The Practice of Community Family Therapy

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Special Section: Family Centered Community Building Section Editors’ Note: We are pleased to bring to *Family Process* the work of a pioneering family therapist who is doing important and sophisticated work with families and communities. Ramon Rojano’s Community Family Therapy breaks new ground by seeing families in poor communities not only as resilient but also as change agents, not only as clients but as citizens. —William J. Doherty and Jason S. Carroll.

This paper presents a summary of the basic theories and methods of Community Family Therapy (CFT), a relatively new therapeutic approach developed in response to the need for effective intervention in treating low-income, urban families. CFT operates outside of the traditional therapeutic box, successfully combining family therapy techniques with developmental and motivational theories, community mental health, social work, economic development, and community mobilization strategies. CFT utilizes a dualistic approach in which both client and therapist become involved with the same three levels of engagement. Specifically, the client strives for: (a) personal and family change and growth — level 1, (b) accessing community resources — level 2, and (c) leadership development and civic action — level 3. Also, CFT calls upon therapists to strive for: (a) personal growth and maturation — level 1, (b) collaboration with community resources for professional support — level 2, and (c) operation as a “citizen therapist,” through civic action and volunteer services — level 3.

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Community Family Therapy (CFT) evolved from the need to develop effective therapeutic interventions with low-income urban families. The approach is based on the premise that dysfunctions and mental health problems commonly seen in economically deprived and socially destitute families are influenced by other variables, including limited access to resources, individual and family underdevelopment, lack of

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The author wishes to thank the following: the CFT clients, a living proof of courage, resiliency and transformation; his wife, children, his mother, and his extended family for the daily inspiration; his co-workers and students for validating the approach; and William J. Doherty and Jason S. Carroll of the Family Centered Community Building project for their support.

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positive experiences, chronic exposure to stressful environments, and disengagement from civic life. CFT is designed as a multi-pronged approach that includes interventions in three different areas of the family and community ecosystem, and builds capacity to simultaneously impact various types of indicators. The intervention not only addresses the issues that motivated the referral for treatment, but also proposes to design a lifelong action plan that includes elements of personal growth, economic development, and leadership training.

Such a comprehensive agenda requires a strong commitment from both therapists and clients. To be successful, CFT requires multi-skilled, flexible, and creative therapists that, in addition to clinical skills, are also competent in implementing comprehensive socioeconomic interventions. Clients need to be ready to learn how to take charge and assume control and responsibility over their own lives. Additionally, both therapists and clients are expected to develop and/or enhance their leadership skills and engage in civic projects that aim to improve the conditions of the surrounding community. Six years after its official appearance, CFT has grown into a promising therapeutic intervention with the potential for long-lasting positive effects on individuals and families. The following case narrative illustrates how CFT works.

Rosa was a 39-year-old, married mother of three children, one 19-year-old daughter and two sons, 13 and 7 years old. She had desperately sought counseling following the recent abandonment by her husband, who had left her and moved in with a former friend of Rosa’s. “Why is this happening to me?” she repeated during our first session. It had taken her 23 years to find out that her husband was a chronic philanderer who had been intimate with some of her closest friends in the bed they shared. Everyone but her seemed to know the truth. Even her daughter seemed to be aware of his behavior. “I always knew that there was something wrong with him,” she said.

The laundry list of clinical issues that emerged in the first two sessions with Rosa and her children was extensive: sadness, frequent crying spells, grief, anger, low self-esteem, recollection of post-traumatic family experiences, fear, insomnia, and insecurity were among them. The initial situation presented enough material for at least one year of individual work. Moreover, in her new role as head of household, she was encountering new problems: her 13-year-old son had become rebellious and confrontational, talking back and associating with people who had a negative influence on him; her daughter had left the house; and her youngest son was constantly fighting with his brother and experiencing nightmares. The family’s socioeconomic indicators presented additional concerns: Rosa had neither employment experience nor formal education; her English skills were limited and her sole source of income was the money her husband provided at his whim.

Rosa and her family’s situation is an example of the many cases that evolve at the interface between clinical and social matters. Obviously, some traditional therapeutic work was needed to help her deal with her grief and heal. But she needed, also, to grow and gather new resources, which would allow her to become self-reliant and self-sufficient. In a matter of just three months, reality had brought her from the role of a middle-class homemaker to a single mother on the brink of poverty. Rosa’s case was not uncommon in the inner-city child guidance clinic where I saw her. In fact, approximately 95% of the more than 2000 individuals seen yearly at the clinic live in low income families.

**SOCIOECONOMIC CONTEXT: DANCING AROUND THE POVERTY ISSUE**

Willingly or unwillingly, therapists across the country are forced to wrestle with the poverty issue on a daily basis. The litany of socioeconomic stressors suffered by...
low-income families has been extensively documented. Significant resource and outcome disparities exist between poor and non-poor children. Poor children are more likely to have health problems, live in inferior housing, have lessened access to computers, attend inferior schools, experience child abuse and parental substance abuse, move frequently, and have increased exposure to environmental pollution (Sherman, 1994).

