The Functional Hypothesis: A Family Systems Contribution Toward an Understanding of the Healing Process of the Common Factors

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In this article, the authors link a central organizing concept and process, The Functional Hypothesis, to the literature on metatheoretical approaches to the psychotherapy process. The Functional Hypothesis is presented as a central thread that runs through all family systems models, the employment of which contributes to successful therapeutic outcomes. The Functional Hypothesis is linked to the literature on client factors in emotional healing and is posited as the creative catalyst for the dynamics of the Common Factors. A Case Example is included, exemplifying the metatheoretical Internal Family Systems Therapy model which operationalizes therapeutic work with the Functional Hypothesis.

Keywords: functional hypothesis, common factors, family systems approach to healing, internal family systems therapy

In their brilliant opus, Hubble, Duncan, and Miller (1999) definitively asserted that psychotherapy, as a process of healing, is successful. They, and their contributing authors, articulated, documented, and differentiated the Common Factors model that contributed to the success of psychotherapy. Following in the groundbreaking footsteps of investigators such as Rosenzweig (1936); Frank (1973); Bandura (1977); Luborsky, Singer, and Luborsky (1975); Wachtel, (1977); Garfield and Bergin (1978, 1986), and more recent contributions to a metatheory and an integrative model of psychotherapy (Asay & Lambert, 1999; Breunlin, Schwartz, & Mac Kune-Karrer, 1992; Mahoney, 2003; Pinsof, 1995; Prochaska & DiClemente,

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1984; Stricker, 1994; Stricker & Gold, 2006) these authors make a solid argument that despite the plethora of treatment models, successful outcomes in the psychotherapy process result from four sets of processes or common factors: client factors; therapeutic relationship factors; placebo, hope, and expectancy factors; and model/technique factors. With much convincing quantitative and qualitative research support, the relative contributions of the common factors are also proposed (Asay & Lambert, 1999). It appears that client factors account for 40% of improvement in successful outcomes; the therapeutic relationship accounts for 30% of improvement in psychotherapy; placebo, hope, and expectancy accounts for 15% of the improvement; and specific techniques/models of treatment account for 15% of the improvement. These findings turn the usual discourse about psychotherapy success upside down, as, typically, clinicians and researchers alike have continued to believe that it is the particular models and specific applications by the therapist that result in therapeutic success.

It would be safe to conclude from this revolutionary finding about psychotherapy that the essence of "what works in therapy" are curative processes present in the client that become activated within a warm, empathic therapeutic relationship. The *artistry* of this process has much to do with the fostering of hope and expectancy and techniques that draw out the healing aspects in the client. What has emerged is a cutting edge group of investigators within the psychotherapy integration movement who are placing their focus on the self-healing aspects of the psychotherapy process (Bohart, 2006; Gold, 1994, 2006; Hubble et al., 1999; Tallman & Bohart, 1999). It is to this group that the current article carries the most resonance.

A quote attributed to the Renaissance master Michelangelo is relevant here: When asked by an admirer how he, Michelangelo, could have sculpted the magnificent David from a solid block of marble, Michelangelo replied, "David was inside the marble all along; I just knew how to bring him out."

The relevance of this view to psychotherapy, as implied by the Common Factors model, is that clients possess their own healing capacity that is brought forth by a therapeutic process that emphasizes listening, empathy, and a drive toward the experience of self-efficacy and acceptance. What constitutes the "bringing forth" of self-efficacy and self-acceptance? What do gifted therapists do to set in motion this healing process? How exactly do all ingredients (client, therapist, expectancy, techniques) form together for a recipe of successful therapy? In other words, what are the dynamics and healing processes of the Common Factors? Can the equivalent of Michelangelo's "genius" be understood and codified for clinicians to employ?

We would like to propose that a step toward understanding and operationalizing the curative psychotherapeutic process is possible, and we

will be focusing on key elements of this process that are at the heart of a therapist's conceptualizations and techniques when treatment goes well. To do this, we will be tracing the contributions of thinkers and practitioners in the field of family therapy during the last half century and proposing a metatheoretical concept, The Functional Hypothesis, that is the centerpiece of the process of eliciting the curative aspects of the client.

