Family Therapy Case Conceptualization

Creating Therapeutic Stories Across Models

Edited by **Michael D. Reiter**

ROUTLEDGE

Family Therapy Case Conceptualization

This textbook provides a comprehensive and in-depth exploration of the primary models of family therapy and helps readers conceptualize various theories around a single case. Designed as a core text for marriage and family therapy courses, this edited volume presents the conceptualization of problem formation, problem resolution, and diversity considerations from 15 of the most influential family therapy models. By applying traditional and contemporary models to a single case, the reader is able to compare and contrast the models. Each theory chapter is divided into five parts: 1) the therapeutic story of problem formation; 2) diversity considerations; 3) the therapeutic story of problem resolution; 4) a hypothetical case transcript of a first session with explanations of how and why the therapist is creating a specific therapeutic story; and 5) the developed therapeutic story. This textbook serves graduate and doctoral students in marriage and family therapy, mental health counseling, clinical psychology, and social work. The book is also a useful resource for practicing professionals who want to explore how to apply a specific model of counseling to family systems.

Michael D. Reiter, Ph.D., LMFT, is an American Association for Marriage and Family Therapy (AAMFT) Approved Supervisor, a therapist with over 30 years of experience, and a full-time faculty member for over 25 years. He currently teaches and supervises at Capella University.

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This book is dedicated to all our teachers and mentors, who taught us what it means to be a family therapist. Special recognition to a few who are no longer with us: Insoo Kim Berg, Norman Epstein, and Salvador Minuchin.

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The views expressed in this work are those of the authors and contributors and do not reflect the views of Capella University.

Preface

I want to tell you a story. A story about how this book came into being. It was born over 30 years ago, when I was first becoming a family therapist. However, that is not quite true. It was born over 100 years ago, when people first began working therapeutically with families. Actually, that's not quite true either. It was born when people began trying to conceptualize why people have "problems" and how those problems can be ameliorated. So, what I am saying here and what will be presented in this book is partial. That is all we ever see is partiality, but we make do with what we have.

Over my career, I've written and edited several books that have a similar format to this book: a sample case; presentation of the theory of problem formation; presentation of the theory of problem resolution; and a sample transcript (see Reiter, 2014, 2019, 2025; Reiter & Chenail, 2017a, 2017b). I've found that this method of theory presentation, where it is embedded within the application of the theory to a case, is extremely useful for students to help them learn the concepts as well as know how they would be used in a session.

What makes this book unique is the slant of creating therapeutic stories. Through my own clinical practice and my years of supervising Master's and Doctoral family therapy students, particularly doing live supervision, I've realized that therapy is all about storytelling. Clients come to therapy telling us their current story—one that they don't want continued. Their problem story usually involves them experiencing a limited identity (Reiter et al., 2020). In therapy, the therapist attempts to change this story so that the client experiences themselves as having more personal agency.

The question becomes: What is the therapeutic story that gets developed? That is the crux of this book. Each model of therapy has its own slant to what is included in the therapeutic story. Some will focus on the client's parents and grandparents. Others will include the client's childhood and relationship with parents. Others will highlight what is happening in the therapy room. Others will include the future in the therapeutic story. While not all therapists operating from the same model will construct the same therapeutic

story with the same family, there will likely be consistent themes. What is presented in this book is just one construction of a therapeutic story from the model. I encourage you to explore how, based on your understanding of each model, you might have constructed a different story.

This is a book about family therapy but also about family. For over 20 years, I was a faculty member at Nova Southeastern University. That was my family, as I received my doctorate in family therapy from there as well as met my wife there—as we both were hired the same week in 1999. Recently, I have been a faculty member at Capella University. They have taken me in so that I could become part of that family as well. Most of the authors in this book are either my Nova or Capella "family members." A few other authors I have gotten to know are from outside of the family. I want to thank all of the contributors to this book: Roxanne Bamond, Marina Bluvshtein, Weston Crafton, Keran Flynn-Kroska, Arlene Brett Gordon, Anastasia B. Hanson, Coreen Haym, Kelly Heenan, Tequilla Hill, Todd Workman Jesness, Kyle Killian, Rosemary Leone, Claire Loucka, Pei-Fen Li, Ashley McErlean, Cindy McIntire, Carol Messmore, Matt Pace, Woochul Park, George A. Pate, Anne Prouty, Carlos Ramos, Natalie Richardson, Kayleigh Sabo, Jon Sperry, and Len Sperry. Thanks also to my wife, Yukari Tomozawa, for creation of the genogram of the Daniels family. Special thanks to my good friend, Michael Reign, for allowing the use of one of his paintings as the cover artwork.

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1 Creating Therapeutic Stories

Michael D. Reiter

What occurs in the process of psychotherapy? How does psychological and interpersonal change take place? What mechanisms enable clients to leave therapeutic sessions with a transformed experience of themselves and their lives? These fundamental questions have occupied the field of psychotherapy since the emergence of talk therapy approximately 150 years ago. The answers to these questions vary depending on the theoretical orientation of the practitioner. This book examines how 15 distinct models of family therapy conceptualize and address these core issues. Through an exploration of case conceptualization and the construction of therapeutic stories, the book investigates the diverse ways in which these models facilitate therapeutic change.

Case Conceptualizations

Case conceptualization is widely regarded as a foundational competency for mental health professionals (Sperry & Sperry, 2020, 2023; Stanton & Welsh, 2011). It serves as a critical mechanism through which therapists organize clinical information, formulate treatment goals, and develop effective intervention strategies. As Gilboa-Schechtman (2024) articulates, a robust case conceptualization comprises three core elements: (1) an accurate depiction of the client's current psychological functioning, (2) the identification of appropriate and achievable therapeutic goals, and (3) the development of a coherent plan—or roadmap—for facilitating change. Through the integration of these components, clinicians are better able to understand the client's presenting concerns, envision meaningful outcomes, and delineate a pathway toward therapeutic progress.

Stanton and Welsh (2011) propose a similar tripartite framework for case conceptualization, emphasizing the sequential progression through three stages: *Problem Identification*, *Case Understanding*, and *Treatment Planning*. In the first stage, Problem Identification, clinicians define the presenting issues, typically during the initial phase of treatment. The second stage, Case Understanding, involves the construction of an interpretive framework that

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explains the development and maintenance of the identified problems. Finally, Treatment Planning focuses on selecting interventions that are both theoretically grounded and practically suited to resolving the client's difficulties.