In economically deprived environments, mental health problems and family disruptions tend to be completely embedded in poly-syndromes that include not only physical health and behavioral health issues, but also other major socio-traumatic indicators. The dynamic and strong interdependency that always exists between these indicators represents a major therapeutic challenge, and could explain the challenge of producing positive therapeutic outcomes in inner city neighborhoods. In reality, across the country urban clinicians frequently report high rates of no-shows, desertion, or poor compliance with “therapeutic recommendations.” Kaplan and Saddock (1994) summarize the data as follows, “The preponderance of evidence indicates that both treated mental health disorders and symptoms of psychological discomfort are found most frequently: (1) in the lowest socioeconomic class, (2) among persons without meaningful social ties, (3) among those who do not have useful social roles, and (4) among those who have suffered the traumatic loss of significant social ties” (p. 199). This clearly means that while a condition of poverty can make people more vulnerable to stressors, such vulnerability is only partially related to income and may be primarily generated by other factors that arise in disenfranchised families. Table 1 outlines a number of the external and internal factors frequently seen in low-income and disenfranchised families and the signs or resulting impacts they often have on systemic and individual levels of functioning and well being.

**Historical Context: Family Therapy and Poverty**

Although family therapy has proven to be a very effective treatment method, in truth, success in this approach, as well as the individual therapy approach, is better among middle class families. In reality, for any form of therapy to be successful a basic...
socioeconomic foundation and a social support system must be present. Unfortunately, that is not the case in the vast majority of inner-city families.

With its traditional tendency to broaden the scope, family therapy has tried to deal with these issues by grouping individual, familiar, and environmental variables into various systemic paradigms. The first documented attempt to broaden the mental health territory from individual to family dates back to 1937 when a young psychoanalyst, Nathan Ackerman, published the article "The Family as a Social and Emotional Unit" (Guerin, 1976). Eventually, the family therapy field grew, experiencing a major breakthrough with Salvador Minuchin’s development of Structural Family Therapy. While Ackerman and other pioneers were able to describe the importance of family history and communication, it was Minuchin (1974) who operationalized and defined the inner and outer boundaries of the family structure. He was able to apply his work to disenfranchised families. In the book *Families of the Slums*, he was able to find that the struggle for survival was the primary quest for low-income families (Minuchin, 1966). Scores of poor families benefited from the structural approach, which enabled them to establish clearer hierarchies and boundaries. However, at the time, structural family therapists did not feel that plugging in socioeconomic supports was a responsibility of the therapeutic team. With a directive approach and a well-defined set of techniques, therapists concentrated on trying to foster family change from within the boundaries of the office-based practice.

In the 1980s, practitioners started to expand the territory further and the larger systems field was developed. By that time, a large web of public and private agencies was providing a large variety of social programs to provide assistance to low-income families. One of the key leaders of this new development was Evan Imber-Black, who described the influence of extended systems in the lives of families. This approach postulated that families and individuals are inherently competent and addressed the need to understand and intervene with the individual, the family, and the larger systems that may create barriers, or bridges, to that competency (Imber-Black, 1988).

Further developments addressed the need to incorporate gender, cultural, and socioeconomic issues into the practice of marriage and family therapy. This movement inspired the development of various new forms of interventions. Besides the larger systems approach, other forms of integrative models were proposed, among them: Multisystems Approach to the Treatment of Black Families (Boyd-Franklin, 1989); Multisystemic Therapy (Henggeler & Borduin, 1990); Metaframeworks (Breunlin, Schwartz, & Kune-Karder, 1992); Medical Family Therapy (McDaniel, Hepworth, & Doherty, 1992); Internal Family Systems (Schwartz, 1995); and Family Therapy Through a Cultural Lens (McGoldrick, 1998). More recently, the Ecosystemic Family Therapy model has tried to refine and better integrate the aforementioned contemporary approaches. As defined by the model, ecosystemic therapists recognize that individuals are part of many systems and take into account the possible relevance of each system to another, as well as to the clients’ presenting problem. This recognition could mean collaborating with physicians or social service providers, for example, or bringing additional people into the therapy room (McDaniel, Lusterman, & Philpot, 2001).

Notwithstanding the high level of motivation shown by family therapists to incorporate poverty-related variables into a systemic description, the fact remains that some hard-core problems tend to remain unresolved, presenting an obstacle in achieving positive therapeutic results. Certainly, clear rules and boundaries could be set or creative new narratives could be proposed to low-income families in masterful therapeutic sessions.

However, the potential impact of this one-hour-a-week remedy is outbalanced and severely damaged by such mundane but constant variables as an empty refrigerator, an intoxicated and abusive boyfriend, an eviction notice, or a violent gang across the street.

**SIMILARITIES AND DIFFERENCES WITH OTHER THERAPY APPROACHES**

CFT was developed out of a conviction that therapists’ attachment to traditional treatment methods is a fundamental obstacle for working effectively with poor families. Traditional ideas about job descriptions, program protocols, policies and procedures, theoretical approaches, and traditional therapeutic roles and boundaries form the walls of a constricting box that limit effective treatment for urban, low-income families. CFT was developed in response to the need to address five primary factors that are not traditionally considered to be a part of therapists’ responsibilities:

1. Moving family income above the poverty line.
2. Increasing availability and access to necessary community resources.
3. Forming an individualized plan for personal and professional growth.
4. Fostering personal responsibility and self-sufficiency.
5. Developing leadership skills and capacity for civic engagement.

The focus on these five indicators marks a difference of CFT from other therapies. CFT calls for a therapist with multiple skills; besides being skilled in therapeutic techniques, clinicians are expected to be familiar with coaching, case management, networking, and economic and job development strategies. Additionally, CFT requires the commitment of both therapists and clients in becoming civically engaged and working actively on finding solutions to key issues in the community where the therapy takes place. Table 2 presents a summary comparison of CFT with several other common therapeutic approaches.