Bateson (1972, 1979; Bateson, Jackson, Haley, & Weakland, 1956/1981) created a paradigm shift in the field of mental health when he and his colleagues in Palo Alto, California studied schizophrenic families in an anthropological manner, that is, interviewing family members while other team members watched through a one-way mirror. In this groundbreaking work, these participant–observers began to think that bizarre symptoms could be understood when viewed within the family context, in other words, the "disease" of schizophrenia was actually an adaptation to skewed and no-escape communication patterns labeled as the "double bind." Although the Bateson Group's findings have fallen into disfavor amid the gathering, but, as yet inconclusive, evidence of physiologic factors, and whereas their own writings fell prey to the then prevalent thinking (e.g., mother-bashing) their observations set in motion a new way of viewing psychological symptomatology (Mones, 2003). What they said was that symptoms are not pathological aspects of illness. Instead, they are attempts at survival within a family context. These survival strategies work in the short run, but create havoc in the long run. For instance, a highly anxious individual may attempt to control his inner turmoil by imposing (on conscious or unconscious levels) a structure of obsessive thinking. This "strategy" actually does work to ward off anxiety. However, the "solution" of obsessive thinking itself becomes a burdensome behavior that constrains the emotional freedom of the client. This solution then becomes a new problem, and likely generates its own new wave of anxiety with new "solutions"—perhaps now the person begins to soothe himself with excessive drinking that relaxes the pressure of obsessive thoughts but will over time deteriorate his health and hamper his relationships. This view mirrors functional models in medicine (Angier, 1991). For instance, physicians began to realize that a physical symptom such as fever is not pathology but the body's defensive strategy to fight off infection and kill off bacteria or parasites. The fever, however, if unchecked, can create havoc of its own by debilitating the person and compromising survival by creating a weakened state. This is a matter of the solution morphing into a serious problem. In addition, there is a growing set of literature documenting the reactivity of the human immune system to life stress and relationship factors (Scovern, 1999), lending support to a systemic view and functionality of symptoms in medicine.

Bateson's seminal work set in motion the field of family therapy with

systems thinking at its core. Essentially, Bateson and company were operating on the path courageously forged by Charles Darwin, the brilliant naturalist and astute observer of survival strategies among animal and human species. Darwin looked at species differentiation and survival as an outgrowth of the drive to survive and asked the basic question: *What purpose does this biological feature (beak of finches, etc.) serve in the survival of the individual animal and for the species in general?*" With that question, Darwin (1859;1871) revolutionized the field of science and challenged the extant view of life—a view that is still being debated, 150 years later (Mayr, 2001).

From Bateson, there is a direct lineage in the models that have evolved in the field of family therapy that embrace *the Functional Hypothesis, that is, psychological symptoms are adaptive in nature and serve a protective function for the individual (and sometimes for the family*). Therapy that is connected to the Functional Hypothesis would have at its core the need to understand and appreciate the survival nature of the symptom. Instead of defining the symptom as pathology, inherent in the medical model (reductionistic) approach with its goal of removing the symptom, treatment informed by the Functional Hypothesis would be centered around helping the client to understand and appreciate the protective nature of their symptom and to work systemically (on intrapsychic and interpersonal levels) to make healthier choices that would accomplish the survival need. We further propose that this process centers on the essential competence or self-efficacy of the client, a thread that weaves throughout the common factors exposition. When the therapist "brings out" and engages the competence of the client, therapy is on its way to a collaborative journey with successful outcomes.

Prominent family theorists like Bowen and Minuchin, have the Functional Hypothesis indirectly embedded in their models as traced below. The most direct lineage from Bateson is the Strategic School of the family therapy field. These practitioners would include, Haley, the Mental Research Institute Group, Milan Group, Neurolinguistic Programming (NLP) and later offshoots, specifically, solution-focused therapy and narrative therapy and even postmodernism. The viewpoint presented here will link these models to the centrality of the Functional Hypothesis. We will then explore a metatheoretical approach, Internal Family Systems Therapy, a model for psychological healing that operationalizes the Functional Hypothesis.