Sperry and Sperry (2023) expand upon these models by delineating four interrelated domains of case conceptualization: *diagnostic*, *clinical*, *cultural*, and *treatment* formulations. The **diagnostic formulation** addresses the question, "What is happening?," and aims to assess the nature, scope, and severity of the client's presenting issues. The **clinical formulation** focuses on the underlying question, "Why is this happening?," seeking to explain the etiology and maintenance of the problem through a specific theoretical lens. Depending on the therapist's orientation—whether cognitive-behavioral, solution-focused, psychodynamic, or systemic—the explanation for a given concern will vary, integrating intrapsychic dynamics, relational patterns, and broader contextual influences.

The **cultural formulation** further explores the "what," but does so through a sociocultural lens. It examines how aspects of the client's cultural background, identity, and lived experiences shape the emergence and expression of psychological distress. Finally, the **treatment formulation** addresses the question, "How can change occur?" This component outlines the goals of therapy, specifies the interventions to be employed, and details a strategy aligned with the client's values, context, and therapeutic needs.

At its essence, case conceptualization operates as a working hypothesis or clinical theory that explains the client's experience and behavior. It synthesizes empirical data, contextual knowledge, and theoretical insight to guide the course of therapy (Eels, 2022). As such, it functions as a dynamic and evolving roadmap, informing therapeutic decision-making throughout the treatment process.

A point of ongoing debate in the literature concerns whether case conceptualization and treatment planning should be conceptualized as discrete processes. Zubernis (2016), for instance, argues for treating them as distinct, while others—such as Reiter (2014, 2025)—advocate for a more integrated view, in which case conceptualization inherently includes both an understanding of problem formation and an articulation of how change is expected to occur.

In this book, case conceptualization is framed as encompassing two interdependent narratives: the *therapeutic story of problem formation*, which accounts for how the client has arrived at their current state of functioning; and the *therapeutic story of problem resolution*, which outlines a prospective pathway toward improved functioning and well-being. This dual-focus approach positions case conceptualization not merely as a diagnostic tool, but as a narrative and strategic framework that underpins the entire therapeutic process.

Therapy and Storytelling

"Stories can powerfully communicate what it is like to be in the world and can provide opportunities to change our view of reality" (Crawford et al., 2004, p. 1). Mental health professionals frequently incorporate metaphors and

storytelling into their sessions to help individuals see their experiences through a different lens. Often, these narratives parallel a client's own life circumstances. What is often overlooked, however, is that therapy itself unfolds as a narrative. The therapist co-constructs a therapeutic storyline that guides the client toward transformation.

Stories are deeply embedded in how humans understand themselves and their environments. They function as the medium through which individuals define their identities and roles in the world. According to White and Epston (1990), this "storying" of experience allows people to feel continuity and coherence in their lives, offering a framework to structure daily life and interpret new situations. Dwivedi and Gardner (1997) further emphasize that individuals assign meaning to their lives through the act of storytelling, creating narratives that help them make sense of their experiences. These stories are usually personal since stories that are pertinent to the client tend to be remembered (Bergner, 2007).

Narratives not only help us process our own lives—they also enable us to connect with others. As Crawford et al. (2004) observe, stories have the unique ability to convey lived experiences and reshape our understanding of reality. When individuals internalize a story, it begins to regulate their self-perception, reinforcing or filtering experiences based on its message. For example, someone who identifies as socially anxious may consistently recall moments when they avoided interaction, while ignoring instances where they engaged confidently. However, if they were to view themselves differently—not as a socially anxious person but as a socially comfortable person—they would likely pay more attention to those times that they were more easily able to connect to others socially rather than those times they avoided interactions.

One widely recognized framework for understanding narrative structure is **Freytag's Pyramid**, introduced in 1863 by Gustav Freytag. Originally designed to map out the structure of fiction, this model has been widely applied across fields such as digital storytelling (Ciğerci & Yildrim, 2024), marketing (Quesenberry & Coolsen, 2019), and music (Simon, 2019). The pyramid outlines five components of plot development: exposition, rising action, climax, falling action, and dénouement.

The **exposition** introduces the characters, setting, and foundational context. In family therapy, this phase would involve understanding the relationship history of the parents, when children were born, demographics, and social identities of the individuals. For instance, Sheldon and Sondra Parsons have been together for 15 years. Sheldon is a 48-year-old African American from the Southern U.S. working in pharmaceutical middle management, while Sondra, 46, is an Asian American science teacher who immigrated from China to New York during childhood. They have two children, Yumi and Zaden, who are 12 and 10, respectively.

Rising action introduces the central issues—why the family has sought therapy. These might include trust issues, frequent conflict, or communication

struggles. Unlike single-protagonist stories, family therapy typically involves two or more main characters with differing views. For example, Sheldon feels Sondra is too lenient with the children, while Sondra believes Sheldon is too strict. Though their interpretations differ, both agree that the relationship is strained and needs repair. Yumi and Zaden are intimidated by their father and tend to seek out their mother.

The **climax** is the critical turning point, often marked by breakthroughs in therapy. Here, therapeutic intervention helps transform conflict into understanding and distance into emotional closeness. This shift often brings forward the main theme of the family's narrative—moving from disconnection to reconnection. Kühn and Boschoff (2023) note that this central message is usually crystallized during the climax phase. For the Parsons, the therapist presented a reframe of rather than viewing their parenting differences as a conflict, Sheldon and Sondra's contrasting approaches can be understood as a blending of cultural strengths—discipline and warmth—that, when integrated, could offer their children a more balanced and adaptive developmental environment.

At this stage, various therapeutic models can be applied. Research shows that while no single method dominates in effectiveness (Miller et al., 1997), using a defined model accounts for about 15% of therapeutic improvement (Lambert, 1992). Other factors include clients' lives outside therapy (40%), the quality of the therapeutic relationship (30%), and client expectations and hope (15%) (Lambert, 1992; Lambert & Bergin, 1994). Regardless of the model used, this part of the journey involves helping clients reshape their existing story into one that aligns more closely with their goals and values.

The **falling action** reflects how the family starts adapting to this new narrative. This is when entrenched patterns are replaced with healthier dynamics. In the Parsons family case, Sheldon and Sondra begin to see their relationship as a partnership built on mutual support rather than disconnection. Their focus shifts from past grievances to present connection and future possibilities. They shift from a story of being at odds with one another to a story of being a team, working together to parent their children. Further, the foursome shifts their story from "Dad is too strict" to "We are a family that gets along."