**Roots of the Community Family Therapy Paradigm**

CFT has its roots in the theories of Erik Erikson, Kurt Lewin, Harry Stack Sullivan, and several family therapy models. Erikson (1950) clearly charted the sequential process of human development within the life cycle. He defined the “epigenetic principle,” explaining that development occurs in progressive life stages. For individuals to be able to move forward, each step needs to be completed. Failure to resolve a particular stage causes cognitive, social, or emotional maladjustment (Kaplan, 1994, p. 260). Specifically, Erikson described eight developmental stages, each with a corresponding conflict that needed to be resolved (e.g., trust vs. mistrust, intimacy vs. isolation, etc.). Grounded in this line of developmental theory, CFT recognizes the need for all clients to grow into the role of mature, productive, and successful adults. CFT, also, goes deeper, postulating that the underachievement, low functionality, and psychosocial malfunctions commonly seen in many low-income individuals are rooted in the lack of an appropriate level of human development. For CFT, individual maturation and family growth are seen as required and mandatory components of successful assessment and treatment.

Among the leaders of psychoanalysis, Sullivan (1953) was the first to address the influence that family and social environments had on an individual’s developing psyche. Instead of deriving from intrapsychic forces, the so-called “self system” was
### Table 2
CFT Compared to Other Interventions

<table>
<thead>
<tr>
<th>Issues Faced by Families</th>
<th>Mental Health Issues</th>
<th>Family-Systems Issues</th>
<th>Socio-Economic Issues</th>
<th>Community Issues</th>
<th>Development Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td>Depression, Personality Disorders</td>
<td>Marital Discord, Communication Problems</td>
<td>Poverty, Unemployment, Homelessness</td>
<td>Lack of Resources, Drug Dealing</td>
<td>Lack of Education and Other Skills</td>
</tr>
<tr>
<td><strong>Most Common Therapeutic Interventions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual Therapy</strong></td>
<td>Therapy medication referral</td>
<td>Individual therapy</td>
<td>Referral to social work services</td>
<td>Included in the dialogue if brought up by the client.</td>
<td>Included in the dialogue if brought up by the client.</td>
</tr>
<tr>
<td><strong>Biological Psychiatry</strong></td>
<td>Medication referral for therapy</td>
<td>Marital/Family therapy</td>
<td>Referral to social work services</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Classical Family Therapy</strong></td>
<td>Individual therapy</td>
<td>Marital/Family therapy</td>
<td>Referral to social work services</td>
<td>Included in the dialogue if brought up by the family.</td>
<td>Included in the dialogue if brought up by the family.</td>
</tr>
<tr>
<td><strong>Larger System Intervention</strong></td>
<td>Medication referral</td>
<td>Comprehensive social work intervention</td>
<td>Wrap around plan conducted</td>
<td>Empowering families in sessions, Advocacy</td>
<td>Referral to education and training programs</td>
</tr>
<tr>
<td><strong>Non-Clinical Social Work</strong></td>
<td>Referral for therapy and/or medication</td>
<td>Referral for therapy</td>
<td></td>
<td>Provides advocacy services</td>
<td>Referral to education and training programs</td>
</tr>
<tr>
<td><strong>Case Management</strong></td>
<td>Referral for therapy and/or medication</td>
<td></td>
<td></td>
<td>Provides advocacy services</td>
<td>Direct links to education &amp; training</td>
</tr>
<tr>
<td><strong>Community Family Therapy Approach</strong></td>
<td>Individual therapy</td>
<td>Marital/Family therapy</td>
<td>Teams up with others for systemic interventions, Wrap-around plan focused on increasing median family income</td>
<td>Calls for leadership training and development and civic engagement of both client and therapist, Advocacy</td>
<td>Always addressed, Life coaching, Comprehensive personal and family life development plan designed and implemented</td>
</tr>
</tbody>
</table>

**Community Family Therapy Approach**
- Calls for leadership training and development and civic engagement of both client and therapist, Advocacy
- Always addressed, Life coaching, Comprehensive personal and family life development plan designed and implemented
conceptualized as the outgrowth of interpersonal experiences. According to Sullivan, the primary role of psychotherapy is the study and transformation of the interpersonal realities of clients (Sullivan, 1953). Like Sullivan’s approach, CFT concentrates on helping clients develop connections with family members, human service providers, and community groups; all with the focus of building inner-power through healthy and effective interpersonal engagements.

Lewin (1948) adapted the field concept from physics to explain individual and group behavior. According to his “field theory,” human behavior is a function of the interaction between people and environment, together making the “life space.” The life space is a field that has “valences” or needs to be satisfied (Kaplan, 1994, p. 257). Within that field, the group’s pressure causes changes in people’s behaviors, but, simultaneously, an individual could also contribute to changes in the entire group (Weiner, 1972). One of the guiding paradigms of CFT is that in urban America, low-income people are trapped in the negative pressures of deprived and oppressive “life spaces” or “fields” in which they are “scheduled” to play the roles of underachievers. Major amounts of energy must be generated to satisfy key “valences” so they can transform their lives and foster change at a community level. People either need to be moved from or helped to develop other, more beneficial “life spaces” and social “fields.” Empowered individuals then have better chances of influencing their previous field of origin and contributing to its transformation.

