

Chapter 15



Couples and Family Counseling

Learning Goals

- To provide a brief history of the field of couples and family therapy that addresses how a number of events and people affected the development of the field.
- To understand the variety of views of human nature espoused by family therapists and to review 12 basic assumptions to which most family therapists adhere when practicing couples and family therapy.
- To examine a number of key concepts that fuel the way most family therapists work, including general systems theory, cybernetics, boundaries and information flow, rules and hierarchy, communication theory, scapegoating and identified patients, stress, developmental issues, and social constructionism.
- To offer an overview of a number of popular couples and family therapy approaches and to highlight the individuals most associated with them, including:
 - human validation process model of Satir
 - structural family therapy as presented by Minuchin
 - strategic family therapy as developed by Haley, Madanes, and the Milan Group
 - multigenerational approaches of Boszormenyi-Nagy and of Bowen
 - experiential family therapy of Whitaker
 - psychodynamic family therapy of Ackerman and of Skynner
 - behavioral and cognitive-behavioral family therapy
 - narrative family therapy of White and of Epston
 - solution-focused therapy of Berg, de Shazer, O'Hanlon, and others
- To examine a number of social, cultural, and spiritual issues related to the use of family therapy.
- To examine the efficacy of couples and family therapy.
- To see how couples and family therapy is applied, through vignettes and case study.

Once upon a time, therapy involved lying on a couch before a bearded fellow who sighed and said, “I wonder why you said that.” Therapy today is a viable option for constructing real solutions to real problems. It also might include a group behind a one-way mirror and a family in front of it with a video camera for a supervisor to study later.

Unlike other approaches to mental health and psychology, family therapy focuses on the *interpersonal* relationship of the members of a system called a *family*. Changing the system involves bringing the whole family together at times and attempting to make changes to reduce misery and distress.

Participation in family therapy does not suggest that something serious is wrong with a family. The family therapist serves as an agent to deal with simple adjustments or a system in misery. The therapy that is *interpersonal* is different from the therapy that is *individual*. Hundreds if not thousands of researchers and therapists are clarifying the cause of family distress and what to do about it. (Haley, 2009, para. 1–3)

In contrast to the other approaches discussed in this text, which focused on how to help *individuals* with their problems, couples and family therapy tends to see “the problem” as residing in the system and thus focuses on the interpersonal nature of “the problem.” This chapter offers a brief history of how couples and family therapy evolved and how it challenged many of the traditional ways of doing therapy. In addition, an overview of some of the more important concepts and common approaches to couples and family therapy will be presented.

FAMILY THERAPY: A BRIEF HISTORY

Although the emergence of couples and family therapy as a profession began around the middle part of the twentieth century, there were a number of events that led up to its birth. For instance, during the 1800s, two approaches to working with families and communities evolved (Burger & Youkeles, 2008). **Charity Organization Societies** had volunteers visiting the poor to assist in alleviating conditions of poverty. These **friendly visitors** would often spend years assisting one family by aiding in educating children, giving advice and moral support, and providing small amounts of necessities. At about the same time, the **settlement movement**, which had staff who lived in the poorer communities, began to arise (Leiby, 1978). These idealistic staff believed in community action and tried to persuade politicians to provide better services for the poor. One of the best-known settlement houses was **Hull House**, established by social activist Jane Addams (1860–1935) in 1889 in Chicago (Addams, 1910). Out of this involvement with the underprivileged, articles and

books arose concerned with finding methods of meeting the needs of the poor and how to work with destitute families within the larger social system. It is here that we see the beginning of social casework and the first time that the “system” is acknowledged as an important component to take into account when helping individuals and families overcome their difficulties.

Paralleling the work of these early social workers was the psychotherapeutic approach of Alfred Adler, who believed that external forces greatly affected personality development and that through education, one could help to alleviate problems. In fact, Adler’s approach to working with children is often cited as an early precursor to family therapy models (Goldenberg & Goldenberg, 2008; Sherman, 1999). At Adler’s child guidance clinics, parents would often meet with therapists to discuss problems with their children, although generally the parents and children were not all in the same room together (Bottome, 1957). For the first time, counselors were suggesting that problems in one family member had a significant effect on the whole family.