Finally, the **dénouement** marks the resolution and closure. This typically aligns with the conclusion of therapy, where the family transitions from therapeutic support to independent functioning, ideally with a renewed sense of connection and hope. This stage happens for many families since family therapy tends to produce positive change, as the efficacy of family therapy is well-documented (Carr, 2020; Wittenborn & Holtrop, 2021).

Recursive Frame Analysis

Within the broader landscape of psychotherapy, Brad Keeney's *Recursive Frame Analysis* (RFA) offers a distinctive framework for understanding the dynamic, evolving structure of therapeutic dialogue (Keeney, 2009; Keeney et al.,

2012, 2015). RFA conceptualizes therapy as a performative and recursive process, organized into a narrative arc composed of three acts. These acts reflect the trajectory of therapeutic transformation: from an impoverished experience, through a transition, and culminating in a resourceful experience.

The first act captures the initial state of client distress, characterized by rigid self-concepts and problem-saturated stories that constrain behavior and perception. Drawing on Watzlawick et al.'s (1974) notion of problem maintenance through attempted solutions, Act I represents a condition of being "stuck"—a state in which clients operate from habitual interpretations of self and others that reinforce dysfunction and erode hope. For the Parsons family, this act is illustrated by ongoing conflict regarding parenting styles and a mutual expectation that their difficulties are enduring and intractable. Within this narrative frame, the family perceives itself as locked into a pattern of interpersonal frustration and diminishing connection.

The second act introduces a critical turning point. Here, the therapist facilitates the emergence of alternative perspectives through reframing,[1] thereby creating narrative space for change. This phase is marked by a movement away from the impoverished storyline toward a therapeutic re-storying process. Regardless of theoretical orientation, therapists shift the initial problem-saturated narrative to one that promotes greater client personal agency. In the case of the Parsons family, Act II is initiated when the therapist frames their parenting conflict—not as a dysfunction, but as a reflection of diverse strengths that, if integrated, could enhance family functioning. This reframing signals the beginning of a new therapeutic story, imbued with hope and possibility.

The third act signifies the consolidation of change. Clients begin to internalize and enact a revised, more empowered narrative identity—what Reiter et al. (2020) describe as the transition from a limited identity to a resourceful one. This stage involves not only insight but behavioral embodiment of the new story in everyday life. For the Parsons family, this might involve a shift from viewing themselves as a "family in conflict" to a "collaborative team," capable of adaptive and responsive parenting. The new narrative promotes agency, resilience, and redefined relational patterns.

RFA is a versatile heuristic that can be integrated across therapeutic models to both track and facilitate change. For example:

- **Bowenian Family Therapists** may map the progression as:

  Act I—Emotional fusion and reactivity
  Act II—Exploration of multigenerational patterns and differentiation
  Act III—Thoughtful, differentiated decision-making

- **Narrative Therapists** might frame the journey as:

  Act I—Dominant, internalized cultural discourses
  Act II—Deconstruction and externalization
  Act III—Re-authoring preferred stories grounded in agency

- **Emotionally Focused Family Therapists** could represent the transformation as:

  Act I—Entrenched negative interaction cycles
  Act II—Exploration of attachment needs and vulnerabilities
  Act III—Development of secure, emotionally responsive engagement

While the thematic contours of each act may vary based on the family's cultural context and the clinician's theoretical orientation, the underlying structure remains consistent: clients begin with limited identities, move through transformation, and end with a sense of a more expansive and resourceful identity.

Structuring Change Through Conceptual Frameworks

In family therapy, therapists rely on their case conceptualization to understand relationship dynamics and guide therapeutic change. For this framework to be meaningful, it must shape the structure and delivery of therapy. Clients place high value on their therapist's ability to organize the therapeutic process effectively (Madden & Timulak, 2024). A core element of this structure involves crafting a **therapeutic story**—a storyline that engages clients and moves them toward their goals. For this narrative to be effective, it must resonate with the clients, capturing their interest and encouraging their participation. As Crawford et al. (2004) note, the stories constructed in therapy reflect the intentions of the storyteller and the cultural and professional context in which they arise.

Conceptual frameworks, while rooted in theory, only become impactful when they are enacted and embraced by clients. Corrie and Lane (2010) pose a critical question: "Who owns the case formulation—and who has the authority to approve, reject, or revise it: the therapist, the client, or someone else?" (p. 51). While clinicians develop and present these stories, clients are ultimately the ones who determine whether the story fits and whether change is possible. Therapists create the conditions for transformation, but it is the clients who must engage with and act on those possibilities. Thus, therapeutic stories are only beneficial when therapists and clients utilize them.

Therapy is inherently a collaborative endeavor. A therapist's conceptualization cannot singlehandedly lead to change. Unless clients accept and engage with the therapist's framing of the problem, they are likely to remain embedded in their own initial perspective. Framing, therefore, is a central element of persuasive and effective therapy (Cheng, 2016). Each individual in the room brings a unique worldview or position regarding the issue at hand. Fisch et al. (1982) referred to this as the "patient's position," asserting that the therapist must understand and work with this viewpoint to foster therapeutic engagement.

In family therapy, each family member often arrives believing that the source of the problem lies in another person. Clients may cite communication

breakdowns but typically believe the breakdown stems from the other's behavior. One of the family therapist's primary responsibilities is to shift these individual frames into an interpersonal context. While clients tend to interpret problems as individual flaws, the therapist redirects focus to relational dynamics (Reiter & Chenail, 2016). Over time, this shift encourages clients to reframe their experiences as part of a shared interaction, rather than a one-sided issue (Moran et al., 2005).

For reframes to be effective, they must align—at least partially—with the client's worldview. As Fisch et al. (1982) explain, it's not just the content of a suggestion that matters, but the manner in which it is presented. What works for one client might be unconvincing to another. Understanding a client's position—including factors like culture, race, gender, age, and sexual orientation—helps therapists shape feedback in a way that feels authentic and acceptable. The therapist's systemic insight becomes truly impactful when this feedback is both relevant and agreed upon by the client (Stanton & Welsh, 2011).

Frames function as vehicles for progress. According to Sussman (1999), framing provides structure, justification, and meaning. For the therapist's narrative to take hold, it must make logical and emotional sense to the clients. The frame's perspective gives context; its rationale links the evidence (such as client behaviors or exceptions) to that context; and its structure shapes how clients interpret past, present, and even future events. In this way, framing helps construct a cohesive therapeutic story.