Although it is rooted in the psychological theories mentioned above, in practice, CFT evolved from experimenting with several family therapy models. Initially, the approach mixed elements of structural family therapy and social work. Then, strategic and constructivist techniques and larger system strategies were added. In addition, elements of the feminist critique and cultural competency were integrated. From Minuchin, CFT adopted a directive approach and an emphasis on a structured family unit with clear boundaries, authority lines, and roles (Minuchin, 1974). From Haley, CFT incorporated the need to find creative and strategic ways of dealing with problems (Haley, 1976). From Imber-Black’s and Sluski’s work came the recognition of the need to facilitate changes in the social support systems and the understanding of the importance of social networks (Imber-Black, 1988; Sluski, 1996). Additionally, following Carter and McGoldrick, CFT began to emphasize the need to include gender and cultural issues into any type of practice (Carter and McGoldrick, 1988). In the early years of its development, CFT primarily consisted of a mixture of these elements that were commonly present in the mental health field. However, in 1993, the CFT concept was consolidated and moved into its second wave of development. It was at this time, that the approach began to step “outside of the box” and started to include non-mental health interventions aimed at generating leadership skills, family economic self-sufficiency, and political activism.

The search for meaningful and long-lasting systemic change has been the primary quest of family therapy. Traditionally, therapists have sought to foster first and second order types of change. First order change occurs within the existing system, when its rules are kept intact. Second order change requires a change in the system and the introduction of new rules into the existing system (Watzlawick, Weakland, & Fisch, 1974). Nevertheless, for disrupted and depleted family systems, the search for change through first or second order interventions can often result in only a limited effect. In these types of families, a solid transformation will only occur when there is a substantial solution to the problems of urban, poor families outlined in Table 1. CFT proposes a third order type of change in which the individual gets out of the system, gets empowered, and forms or
joins other healthier and more functional systems—while simultaneously facilitating the implementation of first and second order changes within the primary system and the surrounding local community.

PRINCIPLES AND OBJECTIVES OF COMMUNITY FAMILY THERAPY

CFT was developed upon the following guiding principles:

1. Mental health problems in poor families are embedded in a tight web of social issues that need to be resolved or at least improved.
2. Well-trained professionals who partner with clients and community agencies can successfully reduce the family level of poverty and other social issues.
3. Personal motivation for change is needed and people should assume responsibility for their own lives.
4. Personal and family problems are strongly related to individual and family underdevelopment.
5. People malfunction because of lack of “voltage” (inner and outer resources).
6. Leadership development and civic engagement contribute to the improvement of emotional and family problems.
7. Civically engaged and highly skilled therapists who provide pro bono services are poised to produce better results in fostering change.

CFT actively pursues the attainment of the following five objectives:

1. Attaining family income above the poverty line: A central component of CFT interventions is to move people from poverty to middle class.
2. Improving availability and access to new sets of resources: Referring clients to other agencies may not be good enough. A strong agreement with other providers to largely guarantee access to necessary support systems is needed.
3. Developing an individualized plan for personal and professional growth: The need for clients to assume control over their own lives is recognized as a mandate. However, for clients to be able to live independent and self-sufficient lives, a solid educational background and specific skill sets are indispensable.
4. Improving personal responsibility and self-sufficiency: Institutions and providers cannot remedy people’s problems without determining their ability to assume responsibility for their own lives. CFT proposes to help people help themselves. From the onset, clients are informed of their expected role.
5. Developing leadership skills and civic engagement: Altruism is a major curative factor. A sense of frustration and impotence to deal with community problems can be effectively conquered with leadership training and civic engagement. Scoring victories at the community level gives clients a sense of agency and empowers them to tackle inner family problems.

ASSESSMENT IN COMMUNITY FAMILY THERAPY

Therapeutic work with low-income families needs to begin with an extensive inventory of problems and assets. CFT aims to quantify the amount of negative “energy” from all past and present problems, measures the amount of positive energy from existing assets, and works on increasing the levels of both intrinsic and extrinsic power to achieve a favorable counterbalance. CFT utilizes a battery of instruments
and charts that help organize and classify multiple factors in a practical way. The Inventory of Strengths and Resources (see Appendix A) is the primary tool used and includes a graphic sheet not shown here. This inventory contains 30 indicators in three areas—psychological, support systems, and skills and strengths, divided into six sub-categories. Both the therapist and the client(s) complete this instrument, typically after the second or third session. Normally, it is completed in 10 to 15 minutes. Then they both compare notes and seek agreement on the scores. Besides the strengths and resources inventory, CFT uses, also, other traditional methods, such as psychosocial assessments, genograms, and eco-maps. Also, as an extension of these methods, CFT utilizes “community-grams”—diagrams designed to allow clients to make an inventory of assets and gaps in both the personal-intimate community and the community of resources.

INTERVENTION IN COMMUNITY FAMILY THERAPY

As stated before, CFT focuses on three treatment goals: (a) constructing an autobiography that focuses on strengths and a life plan that invites positive action and self development, (b) developing a functional and effective community network of personal and supportive resources, and (c) providing for leadership development and civic engagement. These three goals correspond to the three areas covered by the assessment. The therapeutic plan follows accordingly. Namely, therapist and client, after having agreed upon inventory scores, work together to move the scores up. This is accomplished by simultaneously developing three levels of engagement using strategies summarized in Table 3. Our experience is that this type of multi-focused work can typically be completed in 12–25 one-hour sessions in a 1–2 year period. Half of the sessions are used in the initial 2–3 months. The remaining sessions are used bi-weekly or monthly. As individual, family, and community resources are developed, the need