Bowen (1978) viewed emotional struggle as unresolved anxiety and psychic pain transmitted across and within several generations of a family system. This anxiety is carried by all human beings on an existential level, as our species possesses awareness of the finite nature of living. This inherent anxiety is compounded by emotional trauma and injury experi-

enced in our family of origin. Individuals, couples, and families organize their emotional systems, internal and interpersonal, in ways that attempt to cope with this anxiety. The formation of "emotional triangles" in various combinations (two parents/problem child; marital couple/extramarital affair; couple/alcoholism) are symptom formations that aim to stabilize and cool down an overheated family climate. Here we can see that triangles serve a survival function in the short run but do not relieve the underlying anxiety and pain that generates this emotional "solution" in the first place. For Bowen, triangulation is an *interpersonal* strategy of protection for the *intrapsychic* system resulting in constraints on emotional differentiation and growth of Self. For Bowenian therapists, treatment is aimed at the process of de-triangulation, that is, to remove the emotional detour served by the problem child, extramarital affair, addiction, and so forth and to have each spouse work on their own self differentiation from their respective families of origin. The process of differentiation of self is accompanied by much anxiety, the avoidance of which (functional hypothesis/survival strategy), was the trigger for the construction of the emotional triangle and the liberation of which points the person and family toward health (Bowen, 1978; Guerin, 1976; Guerin, Fay, Burden & Kautto, 1987; Guerin, Fogarty, Fay & Kautto, 1996; Kerr & Bowen, 1988).

The Structural Family Therapy Model of Minuchin (1974; Minuchin & Elizur, 1989; Minuchin & Fishman, 1981) posits that symptoms emanate from family typologies that organize around hierarchies, boundaries, and predictable sequences of behavior. On one end of the spectrum are systems that are characterized by unclear and diffuse boundaries between parental and child generations. In these families, there is a heightened emotional reactivity and sensitivity to one another. These families operate with an excess of emotional connection but insufficient allowance for individuation or selfhood. Enmeshed family systems tend to result in symptoms of internalization, that is, anxiety, depression, somatization, and so forth.

On the other end of the spectrum are families that are emotionally disengaged. These families have a dearth of emotional bonding, and excessive emotional distance with rigid boundaries between and/or within generations. The most extreme scenario of emotional disengagement represents children who do not form a reliable bond to parental figures as with children placed in multiple-foster care settings over their key developmental years. Adaptation in these families tends to be expressed via symptoms of externalization such as psychopathy, addictions, violence, etc.

For Minuchin, symptoms arose from attempts at adaptation (functional hypothesis/survival strategy) in the proximity-distance dimension that are aimed at providing security for the family members. For example, conflict avoidance will "make sense" to a child in an enmeshed family while defiance may be a key survival strategy for a child from a disengaged family

(Mones, 1998). Interventions are centered on opening up the communication and emotional connection in enmeshed families and fostering emotional connection in disengaged families.

Minuchin's thinking resonates with Attachment Theory (Bowlby, 1973), a model that views individuals as operating on a spectrum of secure to insecure emotional connection that will generate strategies of emotional survival. In recent years, the Emotionally Focused Therapy Model has employed attachment theory as a basis for therapeutic applications (Greenberg & Johnson, 1988; Johnson & Whiffen, 2003; Johnson, 2004). Interventions are geared toward the therapist safely eliciting emotions connected to attachment injuries in a marital relationship, often compounded with family of origin trauma. Treatment strategies are aimed at the direct experience of repair and reassurance from one's spouse so that the attachment experience is now safe and secure.

Strategic Family Therapy began as a direct outgrowth of the Bateson Group's work and has branched into a magnificent tree that reflects the full-blown human creative spirit. At its core, Strategic Family Therapy emphasizes the process of change— how exactly does the emotional system of individuals and families become constrained (Breunlin, 1999) and how does this same emotional system expand its degrees of freedom so as to allow full individuation and differentiation. Strategic Family Therapy is a purist model that views emotional problems as direct attempts at psychological survival. Haley (1980, 1987) coined the phrase "strategic" in describing the process of the therapist formulating treatment strategies to enable families to shift from maladaptive solutions to problems in living to more adaptive choices. As was the case with his mentor, Erickson (1962; Haley, 1973; Rossi & Ryan, 1992), for Haley, symptoms were viewed as metaphors for the family's struggles. In addition, the therapist–client relationship can reflect this struggle. Change the symptom via a systemic strategy that takes into account all reference points of the symptom and you will alter and maintain new interpersonal relationships that will cope with the presenting issue in a new, healthier manner. Through Haley's work and later with the talented Mental Research Institute (Watzlawick, Weakland, & Fisch, 1974) and the Milan Model (Palazolli, Cecchin, Prata, & Boscolo, 1980) and Neurolinguistic Programming (Bandler & Grinder, 1975) we learn of the powerful nature of symptoms as paradox: we set up strategies and behaviors that serve to protect us from psychological hurt and pain; however, these same strategies, when overemployed, limit our healthy choices. As a Zen Master would do, to change unproductive outcomes of this paradox, the therapist *employs* human nature to improve itself. The essence of this approach became labeled as Reframing— demonstrating verbally or via behavior or paradox, that symptoms serve a protective purpose, but can also create new difficulties. For the strategic