In family therapy, **reframing** is a vital tool. It does not alter the facts but reinterprets their significance (Watzlawick et al., 1974). As Weeks and D'Aniello (2017) describe, reframing invites clients to see the same circumstances through a new lens—one they co-create and are willing to accept. Effective reframes in family therapy are often interactional, reducing blame and increasing hope (O'Brien & Young, 2014). They help shift emotional tone and foster more constructive attitudes (Robbins et al., 1996). A systemic reframe offers a fresh angle that helps families make better sense of their shared experience (Weeks & D'Aniello, 2017).

Clients frequently arrive in therapy with a narrow, zoomed-in view of what's wrong—usually placing blame on the identified patient. Family therapists, however, work from a broader vantage point, offering alternate interpretations that open new possibilities (Minuchin et al., 2021). A well-placed reframe expands the clients' sense of identity and agency, revealing that they are more resourceful than they previously believed.

Constructing the Therapeutic Story

When a reframe becomes part of a case conceptualization, it often evolves into a **therapeutic story**. These narratives are usually constructed in story form, which helps clients integrate new perspectives into memory and identity

(Bruner, 1990). Though reframes are often brief, those rooted in case conceptualization provide a lasting foundation for change.

Therapists tend to develop affirming and optimistic frames in their conceptualizations—developing a therapeutic story that emphasizes growth, connection, and possibility. While these positive frames are typically helpful, there is a risk that clients may perceive them as overly persuasive or disconnected from their lived experience, triggering resistance or disbelief (Koch & Peter, 2017). This highlights the importance of grounding reframes in observable client strengths and experiences, such as exceptions or unique outcomes.

However, negative or undermining frames—such as viewing the relationship as beyond repair or suggesting separation as the only option—are associated with poorer outcomes and shorter therapy duration (Doherty et al., 2024). Fortunately, such approaches are rare. Most therapists frame the therapeutic story in a way that aligns with the family's aspirations, reinforcing the belief that improvement is achievable. Hoyt (2000) explained that "therapy can be understood as the purposeful development of a more functional story; 'better' stories are those that bring more of what is desired and less of what is not desired" (pp. 21–22).

While the use of storytelling has been frequently utilized in psychotherapy (see Bergner, 2007; Crawford et al., 2004; Perrow, 2012), these stories may be separate yet adjacent to the client's actual experience. They tend to be metaphors in hopes that the client takes some meaning from. The therapist may have stock stories that they can use for a multitude of clients who fall within a certain category (e.g., for individuals experiencing depression; for couples dealing with an infidelity; or for families who had a member recently die). In this book, we will talk about therapeutic stories—how the therapist conceptualizes and explains the client's situation. Andolfi et al. (1989) explained the purpose of constructing a therapeutic story, "Within this temporary and 'artificial' story, it is possible for the family to learn how to find different meanings for the events and interactions of family life and eventually to try out new alternatives in real life" (p. 16).

Each model of therapy has various techniques associated with them. Yet, techniques and interventions on their own are just techniques. They are not cure-alls. However, how techniques are put together and interwoven leads to the construction of a therapeutic story that can be useful.

Continuing the Story of Case Conceptualizations

Developing effective case conceptualizations in family therapy extends beyond the identification or diagnosis of problems. It involves the construction of therapeutic stories that facilitate meaningful change and resonate with clients' lived experiences. Through the processes of framing and reframing, clinicians introduce alternative perspectives on interpersonal difficulties—shifting the focus from blame to relational understanding, and from limitation to potential.

These therapeutic stories not only clarify the direction of treatment but also invite clients to envision themselves and their relationships in more hopeful and empowering ways.

Chapter 2 examines the utility and impact of case conceptualizations within the context of family therapy. Importantly, no single theoretical model holds a monopoly on effective case formulation. Rather, each model offers a valid and potentially transformative pathway toward the family's goals. This reflects the systems theory principle of **equifinality**, which posits that there are multiple routes to achieving the same outcome.

Chapter 3 introduces the Daniels family—a fictional composite drawn from clinical experience—who will serve as a case study throughout the remainder of the volume. The subsequent chapters present 15 distinct models of family therapy, each illustrating how the Daniels family might be conceptualized and how a unique therapeutic story might emerge from that model's perspective.

It is important to note that while 15 distinct case conceptualizations are offered, these represent only a subset of the possible stories that could be generated—even within a single theoretical model. Therapeutic stories are inherently co-constructed within the specific therapeutic system that includes the practitioner, the family, and the broader context in which therapy occurs. They are shaped not only by theoretical orientation but also by timing, relational dynamics, and the particular needs and resources of those involved.

The aim of this book is to encourage readers to reflect on their own clinical work through the lens of case conceptualization. Specifically, it invites emerging and experienced clinicians alike to consider: How do I construct case conceptualizations that lead to the creation of therapeutic stories which are both useful and transformative for my clients?

Note

1 Reframing is being used here to explain how a therapist takes the client's initial problem-focused frame and reframes it into a therapeutic story that highlights the client's strengths and resources.

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2 The Effectiveness of Case Conceptualization

A Brief Primer

Kyle D. Killian

A central premise of this edited volume is that case conceptualization is crucial to successful therapeutic processes and outcomes. Effective case conceptualization is a core clinical competency for all trainees and therapists. This chapter focuses specifically on the use of case conceptualization by family therapists, given this book's focus on family therapy case conceptualization. A successful case conceptualization provides a systemic, context-sensitive, parsimonious model of client functioning; outlines relevant, overarching treatment goals and their associated assessment procedures; and presents a treatment plan with intervention phases. This chapter presents evidence for case conceptualization's contributions to positive processes and outcomes, making the case for why it is a critical component of our work as clinicians.

Importance of Case Conceptualizations

Through case conceptualization, we seek to write a concise and coherent story (Reiter & Sperry, 2025) that offers a credible framework for understanding the client's difficulties and informs treatment planning (Eells, 2022; Persons, 2022; Sperry & Sperry, 2026). A theory-informed, comprehensive conceptualization can lead to the development of a flexible, effective treatment plan (Gilboa-Schechtman, 2024). Ideally, case conceptualization: (1) strives to provide a comprehensive understanding of clients' presenting concerns, strains and symptoms, and systemic, relational patterns, and (2) is an *ongoing* process wherein the therapist works to revise, update, and refine it "via new information, insights, and responsivity to specific triggers and interventions" (Gilboa-Schechtman, 2024, p. 2). In best practice, therapists would remain open and attuned to signals from clients (e.g., communications about misalignments in treatment tasks or goals) (Zilcha-Mano et al., 2020), indicating directions for possible modifications or fine-tuning of the case conceptualization (Kealy & Curtis, 2025). Thus, therapists' openness to feedback and responsiveness via reevaluation of a case formulation over the course of treatment is crucial to fostering positive outcomes.