Table 3
Summary of CFT Therapeutic Strategies

<table>
<thead>
<tr>
<th>Strategy One</th>
<th>Strategy Two</th>
<th>Strategy Three</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engagement of First Level</td>
<td>Engagement of Second Level</td>
<td>Engagement of Third Level</td>
</tr>
<tr>
<td>Individual &amp; Family Therapy</td>
<td>Wrap Around Networking</td>
<td>Leadership &amp; Civic Engagement</td>
</tr>
<tr>
<td>Dealing with CRITICAL ISSUES</td>
<td>Activating the NUCLEAR NETWORK</td>
<td>Developing LEADERSHIP SKILLS</td>
</tr>
<tr>
<td>Developing HEALTHIER PARADIGMS &amp; DESCRIPTIONS</td>
<td>Developing an EXTENDED RESOURCE NETWORK</td>
<td>Learning SELF-ADVOCACY</td>
</tr>
<tr>
<td>Identifying and using STRENGTHS</td>
<td>Reducing and/or removing SOCIAL STRESSORS</td>
<td>Learning and using CITIZEN’S PRIVILEGES</td>
</tr>
<tr>
<td>Enhancing SELF-ESTEEM</td>
<td>Meeting BASIC HUMAN NEEDS</td>
<td>Getting engaged in CIVIC LIFE</td>
</tr>
<tr>
<td>Un-learning HOPELESSNESS</td>
<td>Increasing MEDIAN FAMILY INCOME</td>
<td>Self helping by HELPING OTHERS</td>
</tr>
<tr>
<td>Designing and implementing LIFE PLAN TO TAKE CHARGE OF ONE’S LIFE</td>
<td>Taking advantage of OPPORTUNITIES FOR UPWARD MOBILITY</td>
<td>Helping solve COMMUNITY PROBLEMS</td>
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for the therapist decreases. However, a multi-year follow-up plan is often useful to sustain improvements.

First Level of Engagement

This part of the intervention seeks to help clients increase the quality of the connection they have with their own personal history, identity, and self-worth, and to improve their overall mental health status. This work can be done through various forms of individual, couple, or family therapy. It is also complemented using educational and training services to remedy basic developmental gaps, to provide opportunities for new skills development, and to give psychological enrichment. Rather than working primarily on solving problems, CFT concentrates on increasing the capacity of individuals and families to deal with existing issues, and designing power and happiness building strategies that, in some cases, are able to solve critical problems.

Negative representations of personal or environmental facts are frequently embedded in highly influential social constructs or stated another way, “societies construct the ‘lenses’ through which their members interpret the world” (Freedman & Combs, 1996, p. 16). Issues related to unresolved grief, shame, pain, anger, frustration, and hopelessness need to be deconstructed, proposing new paradigms that not only help reframe past and present realities but also promote forward movement. In CFT semantics, the intervention aims for the re-editing of autobiographies, allowing clients to “inhabit” their own history. This type of work can be done by any of the well-known techniques described by constructivist and/or narrative therapies also. CFT has created its own techniques for this work using video or audiotapes or just asking clients to write a summary of their own history.

Case Illustration of First Level of Engagement. In the case of Rosa, the first task was to develop a therapeutic engagement, conduct a complete assessment, and help her deal with her emotional crisis. She did not meet the diagnostic criteria for a major depression, but had features related to an adjustment disorder and grief reaction. These diagnoses did not require medication, but individual counseling was necessary. Her story contained elements of victimization, defeat, betrayal, humiliation, hopelessness, desperation, frustration, and impotence. Stuck for years in the role of a submissive and dependent housewife, she was personally and professionally underdeveloped. She did not complete high school, could not speak, read, or write English, and never had a job. The therapeutic goals described in Table 3 were followed.

The initial intervention focused on helping her stabilize and re-write her story. The proposed alternative story described a relatively young, well-disciplined, dedicated, and highly respected mother who was able to raise three children who were doing well at school. It also included descriptions of a single parent who was showing signs of endurance, courage, and readiness to do whatever was necessary to help her family survive. The pain of the separation was validated, but this fact was also presented as an opportunity to be free to do the type of things that she was not permitted to do before. Coming from a family of a dominant and rigid father who never allowed her to have male friends, she had married very young, quickly passing from an over-controlling father to an over-controlling husband.

Rosa seemed to be re-energized with the new approach. Her feelings of impotence rapidly evolved to feelings of pride and honor. By the fourth session, she was already verbalizing a determination to show everyone what she was capable of doing. Subsequently, a dreams and vision exercise showed that she actually was very ambitious and had high goals for herself.
She accepted the invitation to work on a personal and professional development plan for herself.

Second Level of Engagement
This level seeks to help clients connect or re-connect with the “community of resources” that can offer sources of support and opportunities to meet basic and developmental needs. This work is primarily done through methods most commonly described as case management, outreach, community education, wraparound services, and networking. Also, therapists help clients build/re-build their “nuclear network,” the group formed by the mix of their family members and close friends. We refer to this group as the “personalized community” or “real family.”

CFT also helps clients develop and mobilize a strong social network. This network has been described by Sluski (1996) as the sum of family, friends, coworkers or school peers, and community entities such as health care or religious institutions. It is expected that therapists will tailor a special “therapeutic resource network” formed by various types of community service providers. At first, assembling this group is often time-consuming work for therapists. However, part of the operation will not need to be repeated, and the network that is assembled can later be used to assist other clients.

Case Illustration of Second Level of Engagement. Working at the second level, the intervention focused on helping Rosa identify and access the resources necessary to solve problems, generate income, and enhance development. She was connected with the following resources: (a) a local program that assisted women in her situation with free legal services, helping her get the appropriate financial support from her ex-husband, (b) the Office of Adult Education, where she was able to get English classes and complete her GED, (c) a youth agency in the community that could help her with her adolescent son, (d) a neighborhood school where she initially volunteered and was subsequently hired, (e) a community college where she registered and began taking classes, and (f) a local church where she gained new friends and ultimately a new romantic relationship.