Despite these early efforts at working with families, the embeddedness of psychoanalysis and other individual-oriented approaches to counseling and psychotherapy made it difficult for novel therapeutic approaches to take a hold (Guerin, 1976). Thus, until the late 1940s and early 1950s, therapists who saw the value of working with the whole family often felt pressure to see the “patient” separately from the rest of the family. Soon, however, this new approach to psychotherapy began to take shape.

[At first, some hospitals had a therapist to deal with the carefully protected intrapsychic process, another psychiatrist to handle the reality matters and administrative procedures, and a social worker to talk to relatives. In those years this principle was a cornerstone of good psychotherapy. Finally, it became acceptable to see families together in the context of research. (Bowen as cited in Guerin, 1976, p. 3)

As increasing numbers of therapists believed it was useful to see the “whole” family together, a variety of approaches to family counseling developed during the 1950s that began to use this new model of working with clients (Guerin, 1976). Although some of these evolved independently, there was a core group of early therapists and family therapists who influenced one another and whose training often overlapped. The inside cover of Bitter’s (2009) book, *Theory and Practice of Family Therapy and Counseling*, offers a fascinating series of genograms that shows an intricate maze of close to 100 of these early, and somewhat later, family therapists.

Not surprisingly, although treating the whole family slowly became accepted, with the continued popularity of psychoanalysis, many of the early pioneers of couples and family therapy combined a systemic approach with basic psychoanalytic principles. Probably the most well-known of these was Nathan Ackerman (1958, 1966), a child psychiatrist. Another psychoanalytic trained therapist, Ivan Boszormenyi-Nagy (1973, 1987), stressed the importance of having ethical relationships in families and highlighted the notion that our senses of fairness and our loyalties are unconsciously passed down through generations and create a specific view of the world which may, or may not, match our spouses’ views. Establishing

the **Eastern Pennsylvania Psychiatric Institute** (EPPI), Boszormenyi-Nagy's **contextual family therapy** would sometimes include grandparents and other significant individuals when examining these cross-generational issues, with the goal of helping families develop healthier and more loving ways of communicating. At around the same time, Murray Bowen (1976, 1978) developed what some would later call **multigenerational family counseling**. Working initially at the **Menninger Clinic** in Kansas and later at the **National Institute of Mental Health** (NIMH) in Washington, D.C., Bowen was interested in communication in families who had a family member who was schizophrenic. Working with all members of a family, but one member at a time, his experiences with these families, and later with families struggling with "normal" problems, resulted in new ideas about how family dysfunction is passed on through generations.

Probably the group that was to have the most profound influence on the evolution of couples and family therapy was led by an anthropologist, Gregory Bateson, in Palo Alto, California (Guerin, 1976; Mental Research Institute, 2008). Fascinated by human communication, in the early 1950s, Bateson hired Jay Haley, John Weakland, Don Jackson, and William Fry, and this team began to look at how individuals communicate in systems, particularly families that had schizophrenic members. Their **double-bind theory** attempted to explain how schizophrenics are often caught in a web of mixed messages from family members who hold power. The first to apply principles of **general systems theory** and **cybernetics** to an understanding of family communication, their ideas would fuel the manner in which a generation of couples and family therapists would work and continues to influence how family therapists work today. Out of this project came the **Mental Research Institute** (MRI) at Palo Alto. Led by Don Jackson, and joined by a number of research associates, most notably Jay Haley, Virginia Satir, and later Cloé Madanes, this group focused on communication and family process. Satir's work at MRI, as well as an earlier collaboration she had with Murray Bowen and influences from humanistic psychology, would eventually lead to the development of her **human validation process model**, which emphasized communication and self-esteem in couples and families (Satir, 1967, 1972a, 1972b). Meanwhile, Haley (1973, 1976) and Madanes (1981) would take a different route. Concentrating mostly on making strategic behavioral changes, their **strategic therapy** became one of the most popular and intriguing approaches to couples and family counseling.