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It can be argued that since case conceptualization is a metacognitive competency of couple and family therapists, training and practice are necessary (Seif et al., 2014; Wall, 2021). Trainers and supervisors can seek to develop trainees' ability to assess the completeness of their case conceptualizations by aiming to fulfill the following seven characteristics:

> (a) *comprehensive* in addressing multiple aspects of a client's functioning; (b) *understandable* to the client and thus use language that is precise and non-technical; (c) *parsimonious* yet not simplistic; (d) *coherent*, providing an internally consistent model of the individual's problems, explaining the presenting complaints by reference to predisposing vulnerabilities and strengths, precipitating events, etiological and maintaining factors; (e) *science-informed*, offering explanatory hypotheses linked to knowledge about personality and psychopathology; (f) *generative*, highlighting the ways in which the treatment plan logically flows from the explanatory hypotheses and predicts measurable outcomes; and finally, (g) *cohesive*, offering a treatment plan that links the hypotheses with a therapeutic course of action.
>
> (Gilboa-Schechtman, 2024, p. 6, emphasis in the original)

As we seek to aid therapists to form ever more comprehensive case conceptualizations, specific teaching activities include Chalkboard Case Conceptualization (Eells, 2013), Concept Mapping (Novak & Cañas, 2010), Creative Role Play Activity (Hinkle & Dean, 2017), and Scenarios with Fictional Characters (Cook, 2018).

Case conceptualization skills have been studied using different methods, with researchers attempting to parse different skill sets and/or levels. Lee and Tracey (2008) cited examples of the conceptual level (Holloway & Wampold, 1986), convergent or divergent conceptual strategies (Hirsch & Stone, 1983), cognitive processing (Hillerbrand & Claiborn, 1990), concept mapping (Martin et al., 1989), and cognitive complexity (Ladany et al., 2001). Perhaps unsurprisingly to systemically oriented practitioners, the major takeaway from this research is that conceptualization is best when it reflects high levels of complexity, convergence, abstraction, and integration (Lee & Tracey, 2008). The general conclusion of the research is that clinicians with more training or experience tend to create conceptualizations that demonstrate higher-order cognitive skills outshine their peers on expert ratings.

CFTs engaging in a comprehensive case conceptualization apply multiple metacognitive skills, including monitoring of client and therapist responses, analysis, synthesis, and evaluation of diverse "information streams to develop a cohesive narrative or structure that fosters an understanding of clients' presenting concerns and strengths (e.g., development, course and maintenance) within the clients' varying sociocultural context" (Wall, 2021, p. 5). Case conceptualization also steers CFTs through the steps of diagnosis, recommendations, goals, and interventions (Haynes et al., 2021; Wall, 2021).

A subarea of interest is *multicultural* case conceptualization. There has been a dearth of process-oriented guidance for increasing the cultural responsiveness of evidence-based practice in family therapy. Nevertheless, studies have highlighted how cultural context can deeply affect the way in which individuals and families view therapy and therapy services (Georgiadis et al., 2020; Graham-LoPresti et al., 2017; Kirmayer & Jarvis, 2019; Lewis-Fernandez et al., 2020; Zigarelli et al., 2016). Ideally, therapists seek to develop a picture of clients' functioning across multiple systems and domains, including work, school, social network, and culture (Ridley et al., 2017; Wall, 2021). Sanchez et al. (2022) pointed out that "most evidence-based treatments have been developed mostly within the majority White culture and largely by White clinical innovators and researchers, leading to a lack of systematic consideration of cultural factors relevant to mental health care" (p. 751). Sanchez et al. (2022) stressed the need for more culturally responsive approaches, underlining "how leading case conceptualization models fail to systematically incorporate cultural formulation into assessment and treatment planning" (p. 751), and offered practice guidance for systematically incorporating relevant cultural factors into case conceptualization in the context of family therapy. They defined cultural responsiveness in terms of "the intentional use of strategies that incorporate their [the clients'] cultural backgrounds, beliefs, and values into treatment" (p. 751).

Eschewing a "one size fits all" treatment approach that tends to ignore important individual differences, as well as the significance of intersectionality, a culturally informed case conceptualization allows therapists to ensure that treatment interventions and strategies are relevant to clients' specific needs and contexts (Easden & Kazantzis, 2018; Sanchez et al., 2022). Leveraging cultural assessment permits incorporation of cultural factors into the five stages of Christon et al.'s (2015) science-based case conceptualization model. Conducting a cultural assessment as part of Stage 1—integrating evidence-based assessment—can improve the therapists' understanding of the family's presenting problems. Asking families about their cultural values and strengths shows that therapists value their perspectives. Therapists can identify presenting problems in a culturally responsive way by asking questions such as what is the client's/caregiver's description of their problem, and what troubles the client/caregiver most about their problem? The second stage, generating and assigning diagnoses, can be made culturally responsive by including a review of the cultural definition of the problem and reviewing DSM-5 cultural contexts of distress. Stage 3, development of hypotheses, can include the following questions from the Cultural Formulation Interview: What does the client/caregiver think is causing their problem? Are there stressors that make the client's problem *worse*? Are there aspects of the client's/caregiver's background that make a difference to their problem or are causing them more difficulties (Sanchez et al., 2022)? For Stage 4, treatment plan and selection, Sanchez et al. (2022) suggested inclusion of the following Cultural Formulation Interview questions: Are there any kinds of supports that make the problem better? What types of help have been most

and least useful to the client/caregiver? Has anything prevented the client/caregiver from getting the help they needed? For Stage 5, ongoing treatment monitoring and evaluation, Sanchez et al. (2022) suggested that therapists discuss cultural strengths, acknowledging values consistent with treatment goals.