therapist, the protective and adaptational nature of symptoms is harnessed for curative purposes.

During the past 20 years, the field of family therapy has extended to even more elegant branching of its evolutionary tree. As our culture has raised its consciousness regarding gender issues, the racial divide, poverty, and cultural diversity, family therapy models have adapted to the spiral of change, even courageously offering critiques of itself (M. Nichols & Schwartz, 2004). As we have included the macro level of social forces, the concept of adaptation has been amended and the therapeutic circle enlarged. Without sensitivity to these forces, therapists can inadvertently blame the very family systems they have been trying to depathologize.

In response to this new wave of cultural, ethnic, and gender awareness, new models have been offered. The Solution-Focused movement (DeShazer, 1985) proposed that people do not *need* to have problems. Essentially, we possess the strengths and resources and are already exercising these options some of the time. The central theme of solution-focused therapy is that, with the therapist's guidance, clients will discover their reservoir of strengths and reverse from a negative to positive locus. Although this model drifts away from and discourages a view of symptoms-as-adaptation, the focus on client competency and resourcefulness is certainly a "bringing forth," ala Michelangelo, of the self-efficacy of the individual.

Postmodern approaches to therapy represent a further branching of the tree (Gergen, 2002). Dell (1986) questioned the nature of "paradox" in psychotherapy and connected our field of study to a constructivistic creation of meaning. Hare-Mustin and Maracek (1990) and Goldner (1985; 1998) had us take a new look at the construction of gender. Narrative Therapy (Anderson, 1995; White & Epston, 1990) emphasized the collaboration of therapist and family in an equal partnership. Here the therapist elicits the "stories" of her clients and together they work toward revising their life narrative scripts in a nonjudgmental way. There is much focus on "externalizing," linking emotional struggles to inequities of society—racism, sexism, emphasis on physical beauty (eating disorders), and so forth. In this approach, blame and shame carried by clients are bypassed as they join with the therapist in a crusade to reform the ills of our culture. Although postmodernists have challenged the notion of the Functional Hypothesis, we believe that they too are working within this metatheory—rather than challenging the client to change, it courageously attempts to remove cultural constraints and in so doing liberates the essential competence/self-efficacy of the client and family. Roffman (2005) rightly placed functionality in the context of the therapeutic relationship and encouraged the therapeutic application of the functional hypothesis but was sure to eliminate the edge of blame in its therapeutic usage, something that

Bateson and his original pioneers overlooked. Therefore, create a safe, open, fair and loving emotional climate and the natural goodness and compassion of people will arise to participate in, contribute to, and further generate this emotional climate.

Instead of creating new models, other investigators attempt to link extant models in their quest for integration. Wachtel (1977) was among the first to combine psychoanalytic thinking with behavior therapy concepts. Pinsof (1995) made the link to individual (object relations) and biological models. W. C. Nichols (2001) and Allen (2001) connected the dots from family therapy to cognitive–behavioral theory to psychodynamic/object relations approaches. Gold (2001) approached integration with a treatment model that utilized family and individual sessions in serial and/or concurrent sequences. Heitler (2001) interwove individual and couple work to relieve symptoms by resolving conflicts and building communication skills. Ellis, Sichel, Yeager, DiMattia, and DiGiuseppe (1989); Baucom and Epstein (1990) and Dattilio (1998) worked within a cognitive–behavioral perspective. Jacobson and Christiansen (1996) courageously documented and critiqued their own work and concluded that purely behavioral interventions alone did not prove efficacious over time and began to incorporate ideas and techniques from systems models.