At around the same time, the Palo Alto group was formulating their ideas, a somewhat different approach to working with families began to take shape under the auspices of Carl Whitaker. Influenced by individuals as varied as Gregory Bateson, Carl Jung, the psychoanalyst Melanie Klein, and Buddhist philosopher Alan Watts, Whitaker was known to be unconventional in his approach and willing to freely experiment with his responses during sessions. With the concurrent spread of humanistic psychology during the 1950s and 1960s, it is not surprising that this **experiential family therapy** approach, which drew from a belief in intrapsychic forces, humanistic philosophy, and systems thinking, was to evolve at this time (Napier & Whitaker, 1972, 1978; Whitaker, 1976).

Having worked with families in Israel and low-income and minority families in New York City, and influenced by Bateson and others at Palo Alto, during the 1960s, Salvador Minuchin (1974, 1981) developed one of the most widely respected approaches to couples and family therapy at the **Philadelphia Child Guidance Clinic**. An Argentinean-born psychiatrist, Minuchin would become known for his work with minorities and the poor in Philadelphia as he applied his **structural family therapy** approach that sought to understand how problems in family could be explained by problems in the family's structure. Eventually, Jay Haley joined Minuchin, and the two shared their ideas on working with families. It is also here that Jay Haley and Cloé Madanes met, and eventually married.

In 1966, within MRI, the **Brief Family Therapy Center (BFTC)** was established. Led by Paul Watzlawick, John Weakland, and Dick Fisch, BFTC focused solely on helping families solve their problems, as opposed to spending an inordinate amount of time on “underlying” issues, communication sequences, or systemic patterns (Cade, 2007; Goldenberg & Goldenberg, 2008). These individuals realized that the solutions families tried generally resulted in entrenching the problem more. Approaching families with an attitude of experimentation, these therapists were highly active and felt free to use any methods that were ethical and legal to solve problems or lessen presenting symptoms. Steve de Shazer (1982) and Insoo Kim Berg (1994), both of whom did postgraduate studies at BFTC, became two leading figures in the development of **solution-focused family therapy**.

Intrigued by Gregory Bateson and inspired by the work of Jay Haley, the early 1970s saw an Italian group, known as the **Milan Group**, become popular (Palazzoli, Boscolo, Cecchin, & Prata, 1978). With Watzlawick from BFTC acting as their consultant, this group would borrow many ideas from Bateson's original work but were also influenced by the work of cognitive and constructivist therapists, who believed that language usage is critical to meaning-making and how one comes to make sense of one's family.

As you might expect, with the expansion of behavioral and cognitive approaches to individual therapy in the latter part of the twentieth century, we concomitantly saw these philosophies applied within the family context. Finally, with what has come to be known as the “post-modern” movement, we see the recent rise of what is called **narrative family therapy**. Influenced by Michael White and David Epston (White, 1995; White & Epston, 1990), this approach attempts to understand a family's narrative, or story, and helps them to **deconstruct problem-saturated stories** and then reconstruct how the family comes to understand itself.

In recent years, the field of couples and family therapy has taken off, with 48 states having licensure for marriage and family counseling, according to the **American Association of Marriage and Family Therapy (AAMFT, 2009)**. Today, AAMFT and the **International Association for Marriage and Family Counselors (IAMFC)**, a division of the American Counseling Association, are the two main couples and family therapy associations in the country. These associations, along with their respective accreditation bodies (COAMFTE and CACREP), lead the field in setting curriculum standards for accreditation, making

recommendations to state licensing boards, defining best practices and ethical standards, and helping to set credentialing requirements in the field of couples and family therapy. Today, training in couples and family therapy is commonplace in almost all programs that train helpers.

VIEW OF HUMAN NATURE

Because family therapists can have as their basis any number of theoretical orientations, their views of human nature can vary dramatically. For instance, a family therapist can be psychodynamically oriented and believe that the unconscious plays an important role in one's life; behaviorally focused and view the individual as conditioned by his or her environment; existential–humanistically oriented and see the individual and the family as having a growth force that can be actualized; or have leanings toward social constructionism and believe that there is no one reality and that individuals construct their sense of meaning from language. Despite these differences, most (but not necessarily all!) family therapists believe in a number of assumptions about families and about systems that are integrated into their theoretical orientations. These are summarized below (Barker, 2007; Turner & West, 2006).