Evidence of Effectiveness of Case Conceptualization and Case Conceptualization Training

Case conceptualization is the core of evidence-based practice (Hass et al., 2022). However, studies (e.g., Lau et al., 2017) demonstrate that there continues to be a shortage of clinicians who have received training in the use of case conceptualization to guide decisions regarding treatment, and who have developed the capacity to consistently utilize evidence-based treatments (Austin et al., 2025). Studies on case conceptualization skills in training are of vital importance because these skills are associated with therapy outcomes (Kendjelic & Eells, 2007; Kuyken & Dunn, 2022; Lee & Tracey, 2008). For instance, in the field of psychotherapy, case conceptualization skills are correlated with the degree of therapeutic skill (Morran, 1986) as well as client and observer ratings of therapeutic effectiveness (Morran et al., 1994). Accuracy of therapist conceptualizations has also been found to correlate with client progress (Silberschatz et al., 1986) and positive treatment outcomes (Crits-Cristoph et al., 1988). Despite the importance of understanding how psychotherapy trainees develop in case conceptualization skills, a dearth of research has been conducted in this area (Kendjelic & Eells, 2007; Ladany, 2007; Neufeldt et al., 2006). What follows is a brief review of studies conducted on case conceptualization and the effectiveness of therapy.

Research indicates that "effective case conceptualization is associated with improved client outcomes and shorter lengths of treatment" (Austin et al., 2025, p. 2). For instance, using a sample of 72 early- to mid-career clinicians, Austin et al. (2025) provided a series of trainings using an iterative process where feedback was incorporated throughout and participants' knowledge, self-efficacy, and clinical practice (i.e., evidence-based treatments or EBTs) were assessed pre- and post-completion of the series. The training included dissemination of information on evidence-based interventions and case conceptualization. Austin et al. (2025) concluded that the training was "feasible, effective for improving master's prepared clinicians' self-efficacy surrounding the utilization of EBTs and case conceptualization in clinical practice, and cost-efficient for participants" (p. 1).

Difficulties in applying case conceptualization theory and knowledge in everyday clinical practice persist (Austin et al., 2025; Dudley et al., 2015). When case conceptualization is ineffective, therapists can wind up mismatching symptoms and interventions (Austin et al., 2025; Calloway & Creed, 2022). Research has shown that beginning therapists tend to be "less methodical, more confident in their case conceptualizations, and more likely to consider

less robust treatment options" (Austin et al., 2025, p. 2) when compared to their more experienced counterparts (Dudley et al., 2015). Interestingly, experienced therapists "endorse *low* confidence in their case conceptualization skills, again, indicating that experience and training in case conceptualization are needed to leverage the skills of the existing workforce (Zivor et al., 2013)" (Austin et al., 2025, p. 2). This seems to be a case of less experienced therapists not knowing what they don't know or what they aren't doing as effectively, and more seasoned therapists having an awareness that their case conceptualization skills and use of EBTs could be better.

Eells et al. (2005) conducted a study of a group of 65 clinicians, classified as novice, experienced, and expert, who constructed comprehensive conceptualizations based on six standardized vignettes with a range of presenting problems and disorders. A total of 390 case conceptualizations were created. After reading the case vignettes, therapists took five minutes to verbalize aloud a case conceptualization in an unstructured manner with instructions to "address whatever you think is important." The transcribed case conceptualizations were coded using the Case Formulation Content Coding method (Eells et al., 1998). Then, multiple 5-point Likert scales were rated by pairs of raters to judge the relative presence versus absence of specific skill sets. "Precision of language" (ICC = 0.77), "complexity" (ICC = 0.83), "coherence" (ICC = 0.75), "treatment plan elaboration" (ICC = 0.86), "goodness-of-fit" (ICC = 0.73), and "systematic process" (ICC = 0.77) reflected good to excellent levels of reliability. The study's findings indicated expert conceptualizations were rated as more comprehensive, elaborated, complex, systematic, and better quality overall when comparing experienced with beginning therapists.

Investigating therapist training in conceptualization, Kendjelic and Eells (2007) provided a 2-h conceptualization training session for 20 novice therapists; a control group of 23 therapists did not receive the training. Using data from 99 conceptualizations of anxious and depressed clients, the researchers found a large mean effect size of 1.12, with the average therapist in the training group producing a better case conceptualization than 86% of the therapists who had not received the training. In a subsequent analysis of data from this study, Eells et al. (2011) found that experts had a greater focus on treatment ($d = 0.34$) and psychological mechanisms of change ($d = 0.25$) than nonexperts, and experts generated more descriptive ($d = 0.33$), diagnostic ($d = 0.24$), inferential ($d = 0.35$), and treatment planning information ($d = 0.32$) in their case conceptualizations than nonexperts.

In a study of seven therapists delivering Cognitive Behavioral Therapy (CBT) to 28 adults presenting with depression, Easden and Fletcher (2020) used the Conceptualization Rating Scale (CRS) to comprehensively assess therapist competence in case conceptualization by rating recordings of 225 therapy sessions over the course of the first ten treatment sessions. Using multilevel modeling (MLM) analysis and controlling for time, Easden and Fletcher

(2020) found therapist competence in case conceptualization explained 40% of within-client variance, and 19% of between-client variance, measured as positive change on the Beck Depression Inventory II. Easden and Fletcher (2020) concluded that increased therapist competence in using case conceptualization is associated with greater reductions in depressive symptoms.

Regarding multicultural case conceptualization research, in a series of studies, Constantine (2001a, 2001b) provided psychotherapy trainees with a vignette about a client of color presenting with multiple culturally laden concerns and asked trainees to write a conceptualization including etiology and treatment planning (Lee & Tracey, 2008). Multicultural case conceptualization skills correlated positively with empathy (Constantine, 2001b), ethnic tolerance attitudes (Constantine & Gushue, 2003), and, importantly, multicultural training (Constantine, 2001a, 2001b; Constantine & Gushue, 2003). Further, trainees of color were found to demonstrate higher multicultural case conceptualization abilities than White trainees (Constantine, 2001a). In a qualitative study exploring the general and multicultural case conceptualization skills of psychotherapy trainees, Neutfeldt et al. (2006) exposed 17 trainees to two video vignettes of clients (one upper-middle-class, retired, European American male, and one young, Chinese American, female college student). A semi-structured interview followed each video. Interestingly, Neutfeldt et al. (2006) found psychotherapy trainees incorporated more diversity factors in their conceptualization of the White client versus the Asian client. Finally, studying doctoral-level trainees' case conceptualizations, Wright et al. (2023) investigated whether the integration of culture into the conceptualizations/formulations was influenced using the Wright-Constantine Structured Cultural Interview (WCSCI) compared to the use of the DSM-5 Cultural Formulation Interview and the Patient Cultural Identity Assessment. Clients with minoritized identities and supervisors with minoritized identities were associated with case conceptualizations that integrated culture at higher rates. However, minoritized identities in *trainees* were not a factor leading to cultural integration. Conceptualizations that utilized the WCSCI were between 3.5 and 4.5 times more likely to integrate culture than those that used one of the other two cultural interviews. The tools that therapists utilize to gather information from clients can have a significant impact on the cultural responsiveness of case conceptualization. What we ask, and how we ask it, can have a profound effect on the case formulation process.

