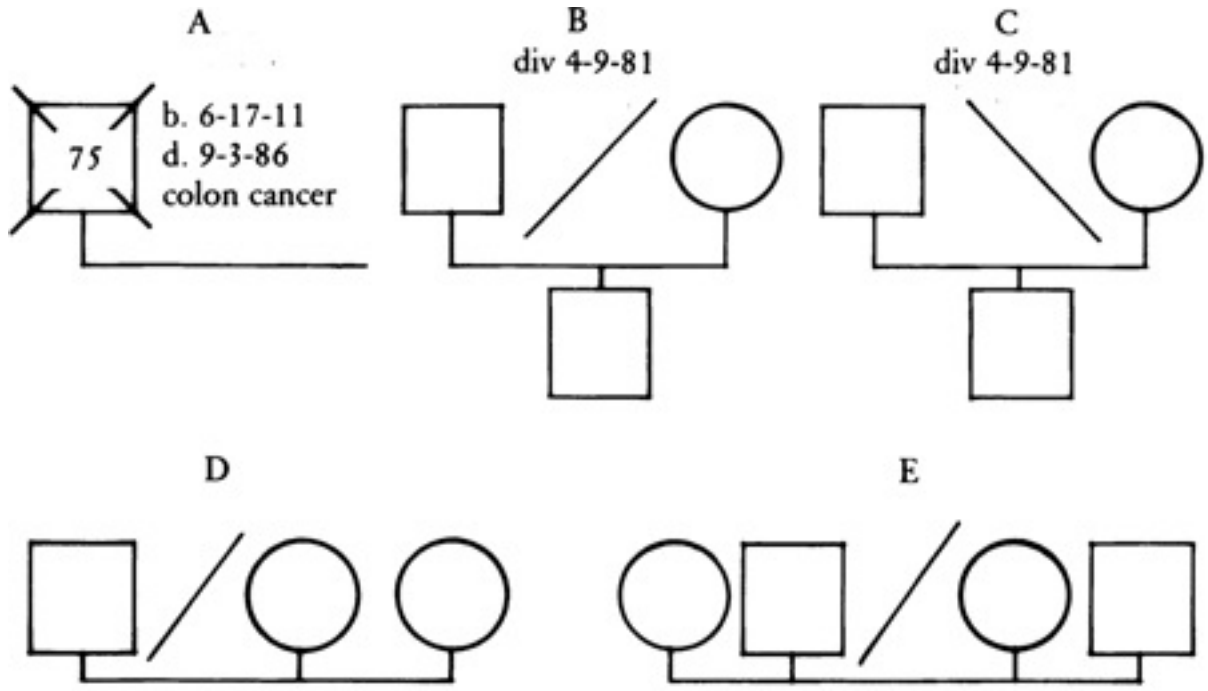


Figure 16. Diagram A shows how a death is recorded. The age at death was 75 years. Diagram B shows a divorce that occurred on 4-9-81 in which custody of the child was awarded to the mother. The date of separation may also be included. Diagram C shows a divorce in which custody of the child was awarded to the father. Diagram D shows a divorce and a remarriage by the man. Diagram E shows a divorce and remarriages by both former spouses. Other data are left out of these diagrams to simplify them.