- The interactional forces in families are complex, and cannot be explained in a simple, causal fashion.
- Families have **overt** and **covert rules** that govern their functioning.
- Understanding the **hierarchy** in a family (e.g., who's "in charge;" who makes the rules) can help one understand the makeup and communication sequences of a family.
- Understanding the **boundaries** of the family system and the subsystems (e.g., spousal, sibling) can help one understand the makeup and communication sequences of a family.
- Understanding whether boundaries are **rigid** or **semi-permeable** (e.g., how information can get in and out of families) can help one understand how communication and change occurs in families.
- Understanding how family members communicate can give insight into how a family maintains its way of functioning.
- Each family has its own unique **homeostasis** that describes how the family typically interacts. This homeostasis is not "bad" or "good." It simply is.
- Communication in families is complex, and the language families use is a message about who they are.
- Change occurs by changing the homeostasis, or the usual patterns in the family.
- Issues passed down by language in families, in culture, and in society affects how families come to define themselves.

- **Stress** from the expected developmental milestones through which most families pass can wreak havoc on the family, and family therapists should be aware of the particular issues involved in such developmental milestones.
- In addition to being equipped to deal with stress from **developmental milestones**, family therapists should have the tools to help families deal with the unexpected stresses of life.

KEY CONCEPTS

The assumptions listed in the “View of Human Nature” section are an outgrowth of a number of ideas that have been generated over the years and will be expanded upon in this section. They include the following concepts: **general systems theory, cybernetics, boundaries and information flow, rules and hierarchy, communication theory, scapegoating and identified patients, stress, developmental issues, and social constructionism.**

General Systems Theory

Living systems are processes that maintain a persistent structure over relatively long periods despite rapid exchange of their component parts with the surrounding world. (Skynner, 1976, pp. 3–4)

The amoeba. The family. The universe. What do these seemingly dissimilar entities have to do with couples and family therapy? Although knowledge of the amoeba and of the universe may seem like a far cry from helping us to understand the family, in actuality, they all have something in common: They obey the rules of a system. The amoeba has a **semi-permeable boundary** that allows it to take in nutrition from the environment. This delicate animal could not survive if its boundaries were so rigid that they prevented it from ingesting food or so permeable that they would not allow it to maintain and digest the food. As long as the amoeba is in balance, it will maintain its existence.

The universe is an exceedingly predictable place, and it has a certain cadence to it. It maintains a persistent structure over a long period of time. However, remove a star, planet, moon, or asteroid, and the system is shaken, momentarily disequibrated as it moves to reconfigure itself. As long as the universe is in balance, it will maintain its existence.

Like the amoeba and the universe, what occurs in the family is predictable, because the family too has boundaries and structure that maintains itself over long periods of time. As long as the family system is in balance, it will maintain its existence.

The concept of system thus treats people and events in terms of their interactions rather than their intrinsic characteristics. The most basic principle underlying the systems viewpoint has been understood for some time. An ancient astronomer once said, “Heaven is more than the stars alone. It is the stars and their movements.” (Baruth & Huber, 1984, p. 19)

General systems theory (von Bertalanffy, 1934, 1968) was developed to explain the complex interactions of all types of systems, including living systems, family systems, community systems, and solar systems. Each system has a boundary that allows it to maintain its structure while the system interacts with other systems around it. So the action of the amoeba, one of the smallest of all living systems, affects and is affected by surrounding **suprasystems**, while the universe, the largest of all systems, is made up of **subsystems** that have predictable relationships to one another. Similarly, the action of subsystems in families will affect other subsystems (e.g., the parental subsystem will affect the child subsystem); family units will affect other families; families make up communities that affect society; and so on.