Third Level of Engagement
CFT works with a dualistic approach in which both client and therapist get civically involved in community life. Third-level engagement refers to the connection of both clients and therapists with the neighborhood and the local sociopolitical community (see Table 4). Indicators targeted in clients and therapists are listed in Tables 5 and 6. This work is done through leadership training, civic engagement, and advocacy methods. Therapists and clients get out of office and seek to transform outside realities in the surrounding ecosystem.

The therapeutic expectation is for clients to be able to take control over their lives. This charge could be easy to follow in a perfect world where fairness and opportunities are available for everyone. But in reality, more than 30 million people in the United States live in communities where various forms of social oppression are prevalent. This reality calls for further human development work to help clients use their entire human capital, become self-sufficient, and develop a deeper sense of agency. The idea is to build the capacity for clients to be able to take care of themselves and minimize the need for therapists. This goal can be accomplished by providing leadership development opportunities or connecting clients with volunteer or action groups. For
example, they could begin by attending a parent-teacher association or church council meeting, or volunteering to help organize a street festival or a sports league.

Beyond the immediate practical benefits of accessing and exercising political power, social activism has also proven to have a positive impact on both the physical health and mental health of individuals. After conducting extensive research over many years, Putnam (2000) found a strong correlation between social engagement and wellness, noting that, “the single most common finding from a half-century of research on the correlation of life satisfaction, not only in the United States but around the world, is that happiness is best predicted by the breadth and depth of one’s social connections” (Putnam, 2000, p. 332).

For clients, the value added by civic engagement can be immense. Volunteer and community action groups can have the same curative effects sought in therapeutic groups or communities, particularly when we consider that these are not systems that have been put together temporarily, but represent real life ecosystems with higher levels of permanency. Belonging to a community action group has the potential to automatically change a client’s position in the immediate neighborhood constellation. Moving away from a position of isolation and victimization, the person is now an empowered and committed community member. Shifting from the passive role of user

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**Table 4**

<table>
<thead>
<tr>
<th>CLIENT</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Targeted Outcomes</strong></td>
<td>Commitment to process, Dealing with issues, Problem solving, Healing, Facilitating a process for personal and family change and development</td>
<td>Access and full utilization of community resources—such as, jobs, health services, child care, education, and training</td>
<td>Assuming control of own life, Getting active in the community, Joining civic or charitable groups, Solving community problems</td>
</tr>
<tr>
<td><strong>Methods &amp; Practices</strong></td>
<td>Individual and family therapy</td>
<td>Referral and case management</td>
<td>Leadership training—civic engagement and advocacy</td>
</tr>
</tbody>
</table>

**THERAPIST**

| Targeted Outcomes | Ability to relate well to the clientele, Personal commitment and motivation, Mechanisms to prevent burn out, Personal growth and development | Familiarity with existing support systems and available resources, Personal linkages with other agencies and some of their workers | Familiarity with community issues, Active participation in at least one community project |
| Methods & Practices | Supervision, Training, Coaching, and/or Therapy | Training, Networking | Leadership training, Civic engagement, Volunteer work |

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or recipient of the services and the good will of others, the person becomes the helper and provider of assistance to others. Thus, a new sense of usefulness and power is discovered or reinforced. Low self-esteem feelings can become replaced with feelings of self-worth and self-efficacy.

**Table 5**

Targeted Indicators and Examples of Developing Capacity in Clients

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Education attainment</td>
<td>a. High school completion b. College enrollment c. Professional training</td>
</tr>
<tr>
<td>2. Employment</td>
<td>a. Well-paid job with benefits</td>
</tr>
<tr>
<td>4. Life planning and management</td>
<td>a. Lifelong plan b. Discipline</td>
</tr>
<tr>
<td>6. Resource management</td>
<td>a. Knowledge of community resources b. Learning how to navigate systems</td>
</tr>
<tr>
<td>7. Self-sufficiency</td>
<td>a. Independence b. Problem-solving skills</td>
</tr>
</tbody>
</table>

**Table 6**

Targeted Indicators and Examples of Developing Capacity in Therapists

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cultural competency</td>
<td>a. Ability to be effective with different populations b. Comfort working with disenfranchised populations</td>
</tr>
<tr>
<td>2. Community engagement</td>
<td>a. Familiarity with surrounding community b. Relationships with community members</td>
</tr>
<tr>
<td>4. Life coaching</td>
<td>a. Knowledge of life-long planning</td>
</tr>
<tr>
<td>5. Economic development</td>
<td>a. Familiarity with employment programs b. Familiarity with economic development programs</td>
</tr>
<tr>
<td>7. Commitment and volunteerism</td>
<td>a. Motivation to help a particular community b. Willingness to do whatever it takes c. Willingness to volunteer d. Flexibility</td>
</tr>
</tbody>
</table>

_Fam. Proc., Vol. 43, March, 2004_
From analysis of past successful cases, there appears to be a correlation between the level of mastery clients have over their immediate environment and their ability to control their emotions and solve personal and family problems (Rojano, 1997). This finding might explain why it is so difficult to motivate some clients to follow treatment recommendations. The emerging hypothesis suggests that when a person is in a “social hollow,” with little social support and no leadership role, he or she may feel so disempowered and overwhelmed that he/she lacks the energy or motivation to take action. Metaphorically speaking, we could say that such people malfunction because of a “lack of voltage.” It is true that power can be generated from the inside out, but this is only possible when there is a constant input of external nutrients. Intrinsic power can generate extrinsic power and vice versa. Altruism and compassion can be two of the internal forces that generate motivation for self-improvement. In some way, it is easier to take care of the pain in someone else than in oneself. Once a person starts helping others, their “social position” will automatically begin to change. The person becomes a helper and no longer a non-functioning individual.