Prochaska and DiClimente (1984) focused on a meta-approach to stages and processes of change. Breunlin et al., (1992) presented a meta-framework that encompassed structural family concepts, internal experience, and cultural context. Mones and Patalano (2000) described a meta-model of marital therapy, employing a developmental schema at the confluence of interpersonal and intrapsychic experience. Mahoney (2003) creatively entered the experiential world of the change process. Scheinkman and Fishbane (2004) understood marital conflict as clashing behavior (survival strategies) aimed at protecting vulnerabilities of each partner. Melitto (2006) offered a structural-developmental schema linking the complexities of individual and family psychology. His view of a "multifaceted self" is of special interest for our meta-model.

Sprenkle, Blow, and Dickey (1999) reviewed common factors and non technique variables in marital and family therapy. Consistent with our view, these authors pointed to the depathologizing of symptoms by understanding a client's problems within a relational context and that systemic interventions span behavioral regulation, cognitive mastery, and affective experiencing. The experience of acceptance of one's vulnerabilities and the vulnerabilities of others along with increasing self-efficacy represents the growth and healing trajectory of the therapy process.

These authors, gleaning from Frank (1973) and Garfield (1991; 1992), pointed to reattribution as one of several "generic techniques described in individual therapy" that is also part of successful marital and family ther-

apy and other psychotherapeutic models as well. *Reattribution* refers to the process of the therapist and client collaborating to make "meaning" out of the clients' behavior, thoughts, and feelings. This can take place via interpretation, as employed in psychodynamic therapy or correcting "faulty thinking" explored in cognitive–behavioral treatment or can be primarily client generated, proposed here as the most powerful of the reattribution experiences. There have been some encouraging empirical findings for the therapeutic nature of reattribution (Robbins, Alexander, Newell, & Turner, 1996) to support the essence of functional family therapy with adolescents (Alexander, Waldron, Barton & Mas, 1989; Morris, Alexander, & Turner, 1991). Sprenkle et al. (1999) went far to promote a meta-theory view of common factors in marital and family therapy. However, we feel that they neglected to refer back to Bateson, the "grandfather" of family therapy who set the foundation for meta-theory. It is this meta-theory, we feel, that strongly anchors the several generations of our field. In addition, we feel that the integrationists mentioned above are very effective in depicting "elegant pearls" (psychotherapy models) that are used in various combinations. We are attempting to link those jewels with a string (meta-theory) that captures the essence of emotional healing.

The final model to be described in some detail, as it is a meta-theoretical approach to understanding human nature with direct applications to the healing process, is Internal Family Systems Therapy (IFS) as developed by Schwartz (1995, 2001; Schwartz & Goulding, 1995). IFS is a model that elucidates the themes of family therapy reviewed above and extends the work to the internal, intrapsychic world of the client.

IFS views the internal psychological world of human beings as made up of an ecological system of Parts. The choreography of the Parts is consistent with the models of family systems therapy as applied in the relational sphere. At the center of the internal system is the core Self that holds and expresses the compassion, courage, curiosity, clarity, confidence, creativity, calm, and ability to connect to others. In other words, the Self is that good, healing energy that the therapy process "brings forth" when it is successful. These attributes of Self are consistent with Eastern philosophy and teachings and the focus on self-efficacy and self-acceptance woven throughout the more recent conversation about common factors. In contrast to many models that posit a Self, in IFS, the core Self is not viewed as an introject (Cohen & Johanson, 2003).

Here, Self is our basic pure human nature that we possess from birth. It is the pure "David" who lives in the block of marble waiting for a gifted artist to bring out. For all of us, to some degree, this healing energy of Self is blocked as a result of traumatic emotional experiences, imperfect caretaking, and existential anxiety (Becker, 1973). The reader will note a resonance here with Bowen Theory, described above. As a result, we carry

sadness, fear, shame, and emotional pain that is not fully metabolized because we were too young and ill- equipped to process it and because parents were not fully available and not fully capable in helping us through these experiences due to their own constraints on Self energy. The residue of this emotional pain is labeled *Exiles* in this model. For our survival, the full experience of Exiles is felt to be too overwhelming so they are compartmentalized and guarded at all costs.