Cybernetics

The study of **cybernetics**, or control mechanisms in systems, has been used to explain the regulatory process of a system (Becvar & Becvar, 2009). The distinctive manner that each system has to maintain its stability is called its **homeostasis**. One type of cybernetic system of which we are all aware is the thermostat. As it becomes colder, the temperature drops, and the thermostat turns on the heating system; as the temperature goes up, the thermostat shuts down the heat. This type of cybernetic system is called a **negative feedback loop** because it keeps the irregularities within the system at a minimum. **Positive feedback loops** occur when change in one component in a system leads to a change in another component within the same system, which leads to a change in the first component, and so on. On the relationship level, cybernetics explains how couples and families regulate themselves using their unique ways of communicating as they maintain their homeostasis. Although most couples and families are engaged in negative feedback loops most of the time, sometimes you will see a positive feedback loop such as when spouses egg each other on in a continual escalation of a fight. Look at Box 15.1 for an example of a couple engaged in a positive feedback loop.

Based on the example in Box 15.1, you might conclude that negative feedback loops are good and positive feedback loops are bad. Actually, this is not the case (Becvar & Becvar, 2009). Negative feedback loops are good if they result in healthy behaviors in families (good communication, good feelings, etc.). However, negative feedback loops will sometimes maintain dysfunctional behaviors (lack of communication, negative feelings), and although positive feedback loops can lead to abuse, they also can be the impetus for shaking up the system and having it move toward healthier ways of communicating. In fact, couples and family therapists will often encourage the disequilibrium of the “safe” yet unhealthy ways of relating that can be found in some negative feedback loops so that the couple or family can take on new ways of relating. Each family has its unique way of interacting, which includes negative and sometimes positive feedback loop systems. If you examine communication sequences in any family, you can begin to understand the unique boundaries, feedback loops, and homeostatic mechanisms involved.

Box 15.1 Joyce and Antonio: A Positive Feedback Loop

In the dialogue below, Joyce and Antonio are discussing going out to a play. As they realize that their expectations about the evening differ, they begin to get angry at each other. Eventually, there is an altercation, at which point Antonio defuses the situation by leaving.

- JOYCE: Are you going to the play with me tonight?
- ANTONIO: Well, I was actually thinking I might go out with my friends. You know, I haven't really seen them for a while. Besides, I didn't really think that I committed myself to the play.
- JOYCE: Well, you did say you thought you would go with me.
- ANTONIO: I don't remember saying that. I was thinking all along that I would go out with my buddies.
- JOYCE: I remember distinctly you telling me you would go. It's clear as day to me. You're either lying or have early dementia.
- ANTONIO: Look, I don't want to get into a fight. You're always forcing me to get into a fight with you. I don't know why you egg me on like this. You must have a need to fight with me. I bet it has to do with the fact that you never felt loved by your father—you know, we've talked about that before.
- JOYCE: Not being loved by my father! Who are you kidding? The only one I don't feel loved by is you. At least my father was around. You just take off whenever you damn please! Half of the time you leave me with the kids, as if you have no responsibility around here. You just go out, get blasted and God knows what else.
- ANTONIO: Look, I'm no slacker around here. You don't do a damn thing around this house. Look at it. It's a mess. I do plenty, and you can't even keep this house together. I work hard to fix this place up, and you can't even run a vacuum once in a while. You ... it's disgusting!
- JOYCE: Don't call me disgusting!
- ANTONIO: I didn't! I said *it's* disgusting—the house.
- JOYCE: No, I heard you, you were going to say I'm disgusting. I hate you! You and your drinking, you and your friends. You and those sluts you hang out with at work. I know what you're doing behind my back!
- ANTONIO: Screw you!
- JOYCE: Go to hell! (Swings at him.)
- ANTONIO: (Grabs her arm as she swings and throws her on the floor.)
- JOYCE: You abusive bastard!
- ANTONIO: Screw you.... I'm getting out of here. (Leaves the house.)
- JOYCE: (Sobs as Antonio leaves.)

Boundaries and Information Flow

A healthy system has **semi-permeable boundaries** that allow new information to come into the system, be processed, and then incorporated into the system. When a system has **rigid boundaries**, information is not able to easily flow into or out of the system, and change becomes a difficult process. Alternatively, a system that has **diffuse boundaries** allows information to flow too easily into and out of the system, causing the individual components of the system to have difficulty maintaining a sense of identity and stability (Nichols & Schwartz, 2009; Turner & West, 2006). Rigid boundaries will often lead to disengagement on the part of family members and a heightened sense of autonomy. In extreme cases, such families will have family secrets (e.g., child abuse), with their rigid boundaries maintaining the secret within the family. Diffuse boundaries, on the other hand, often lead to enmeshment and a lack of independence on the part of family members.