Case Illustration of Third Level of Engagement. The intervention invited Rosa to consider the possibility of becoming engaged in a volunteer project. Initially she decided to volunteer for the Parent and Teachers Association at her younger son’s elementary school. Every morning, she assisted a teacher in a classroom. This volunteer work quickly paid results. Two months later, a part-time teacher’s aide position was offered to her, and she accepted her first job. Also, she started attending community meetings led by a local minister. The minister was seeking to organize neighbors to advocate for the construction of a children’s playground in a deprived neighborhood of the city. Her giving spirit quickly moved her to a position of leadership within the group. The minister subsequently invited her to his church, where she made new friends. Helping other people seemed to have a highly positive effect on her. Several months later, on a Saturday morning, when she and 20 other volunteers were building the playground a corporation had donated, she was, indeed, a very happy woman.

The Role of the Therapist

Working constantly with destitute urban families is, per se, a very stressful job. In the majority of cases, therapists go through a predictable cycle. New professionals in the field begin with enthusiasm, ready to foster family change by applying the interventions learned in school. But just months later, they begin to recognize that following textbook strategies may not be enough, and subsequently they begin to demonstrate signs of frustration and burnout. Therapists often feel overwhelmed, not only by the multiplicity of problems at hand but also by the absence of appropriate support from supervisors, institutions, and funding sources. As a result, many family therapists across the country now avoid working with disenfranchised populations. Simultaneously, while surviving multiple socioeconomic stressors, many clients do not demonstrate high levels of compliance with appointments or other treatment recommendations. For many, the mismatch between the proposed therapeutic routine and the problems faced at home prevents them from considering family therapy beneficial enough to continue treatment. The result can be absent clients and demoralized therapists.

For therapists to be ready to practice CFT, the following elements are needed: (a) a willingness and desire to work with a particular individual and family; (b) the ability to see the client as equal, deserving the same rights and opportunities as themselves; (c) a knowledge of existing systems and resources; (d) a personal connection with providers of at least 10 different services; and (e) a basic degree of cultural competency. On the last
element, the lack of cultural competency has been found to be related to miscommunication, misdiagnosis, inappropriate treatment, ineffective case management, inadequate referrals, and non-adherence to treatment. Leaders of the family therapy field are now openly talking about the need for therapists to self-evaluate and recognize the possible negative influence of their own upbringing. Walsh wrote: “. . . We have become more aware that clinicians—as well as researchers—co-construct the pathologies that they ‘discover’ in families. . . . This makes it imperative for clinicians to be aware of their own assumptions and cognizant of cultural norms” (Walsh, 1993, p. 46).

In CFT, the therapist serves as the facilitator of a process of personal and familial development, functioning both as therapist and coach. Practitioners are expected to become “citizen therapists,” partnering with the community in various forms of social actions. In the late 1990s, the citizen therapist concept was simultaneously included in the CFT approach (Rojano, 1997) and in the Families and Democracy Project (Doherty & Carroll, 2002). CFT recognizes several stages in the process of becoming a citizen therapist, namely: (a) awareness—the therapist needs to be aware of situations where some citizens are actively working on one of more civic projects; (b) familiarity—to be civically-minded requires detailed knowledge of and specific information about the issues, facts, and other reasons that led to the development of a civic campaign, struggle, or project; (c) engagement—therapists must maintain a minimum level of connection with individuals and groups in the community; and (d) activism—a citizen therapist is one who is an active volunteer in one or more civic projects.

While a strong code of ethics needs to be always followed, therapeutic boundaries need to be flexible. CFT interventions transcend the confines of the office. They could happen at home, school, or other places. Non-traditional boundaries can be managed effectively by having frequent access to consultation with supervisors and coworkers. Therapists working with poor families frequently show signs of frustration and burnout. They feel overwhelmed by the multiplicity of problems at hand, the relative lack of success, and the absence of appropriate support. Remaining immune to the pressures, pains, and frustrations that clients bring into our offices is an impossible goal. To survive and develop resilience to the pressures of working in difficult environments, practitioners must work in partnership with others, live healthy lives, and enjoy relaxing and enriching experiences. Therapists who work in isolation are doomed to burnout.

**ETHICAL ISSUES AND FUTURE DEVELOPMENT OF CFT**

CFT goes beyond existing ethical codes and raises the bar of accountability, encouraging therapists to incorporate issues of social justice into their values. Article 6.5 of the American Association of Marriage and Family Therapy (AAMFT) Code of Ethics for Marriage and Family Therapists mandates practitioners to “recognize a responsibility to participate in activities that contribute to a better community and society, including devoting a portion of their professional activity to services for which there is little or no financial return” (Huber, 1999). This article gives a clear mandate. However, to encourage this type of work, supportive and monitoring mechanisms need to be in place. Unfortunately, contemporary reimbursement schemes force therapists into the confinement of office-bound individual therapy, which often seeks quick solutions by manipulating internal variables.
To generate a new cadre of both highly skilled and socially committed professionals, policy changes, institutional support, and regulatory reforms are badly needed. Re-writing program curricula, job expectations, and licensing criteria will certainly provide family therapists with the mandates and resources to be able to work with larger systems and, thereby, hear and respond to all types of voices and expand the scope.