To help accomplish this banishment of emotional pain, two sets of other Parts are activated. One category is called the Managers. These Parts emphasize internal and interpersonal control and do all that they can to keep the "gate" locked so that the person does not go too close to the experience of painful Exiles. The Managers protect the Self from this pain (functional hypothesis/survival strategy) but in the process create new difficulties as in the example of obsessive thinking described above.

On the other end of the spectrum, is another set of protective Parts, called Firefighters. These Parts serve the same purpose as Managers, that is, to protect the emotional pain from overwhelming the person. Firefighters act to soothe and distract from this pain (functional hypothesis/survival strategy). The most common Firefighters are addictions of all sorts, providing a "quick fix" analgesic to the long-held residue of trauma. In our example of obsessive thinking, excessive drinking of alcohol would be Firefighter activity. As Managers and Firefighters are called into service of blocking intrapsychic pain, the energy and qualities of Self are eclipsed. As Self is constrained, defensive, self-protective survival strategies (i.e., Managers and Firefighters) play a dominant role in our internal emotional system and interpersonal relational experience and who we are, our identity, begins to resemble these defensive parts and not our compassionate, competent Selves. So, consistent with our central theme, the solutions in the service of protection of our emotional system, when overworked, will create new constraints on our mental health.

The therapeutic process in IFS is to help guide the Self back to its rightful leadership position within the internal system through safe experiential coaching. First, protective Managers and Firefighters need to be differentiated and unblended from Self. Recognition of the positive intentions of these Parts—their protection of the person is a central part of this process and a direct application of the Functional Hypothesis. Once the Self energy is liberated, the next phase of treatment consists of Unburdening the Exiles so that there are new degrees of emotional freedom throughout the internal system.

The IFS Model places great emphasis on the process of Unburdening the remnants of trauma held by the Exiled Parts. It is necessary but not sufficient to apply the Functional Hypothesis without having the Self of the client *experiencing* the emotional pain as the client and the therapist bear witness to this experience. Without this deep emotional process, the client

will not be fully free from the effects of past trauma and will predictably become retraumatized from intrapsychic and/or interpersonal triggers that are embedded in body memory (Pert, 1997; Rothschild, 2000). This is consistent with an ecological (systems) model. As the Functional Hypothesis is applied so that the Self is in a leadership position, protective Parts will become activated, vigilant in their attempts to buffer the surfacing of pain. Ultimately, this pain seeks expression and needs healing and unburdening. Clients often choose to create a ritual through which to unburden deeply held emotional pain. This is consistent with Garfield (1992) who viewed therapeutic rituals linked to reattribution as a meta-level process in all therapy models.

CASE EXAMPLE (IFS)

Patricia, age 52, a woman who outwardly is successful in her career and relationships, initiated therapy with Dr. Richard Schwartz with the request to work on a fear of appearing stupid, especially around other women at work. At times the client feels paralyzed to speak. *The therapist identifies the Paralyzed feeling as a Part of the client's internal emotional system and asks her to turn her focus inward and to emotionally experience the Part in the session. By asking, "How do you feel toward that Part?", there begins differentiation and unblending of Self and Part.* The client responds that she is mad at the Paralyzing Part and feels it as something holding her back, like a harness and wants the Part to "get away." *The therapist, wanting to create a clear channel between Self and the target, Paralyzing Part, asks the client to gently move back, one at a time, the other Parts (Mad Part, etc.) that are pushing away the Paralyzing Part or critical of it and want to be in control of the internal system. In IFS, these would be Manager Parts. Managers need to be able to step back for Self to be in a healing position with the target Paralyzing Part, in this case.* The client responds that the Manager Part is cautious about stepping back but agrees to try. *The client is becoming comfortable with Parts language. This is the case for most clients as this resonates with human emotional experience. The reader will note that the therapist speaks to Parts as separate individuals who are related to one another in the internal system, much like in a family therapy session. If the Manager Part is not willing to step back, then the Therapist asks the client if she would like to understand its reluctance and the session would shift to work on this and any other Protector Parts.*