Box 15.2 Jim Jones and the Death of a Rigid System

During the 1950s and early 1960s, Jim Jones was a respected minister in Indiana. However, over the years, he became increasingly paranoid and grandiose, believing he was Jesus. He moved his family to Brazil and later relocated to California, where approximately 100 of his church followers from Indiana joined him. In California, he headed the "People's Church" and began to set rigid rules for church membership. Slowly, he became more dictatorial and continued to show evidence of paranoid delusions. Insisting that church members prove their love for him, he demanded sex with female church members, had members sign over their possessions, sometimes had members give their children over to him, and had members inform on those who went against his rules. In 1975, a reporter uncovered some of the tactics Jones was using and was about to write a revealing article about the church. Jones learned about this and, just prior to publication of the article, moved to Guyana, taking a few hundred of his followers with him. As concerns

about some of the church practices reached the United States, California Congressman Leo Ryan and some of his aides went to Guyana to investigate the situation. Jones and his supporters killed Ryan and the aides, and Jones then ordered his followers to commit suicide. Hundreds killed themselves. Those who did not were murdered.

Jim Jones had developed a church with an extremely rigid set of rules. The writing of a revealing article as well as the congressman's flying into Guyana were perceived as threats to the system. As with many rigid systems, attempts at change from the outside were seen as potentially lethal blows to the system. Jones dealt with the reporter's threat to the system by moving his congregation to Guyana. Then, rather than allow new information into the system, Jim Jones killed off the system, first killing the congressperson and then ordering the church members to commit suicide. The members had become so mired in the rules of the system that nearly 900 of them ended up committing suicide or being murdered. (Axthelm, 1978)

American culture allows for much variation in the permeability of various systems, but systems that have boundaries that are too diffuse or too rigid tend toward dysfunction. In the United States, it is common for us to find families and community groups (e.g., some religious organizations) with a fairly rigid set of rules that maintain their functioning in relatively healthy ways. Alternatively, we may also find families and community groups that allow for a wide range of behaviors within a fairly diffuse system (e.g., communes). Unfortunately, all too often, we have seen the dysfunction that results from a system whose boundaries are too rigid or too diffuse (see Box 15.2).

Rules and Hierarchy

Families have **universal** and **idiosyncratic rules**, which can be overt or covert, that are partly responsible for determining the nature of the family. Universal rules are those rules that all families tend to follow and are often related to hierarchical structure. For instance, almost all cultures have a hierarchy in which parents, guardians, or an older "wise" person is on a higher level of authority than children. Not following this rule has a consequence, although the kinds of consequences will vary as a function of the culture. Idiosyncratic rules are unique to the family. For instance, a family might have a rule that whenever there is tension in the couple's relationship, the youngest child is yelled at for doing something wrong. In a situation such as this, it is likely that the child is being **scapegoated** in an effort to

diffuse tension between the couple. There are an infinite number of idiosyncratic rules, and they usually happen in an automatic manner.

Communication Theory

The work of Paul Watzlawick and others at Palo Alto greatly changed the manner in which therapists understood the communication process (cf. Watzlawick, Beavin, & Jackson, 1967; Watzlawick, Weakland, & Fisch, 1974). Understanding the complexities of human communication helps therapists recognize the unique characteristics of couples and families and is often the first step toward developing a plan for change. Some of the principles of communication highlighted by Watzlawick and others include the following (Barker, 2007):

- “Normal” or “abnormal” is a contextual phenomenon, not an objective state of being.
- Behaviors tell a story about communication between people and are often more a sign of what’s going on than the actual words that are communicated.
- One cannot *not* communicate. Not saying anything is a communication about communication.
- A message sent is not necessarily the message received. A person might send one message, but a different message might be heard.
- Communication has two ways of expression: digitally, or the exact meaning of the words, and analogically, or the meaning about the meaning, often expressed nonverbally. For example, a person may be angry and say “I love you” in an angry tone. The digital message “I love you” is at odds with the analogical message.
- Communication makes a statement about the content of the conversation and about the relationship one is in. In other words, each statement a person makes is an expression about the relationship.
- A series of communications gives important meaning about the relationship (a husband might always discuss issues with a flat affect to his wife; this continual flat message may be more important than the actual words he says).
- Any intervention made within the system, be it with one or more of the family members, will reverberate throughout the system.
- The unconscious is not an important factor in working with individuals; instead, what is important are the current behaviors people are exhibiting.
- The *whys* are not as important as *what* is going on between people.