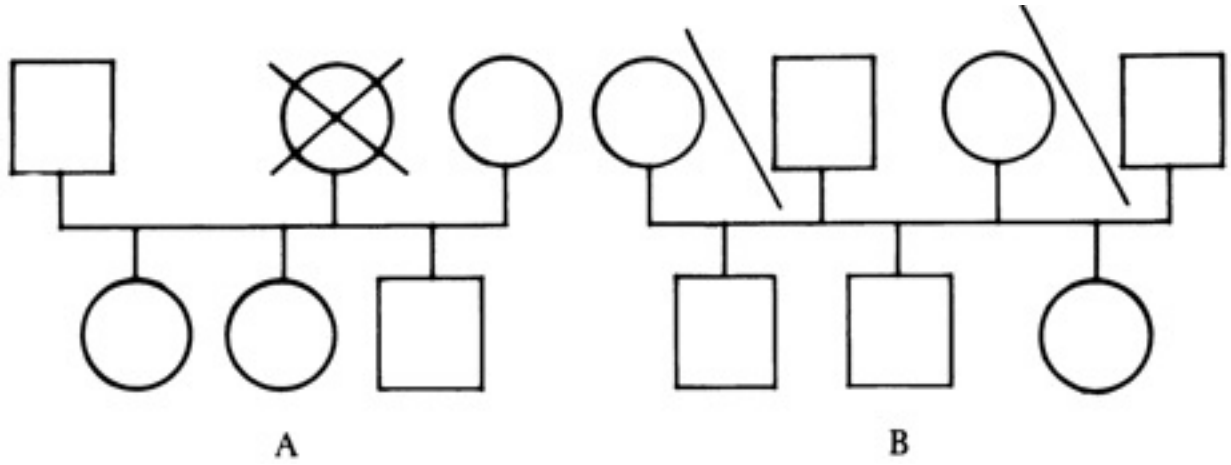


Figure 17. Diagram A shows a man whose wife died after having two daughters. He remarried and had a son by the second marriage. Diagram B shows a marriage between two people who had each been married previously. The husband was divorced and custody of his son went to his former wife. The husband's present wife was divorced and custody of her daughter went to her. There is also a son from the present marriage. Multiple marriages may preclude showing children in the correct order of their births. When dates and other information are included on a family diagram, it provides a clearer picture.

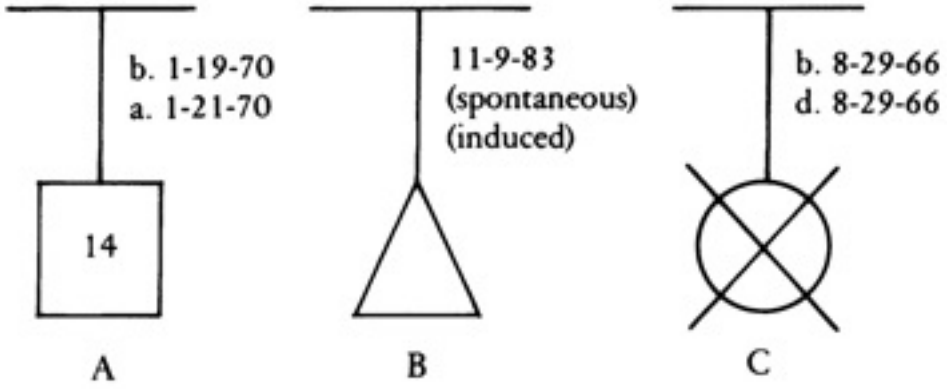
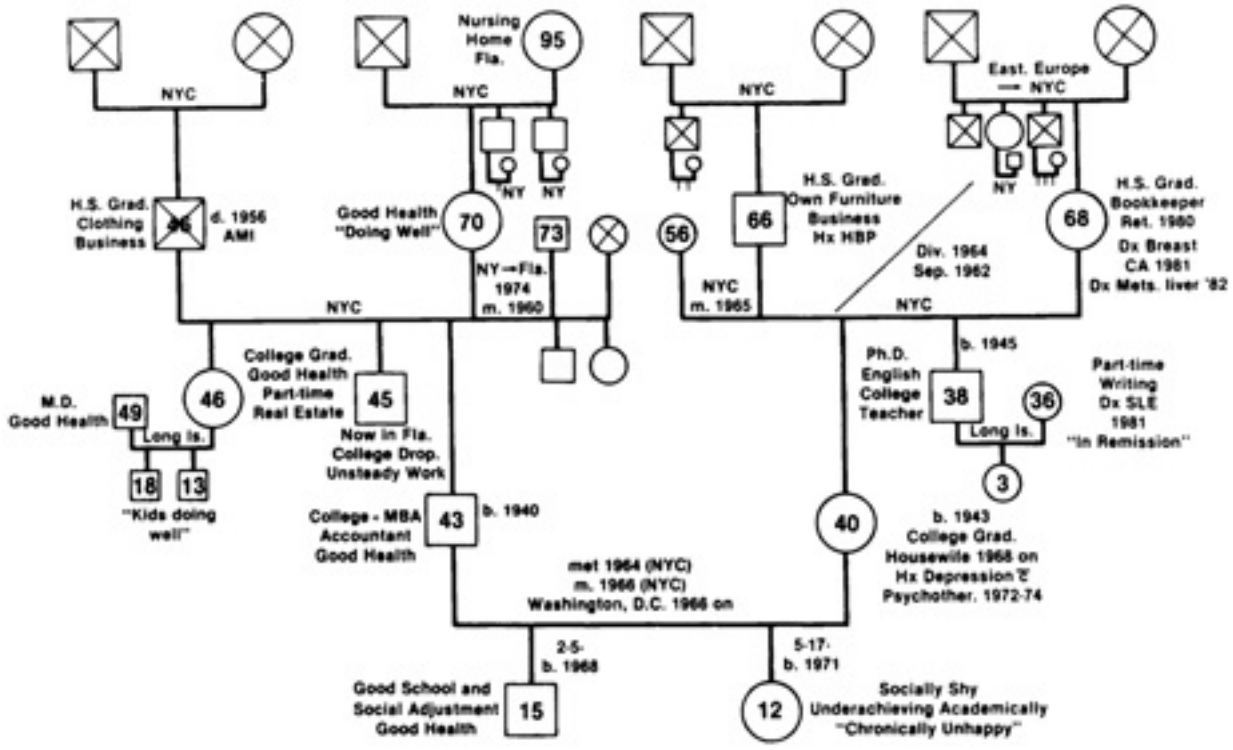