The therapist asks again, "How do you feel toward the Paralyzing Part"? The client pauses and says that she is very familiar with this Part. She begins to cry and wonders if she can answer any more of the therapist's

questions. *Therapist reassures Patricia and asks again about her feeling toward the Paralyzing Part.* The client responds that she is curious and compassionate toward it now. *Curiosity and compassion are traits of Self, so the channel of Self to Part is more clear.* Client likens the Part to a dog that hasn't been fed for a long time and is not sure that it's safe to move toward or away from the person offering food. *The therapist recognizes this feeling as an Exile (remnants of past trauma). Therapist encourages Client to reassure the Part that it is safe in the session to have the Part begin to trust. Therapist encourages Client to gradually get close to Part internally.* The Paralyzing Part begins to relax and feels comforted by Self. Client is pleased with this realignment of her internal emotional system.

Next, Therapist asks the client to have the Paralyzing Part tell Patricia (Self) what it would worry would happen if it relaxed and allowed her to express herself (Constraint question, Breunlin, 1999). The Paralyzing Part states that it would worry that Patricia would be very shaky and vulnerable if someone were to criticize her. It tells its story of how it came into being in her inner world. Patricia is able fairly easily to trace the Paralyzing Part to experiences in her family of origin. She had experienced a harsh and critical mother and felt that it was emotionally dangerous to speak out in an assertive manner. She described needing a strategy to protect herself without feeling annihilated. *Patricia's demeanor changed. She now viewed this "pathological symptom," the Paralyzing Part, as a Protector in her developing years. This is the therapeutic experience of the Functional Hypothesis, that is, the client begins to experience the positive intentions and adaptational aspects of a psychological symptom. She begins to realize that the Paralyzing Part kept her safe in her family-of-origin, but as she overemployed this survival strategy, it created many other problems intrapsychically and interpersonally over the years. This begins the healing process. Patricia went on to deeply explore this process and became quite impressed with her intelligence, to have "devised" such a survival strategy. With continuing work, more of the Exiled Feelings of sadness, fear, and shame were witnessed by Self and the Therapist and further emotional Unburdening was accomplished. This client chose the ritual of releasing her past emotional trauma into "the light" so that healing could be complete.* (Note: IFS is an experiential model. This brief vignette is only a sampler of its potency.)

It is our belief that the process around the therapeutic formulation of the Functional Hypothesis represents powerful healing and is the active ingredient in setting in motion the dynamics of the Common Factors. It is possible that practitioners of other models may recognize similarities in their work, although they may use a different language to describe the therapy process. We very much hope that this would be the case. We suggest, that when looked at closely, the Functional Hypothesis, as operationalized in elemental form in IFS, is a very key ingredient in all successful

therapy. A growing number of clinicians have been applying IFS to a wide range of presenting problems with very encouraging results. It is our hope and intention to gather data on the lasting results of some impressive changes we have observed and that clients have experienced.

CONCLUSIONS

What then is the nature of psychological healing? The evolution of the field of family therapy, as traced above, from Bateson to Schwartz, views and understands the nature of psychological symptoms within their multiple contexts. Our view is that psychological symptoms should not be viewed as pathological aspects of human experience. Instead, such symptoms are attempts at adaptation and strategies for survival, when understood within internal, interpersonal, and cultural contexts. When the therapist guides clients to explore and experience their adaptational strategies of survival, and to unburden residue from past trauma, the result is self-acceptance and self—efficacy, markers of successful therapy that are part of the fabric of the common factors. It is believed that this is what the therapist does to "bring forth" the goodness of the individual, much like Michelangelo's artistry in bringing forth David from his block of marble. We are suggesting that the Functional Hypothesis is a powerful element of a meta-theoretical understanding of the healing process of psychotherapy and the curative dynamics of the Common Factors.

As mentioned above, we truly hope that clinicians who read this article will recognize their own successful therapy process as we have discussed and delineated the Functional Hypothesis. If this is the case, then the Functional Hypothesis can begin to be recognized as part of the meta-theory that informs the successful elements in the Common Factors and strengthens the view of psychotherapy integration that is client focused.

We would welcome a discussion of these ideas among practitioners and researchers who represent the many extant therapy models and hope that this article will enhance and deepen the conversation.

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