Scapegoating and Identified Patients

All couples bring unfinished business to their relationship. The more serious the issues, the more likely they will affect their relationship and others in the family.

For instance, a wife who was sexually molested as a child and as a result feels mistrust toward men may choose a man who is emotionally distant (and safe). Perhaps he is a workaholic. Alternatively, a man who has fears of intimacy might choose a wife who allows him to be distant (and safe). Perhaps she was sexually molested and distrusts men. As the relationship unravels, the issues that each spouse brings to the marriage will get played out on one another or on the children. The emotionally distant workaholic husband may become stressed at work, irritable, and nasty toward his wife and/or children. The distrustful wife may become discontented with her marriage due to its lack of intimacy and subsequently become depressed and nonresponsive toward her husband and children. Is it surprising that there are so many affairs and divorces?

When family members are discontented with one another and when they directly or indirectly take out this unhappiness on a specific family member, that member is said to have been **scapegoated** (Nichols & Schwartz, 2009). Sometimes, when a family member is scapegoated, that person takes on the role of **identified patient** (IP), or the family member who is believed to have the problem. System theorists, however, view the whole family as having the problem. For instance, when a child acts out in the family, in school, or in the community, couples and family therapists will typically view that child as the family member who is carrying the pain for the family. Why is someone in a family scapegoated? Usually because it has become too painful for the couple or family to look at some other painful issue (Hull & Mather, 2006). Rather than sharing their concerns within the family or seeking marital counseling, the couple or family scapegoats a member in the family, often a child (see Box 15.3).

Psychotherapy, particularly marital psychotherapy, threatens to “uncover” the anxious turmoil in the marriage. “If we seek help as a couple,” the partners say silently to themselves, “it will all come out.” The anger, the bitterness, the hurt, the sense of self-blame that each carries—this will be the harvest of the opening up to each other. “Maybe it will destroy what we have” is their fear. They dread not only losing the stability of the marriage, but damaging their fragile self-images. Rather than risk their painful and tenuous security, they suppress the possibility of working on their marriage together. (Napier & Whitaker, 1978, p. 148)

Stress

Living is stressful, and at some point in the life of the family, it will be faced with mild to oppressive **stress**. Families with semi-permeable boundaries, clearly defined subsystems and suprasystems, little scapegoating, good communication skills, and a healthy hierarchical structure will have an easier time managing stress (see Box 15.3). On the other hand, families with ill-defined boundaries and poor communication skills will tend to blame others for their problems, not take responsibility for their feelings and actions, and have a difficult time dealing

Box 15.3 A Situational Family Crisis

When I was between the ages of 8 and 13, I had a heart disorder called pericarditis. This was a somewhat debilitating illness that enlarged my heart, caused me much chest pain, and left me periodically bedridden with a resulting mild depression. Although not considered extremely serious, this illness certainly affected my life in a major way. However, it also affected my parents' lives and the lives of my siblings.

Although my illness potentially could have been a threat to the homeostasis in the family, it became clear that the family was healthy enough to deal effectively with this situation. As my parents' marriage was solid, the added stress did not dramatically affect their relationship. In addition, they were able to maintain the functioning of the family in a relatively normal way. This normalization of family patterns during a period of stress speaks highly of the health in the family.

with stress. Minuchin (1974) identified four types of stress with which families typically struggle at some point in their development:

- *Stressful contact of one member with extrafamilial forces* (e.g., difficulty at work)
- *Stressful contact of the whole family with extrafamilial forces* (e.g., a natural disaster such as a hurricane)
- *Stress at transitional or developmental points in the family* (e.g., puberty, midlife-crises, retirement, aging)
- *Idiosyncratic (situational) stress* (e.g., unexpected illness)

Developmental Issues

All families face **developmental milestones** that will result in some amount of stress. Becvar and Becvar (2009) suggest that families traverse nine stages of a family cycle, each of which has its own critical emotional issues and tasks that need to be addressed (see Table 15.1).