Figure 18. Diagram A is of a 14-year-old boy who was adopted when he was two days old. The date generally used is when the child came to live with the family rather than when legal procedures were completed. Diagram B is of an abortion, spontaneous or induced. These can be extremely important in the emotional life of a family. Diagram C is of a stillborn child and shows the sex of the child. The cause of death may be included if it is known.

The mother in the family coming for therapy is the older of two children

and grew up in New York City. Her parents separated when she was 19 years old and divorced two years later. Her father remarried one year after the divorce and is in New York City. Her mother never remarried. The wife's mother, who retired in 1980 and who is still in New York, was diagnosed to have breast cancer in 1981. Metastatic lesions were discovered in 1982. The wife's younger brother lives on Long Island and has had some recent difficulties in his family. The brother's wife was diagnosed to have systemic lupus erythematosus two years ago. She responded to therapy and is currently in remission. The wife in this nuclear family has an aunt and uncle living in New York who are on the maternal side of the family and some first cousins on both sides of the family. This wife experienced a "depression" after the birth of her second child and underwent two years of psychotherapy. Her husband has not had symptoms, nor has their older child, a 15-year-old boy.

After two interviews with this husband and wife, the family diagram appeared as follows:



Based on the information gathered in the family evaluation interview and shown on the family diagram, impressions can be formed about the emotional

process in this family. The available data suggest that the wife tends to be the more adaptive one in the marriage. This impression is based on her period of symptoms following the birth of the second child. However, the wife has not been symptomatic in recent years. This suggests that the primary pattern of emotional functioning in the nuclear family is the parents' emotional overinvolvement with the daughter. This appears to be a situation in which the level of external stress on the family has pushed the process to a symptomatic level. The most evident stress is the wife's mother's metastatic cancer. The wife's present position emotionally in relationship to her family of origin, most especially in relationship to her mother and brother, and the husband's reactions to his wife's position would probably be an important focus of therapy. It would be constructive for the 12-year-old daughter if her parents stopped focusing on her "needs" and started focusing on broader issues.

When a family evaluation interview has been completed and a family diagram has been constructed, it is useful to make a systematic interpretation of the information. The interpretation could be considered a form of "family diagnosis."

INTERPRETATION OF THE DATA (FAMILY DIAGNOSIS)

Interpretation of the data from a family evaluation interview and from a family diagram are broken down into the following ten areas: (1) the symptomatic person, (2) sibling position, (3) nuclear family emotional process, (4) stressors, (5) emotional reactivity, (6) nuclear family adaptiveness, (7) extended family stability and intactness, (8) emotional cutoff, (9) therapeutic focus, and (10) prognosis.

The Symptomatic Person

The symptomatic person is the primary focus of conventional medical and psychiatric diagnosis. Defining which family member is dysfunctional and the nature of the clinical dysfunction is also the first step in family diagnosis. The symptomatic family member can be identified as follows: "37-year-old wife and mother" or "16-year-old son" or "84-year-old grandmother (husband's