Conclusion

To enhance therapist competence, there is a "need for robust training of therapists to become proficient in skills pertinent to…case conceptualization" (Easden & Kazantzis, 2018, p. 381). Indeed, developing case conceptualization skills is an ongoing, lifelong endeavor. This effort can be aided by supervision,

training, and mentoring that help supervisees and trainees hone and expand their skill sets. Provision of additional training opportunities carries the potential of improving "the quality and effectiveness of services delivered by master's prepared clinicians who may not have had the opportunity to obtain rigorous training" in these skill sets (Austin et al., 2025, p. 13). Striking a balance, supervisors "who model intellectual humility and healthy skepticism as parts of their professional improvement process are likely to foster up to date… methods among their supervisees" (Gilboa-Schechtman, 2024, p. 6). Further, developing model-based case conceptualization skills will be useful to couple and family therapists, as a more comprehensive case conceptualization process is the launch pad for more effective treatment outcomes and increased quality of therapeutic practice.

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3 The Daniels Family

Michael D. Reiter

The Presenting Complaint

The Daniels family is coming to therapy because Murray (39) and Fran (38) are concerned about their daughter, Pam, who is 17 years old. Two years ago, she was diagnosed with Anorexia Nervosa. However, within the past six months, her weight has severely declined. She is five feet three inches and weighs 88 pounds. Pam is the oldest of three children, Oliver, 15, and George, 13.

Pam had been hiding her eating habits for the year preceding her diagnosis. At times, Fran would comment at the dinner table that Pam was not eating enough. Pam would counter by saying that she was not that hungry. After six months of these types of exchanges, Murray and Fran realized that things were more serious than they had realized. They sent Pam to a therapist who diagnosed her as being anorexic and worked with her, but with no positive changes. Pam continued to lose weight. The therapist recommended that Pam be placed in an inpatient facility for people with eating disorders. Murray and Fran think that it is an extreme situation to put her in an inpatient facility. They are hoping family therapy will help. If not, they are going to place her in the facility.

The Formation of the Family

Murray and Fran have been married for 20 years. They view themselves as a normal couple and family, and are very confused why Pam has this disorder. They are not sure what is wrong with her, as they believe they have provided a solid foundation for each of their children to grow and succeed. The family is a middle-class family where Murray is the primary breadwinner and Fran, who had been studying to become a teacher, became a stay-at-home mother once Pam was born. She has always had a close relationship with Pam, and the current medical issues for Pam are extremely scary for her.

Murray and Fran met on a blind date arranged by their mothers who knew each other through a book club. They hit it off and started dating. Murray was 19 at the time and Fran was 18. Murray was in his second year of college,

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Fran her first. They attended the local community college and lived at their respective parents' houses. Murray received his Associate of Arts degree in business and began working for his father, who owned an appliance store. Fran completed her Associate's in education but did not enter the workforce because she became pregnant with Pam at the age of 20.

The transition from couplehood to parenthood seemed to be fairly smooth. Murray and Fran both had traditional U.S. beliefs, where Murray was the family's financial provider and Fran had primary responsibilities with the children and the home. After Pam was born, they had children every two years for the next four years. Fran found comfort in being a mother. She had always loved children and had planned on being an elementary school teacher before getting pregnant.

The childhood for each of the children seemed to be a normal U.S. upbringing. Each of the children was on time with their developmental milestones. Fran always seemed to be closest to Pam. Murray would joke that since they were the only two females, they had an extra-close relationship. Murray found that he gravitated more toward his sons, being able to play sports with them. Currently, he is an assistant coach on each of his sons' city baseball teams. Oliver and George are athletic, each being able to play multiple sports. They both seem to enjoy baseball more than any other sport. They are doing well academically, with low A to high B averages.

Pam is in her senior year of high school and has a low B average. She did better in middle school, with an A average in her classes. After her transition to high school, Murray and Fran became concerned as to why she had decreased her scores. They were also concerned that Pam did not seem that concerned. Fran tried harder to push Pam to do better, which led to arguments between the two of them. Murray, although concerned about the situation, let Fran attempt to deal with it.

Murray's Family-of-Origin

Murray was born into a Protestant family in the Virginia area. He is an only child. His parents, Milton and Dorothy, have been married for 65 years. They still live in Virginia and see their grandchildren quite often. Murray is close with his father, Milton, based on his working in the appliance shop his father owned, and that he eventually took over.

Milton is the oldest child of Frank and Kitty. He has two younger siblings, Christine, two years younger, and Jeffrey, five years younger. Frank originally worked on an assembly line and quickly learned how to fix and work with a variety of mechanical equipment. Eventually, he opened up an appliance store where he also fixed various machines such as sewing machines, refrigerators, and other such equipment. Milton spent much of his time after school working in his father's store. When he was 16, Milton stopped going to school and worked full-time in the appliance store.

Milton's siblings never seemed to take a liking to the appliance store. Christine went to a university and became a nurse. Jeffrey went to college and then law school and is currently practicing law in Pennsylvania. Milton was never that close with either sibling, although there were no severe disagreements and fights.

As Murray was growing up, Milton would bring him into the store. Murray seemed adept at working in the store, providing good customer service, stocking shelves, and eventually learning how to fix various pieces of machinery. Milton suggested that Murray go to business school so that he could one day take over the store. Once he received his AA degree in business, Murray worked full-time in the store. Eventually, Milton made him a partner. Two years ago, Milton informed Murray that he was going to retire and that he was giving over ownership of the business to him.

Fran's Family-of-Origin

Fran comes from a Catholic family. She is the oldest of four siblings: her brother Paul, two years younger; her brother Michael, three years younger; and her sister, Tamara, six years younger. Tamara was sickly as a child, and Fran seemed to be the person in the family who most looked after her. There were many days after school, when Tamara was between four and six years old, that Fran would go straight from school and spend several hours taking care of her.