CFT is a replicable model that has been effectively tried by family therapy students and practitioners in different places across the country. Therapists who have used this approach report that they have found it to be useful, but it still has not been formally adopted in its entirety by any institution. It has worked better in environments where at least a minimal level of institutional support for the model was available. Some agencies have mentioned reimbursement schemes, lack of funding for out of office community work, and fear of relaxing traditional therapeutic boundaries as areas of concern. Doing off-hours neighborhood work, bonding with inner-city multicultural communities, and working pro-bono are three challenges that have prevented some clinicians from routinely practicing the approach.

A multiyear follow up of some cases has shown promise of long-lasting effects. However, no formal evaluation of the CFT model has been conducted yet. A thorough evaluation of this approach will require a novel and comprehensive method of assessment. The study of the impact of such variables as empowerment and civic engagement will need to use creative and non-traditional evaluation tools and techniques. Even though some quantitative data could be obtained through pre and post measures of the CFT instrument, this model of therapy seems to be better suited for qualitative, ethnographic, and participatory-action assessments.

CONCLUSION OF CASE ILLUSTRATION

In Rosa’s case, therapy worked concurrently in various areas. While she was helped to deconstruct the oppression caused by her husband’s discourse of feminine submission and guilt, she hired a lawyer, completed high school (GED), registered in a community college, got a part-time job, and made new friends. The in-office therapy helped her overcome the difficulties she experienced enjoying the attraction and passion she felt for her new boyfriend. However, it was evident that she had already incorporated new positive elements into her ecosystem. Obviously, the change of one indicator could always lead to improvement of others. Social indicators targeted in levels two and three have the potential of positively impacting psychological indicators and vice versa. For example, Rosa has come to appreciate the therapeutic value of a good job, or, figuratively speaking, the healing power of “J-o-b therapy.” Simultaneously, knowing that her therapist was engaged in various pro bono projects served as a model for her. Rosa’s case shows the positive outcome of a good partnership between therapist and client. Nine months later, in session eleven, she was already having difficulty finding time in her busy schedule to come for therapy. Therapy was no longer the center of her universe.

REFERENCES


www.FamilyProcess.org


APPENDIX A

INVENTORY OF STRENGTHS & RESOURCES

Name:______________________ Date:___/___/__ Interviewer:

INSTRUCTIONS: Scores ranging from 0 to 10: 0 = Extremely poor, 10 = Excellent

AREA I: Psychological Clearance & Drive
Response Question: Is there enough emotional drive and clearance to create/enjoy a successful life?

A. Psychological Clearance
___ I-1a. SELF-ESTEEM: Thinks and feels positive about self.
___ I-2a. CLEAR GOALS: Clear goals have been decided and established.
___ I-3a. JUDGMENT: Exercises good judgment. Makes sound decisions.
___ I-4a. MENTAL HEALTH: No current incapacitating personal conflict/problem.
___ I-5a. SOBRIETY: No personal problems with substance abuse/alcohol.

B. Emotional Drive
___ I-1b. DESIRE: Desire to improve life and move forward.
___ I-2b. ATTITUDE: Willingness to do whatever it takes to move forward.
___ I-3b. ENDURANCE: Able to endure problems. Good tolerance to frustration. Persistent.
___ I-5b. SELF-HELP HISTORY: Past and present history of taking action to achieve goals.

Sub-total ______

AREA II: Support Systems
Response Question: Does the person have good/sufficient support systems available?

A. Family & Social Network
___ II-1a. HOUSEHOLD: A cohesive, supportive, and friendly family in household.
___ II-2a. FRIENDS: At least two friends who provide unconditional support and good company.
___ II-3a. EXTENDED FAMILY: Extended network provides support and company for leisure.
___ II-4a. PARTNERS: A group of individuals available to partner with in different projects.
___ II-5a. MENTORS: A group of individuals available who nurture and foster personal growth.

B. Financial & Socioeconomic Support
___ II-1b. FINANCIAL: Regular income allows for meeting basic financial needs. (Above poverty line).
___ II-2b. JOB (School): The person has a good job/good working conditions. If minor, good schooling is available.
___ II-3b. HEALTH SERVICES: Necessary health services are available and well utilized.

www.FamilyProcess.org
II-4b. SOCIAL SERVICES: Social services, enrichment programs, and opportunities are available and well used.

II-5b. NEIGHBORHOOD: Lives in a healthy, safe, and clean neighborhood.

Sub-total ______

AREA III: Skills & Strengths

Response Question: Does the person have the necessary skills and strengths to be well-positioned in his/her own social environment?

A. Basic Skills

III-1a. WORK HABITS & EXPERIENCE: Good working habits (discipline, etc.) Experience and skills in at least one type of job.

III-2a. EDUCATIONAL BACKGROUND: Appropriate education for his/her age.

III-3a. FINANCIAL MANAGEMENT: Financially literate. Has available and implements a financial plan.

III-4a. COMMUNICATION: Good communication skills. Able to express ideas well.

III-5a. INTERPERSONAL SKILLS: Good interpersonal skills. (Gets along well with people.)

B. Leadership and Empowerment

III-1b. NETWORKING: Capable of developing new working relationships and/or friends and join groups.

III-2b. PROJECT MANAGEMENT: Capable of initiating and completing a project.

III-3b. ADVOCACY: Knows how to get basic needs met from government or other agencies/institutions.

III-4b. LEADERSHIP HISTORY/CIVIC ENGAGEMENT: Serves now or has served as a leader of a group or a community project.

III-5b. QUALITY OF LIFE/RECREATION & LEISURE: Knows how to relax and enjoy life.

Sub-total ______

TOTAL SCORE: ________