Fran was always good with children and decided she wanted to be a teacher. She was close to her mother, Nancy, who was also a stay-at-home mother. Her father, Horace, worked in a book-binding factory. Fran was not especially close with him, but not too distant. Horace was a serious man who worked hard at his job and came home to relax. He allowed Nancy to do almost all of the parenting with the children.

Horace and Nancy both worked in the book-binding factory when they first met. They began dating, broke up, and then one year later began dating again. After several months, Nancy became pregnant, and they decided to get married. They did not have a tumultuous marriage, but it was also not very loving. Horace was not a very affectionate person. Fran does not recall ever seeing her parents kiss or hold hands.

Ten years ago, Horace had a heart attack and passed away. Nancy did not seem to be too impacted by the death. However, she decided to move to South Florida. She only sees Fran and her grandchildren about two times per year. This is distressing for Fran as she would like to have a closer relationship with her mother, not only for herself but for her children as well.

Current Status of the Family

The Daniels believe they are a close family, yet they see that there are areas where they are not as close as they think. There has evolved a division in the

family between the males and the females. Murray, Oliver, and George tend to unite with one another, especially around sports. Oliver and George get into competitive battles with one another, especially around who can shoot a basketball better, hit a baseball farther, or other such athletic endeavors. Murray enjoys challenging his sons to become better at sports. He has at times talked to Fran that he will be more of an influence in his sons' lives, so that Fran can be more of an influence in Pam's life.

Pam feels isolated from her brothers, Oliver and George. She sees that they have a bond she does not have with them. Pam was never that athletic, engaging in activities such as arts and crafts and music (she had taken piano lessons for seven years). She does not fight with Oliver and George, but she does not engage them too frequently in activities, except when the family goes together as a group to some event, like their recent trip to some of the theme parks in Orlando, Florida. Ever since the diagnosis of anorexia, Pam's relationship with her brothers has become more distant. Pam also feels isolated from her father. She sees that Murray spends a lot of time with her brothers, but not really with her. She has not brought this hurt up to him. She had been close with Fran, but in the last year, the relationship has become very strained because her mother's interactions with her now usually center around her weight and what she is eating.

4 Bowen Family Systems Therapy

Tequilla Lynn Hill and Cindy McIntire

Bowen Family Systems Therapy (BFST), also known as **Multigenerational Family Therapy**, was developed by psychiatrist Murray Bowen. Originally trained in psychoanalysis, Bowen shifted his clinical focus after years of work with schizophrenic patients and their families. Through these experiences, he recognized that symptoms could not be fully understood when viewed in isolation from the family system (Kerr & Bowen, 1988). He was among the first to conceptualize human behavior as embedded in an emotional system, emphasizing how patterns are transmitted across generations rather than focusing solely on the individual's pathology (Bowen, 1985). Bowen theory, as a natural systems theory of human emotional processes, offers a framework for understanding how people emotionally engage with their environments. Rather than centering solely on individual behavior, it expands the lens to examine how relationship systems function as interconnected units, with members mutually influencing and responding to one another and to external forces in dynamic and ongoing ways (Bregman & White, 2011).

Bowen theory explains emotional process as an inherent part of human relationship systems, unfolding automatically through the reciprocal interactions of individuals with one another and with life conditions to which they must adapt for survival and well-being (Bregman & White, 2011). The Bowen approach provides individuals with tools to manage emotional processes both within themselves and in relation to their family system, especially when faced with anxiety-provoking life situations in the present and future (Titelman, 1998a).

Bowen argued that the human family must be understood through the lens of evolution, asserting that any scientific family theory needed to be grounded in biology and evolutionary processes. Unlike other early family researchers, he uniquely conceptualized the family as an "emotional system," aligning his use of the term with Darwin's evolutionary framework (Noone, 2017).

Bowen theory offers a framework for examining human behavior and functioning across multiple levels within individuals, between members of a system, and in the broader dynamics of the system. Effective application of the theory is closely linked to one's ability to observe and reflect on their own

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emotional functioning within the relationship systems to which they are connected (Wiseman, 2011).

Family functioning is highly sensitive to anxiety and stress levels. When a family is calm, its psychological and behavioral patterns differ significantly from when it is anxious. These predictable shifts point to both the family's level of tension and the relationship processes likely to occur. The dynamics are further shaped by circumstances such as the people involved, the quality of relationships, the resources available, and how leadership is exercised within the family (Papero, 2017).

At its foundation, Bowen Family Systems Theory asserts that symptoms emerge from relational patterns rather than existing independently. By learning to observe and regulate emotional reactivity, individuals strengthen their differentiation of self, which is the ability to balance individuality with connectedness. This growth enables people to engage more effectively with their family and broader social systems, reducing chronic anxiety and interrupting dysfunctional multigenerational patterns. From a Bowenian perspective, *anxiety* is not the same as the DSM-defined disorder of anxiety; instead, it refers to the emotional intensity or reactivity that flows through relationships and systems when individuals or families feel threatened or under stress (Kerr & Bowen, 1988). Importantly, this approach does not aim to eliminate anxiety. Instead, it seeks to help individuals respond thoughtfully rather than reactively when stress inevitably arises (Meyer, 1998).

Human efforts are profoundly shaped by how we think, making it essential to examine how we approach relationships (Gilbert, 1992). Developing awareness of the emotional systems at work in our lives and in the lives of clients allows us to adopt a systemic lens and focus on processes rather than isolated events. This perspective helps both therapists and clients recognize their position within a relationship, the position of others, and how the two fit together. Such awareness strengthens one's ability to function in relationships with greater balance, clarity, and responsibility (Bowen, 1985). Bowen theory views the family as an **emotional unit**, a natural system that has evolved much like other living systems. Its central concept, differentiation of self, offers a framework for understanding how individuals function in relation to others across emotional systems of family, work, community, and society (Titelman, 2014).

Anyone living within a household becomes part of its emotional unit, or "family," regardless of blood ties. At the same time, those working within a Bowen framework observe relational patterns and systemic functioning. According to Meyer (1998), Bowen theory stands in contrast to models that frame the human condition primarily through the lens of health versus pathology or by applying discrete, differential diagnoses. From Bowen's perspective, diagnosis is better understood as perceiving emotional problems along a continuum, with qualitative differences evident across individuals and families. The emphasis is not on the surface phenomenology of symptoms, but rather on the deeper challenge all families face—the ongoing effort to balance the