Whereas some families have developed ways of communicating that allow them to effectively deal with stressful situations, others have not (Turner & West, 2006). One function of the family therapist is to be aware of potential developmental crises that may affect a family and understand how families tend to respond to stress that results from these normal developmental tasks. Having the skills to help families change their response from one that is harmful to one that allows the family to function at an optimal level is an important role of the family therapist.

Social Constructionism

The addition of social construction to systems theory, then, helps address the criticism that systems theory focuses too much on stability, ignores cultural context, and operates as though the research can find objective truth. (Turner & West, 2006, p. 70)

TABLE 15.1 Stages of the Family Life Cycle

Stage	Emotional Issues	Stage-Critical Tasks
1. Unattached adult	Accepting parent-offspring separation	a. Differentiation from family of origin b. Development of peer relationships c. Initiation of career
2. Newly married adults	Commitment to the marriage	a. Formation of marital system b. Making room for spouse with family and friends c. Adjusting career demands
3. Childbearing adults	Accepting new members into the system	a. Adjusting marriage to make room for child(ren) b. Taking on parenting roles c. Making room for grandparents
4. Preschool-age child(ren)	Accepting the new personality	a. Adjusting family to the needs of specific child(ren) b. Coping with energy drain and lack of privacy c. Taking time out to be a couple
5. School-age child(ren)	Allowing child(ren) to establish relationships outside the family	a. Extending family-society interactions b. Encouraging the child(ren)'s educational progress c. Dealing with increased activities and time demands
6. Teenage child(ren)	Increasing flexibility of family boundaries to allow independence	a. Shifting the balance in the parent-child relationship b. Refocusing on mid-life career and marital issues c. Dealing with increasing concern for older generations
7. Launching center	Accepting exits from and entries into family	a. Releasing adult children into work, college, marriage b. Maintaining supportive home base c. Accepting occasional returns of adult children
8. Middle-aged adults	Letting go of children and facing each other again	a. Rebuilding the marriage b. Welcoming children's spouses, grandchildren into family c. Dealing with aging of one's own parents
9. Retired adults	Accepting retirement and old age	a. Maintaining individual and couple functioning b. Supporting middle generation c. Coping with death of parents, spouse d. Closing or adapting family

SOURCE: Becvar, D. S., & Becvar, R. J. (2009). *Family therapy: A systemic integration* (7th ed.). Boston: Allyn & Bacon. p. 111.

In recent years, there has been a shift for some family therapists in their understanding of how families are formed and make sense of themselves (Tomm, 1998; Turner & West, 2006). Having a **social constructionist** philosophy, these family therapists believe that systems theory, and its close cousin, cybernetics, placed too much emphasis on causal factors and did not stress cultural context enough. The social constructionists suggested that these earlier family therapists tended to see themselves as experts and objective observers who make interventions on the family. In contrast, the social constructionists focus on the ongoing, changing manner in which family members come to understand themselves. They believe that families continually co-construct (construct together through ongoing dialogue and nonverbal interactions) their understanding of who they are, and that this construction is a function of the language used in the family and beliefs from their culture and society. Change occurs, therefore, by the therapist's entering the family with a respectful curiosity and exploring, with the family, how they co-construct a sense of meaning for themselves. Then, through the use of thoughtful and respectful questioning, social constructionists believe that they and the family can co-construct a new language for the family that is positive and focuses on solutions. Although many family therapists today integrate this perspective into their existing systems framework (Becvar & Becvar, 2009), some, such as the narrative and solution-focused purists, question these earlier theories (e.g., systems theory, communication theory) and discard them for a belief in the importance of how language defines the person and the family.

MODELS OF FAMILY THERAPY

The key concepts just discussed are the driving force behind the various approaches to family counseling. As some approaches adhere more to certain concepts than others, as you read the theories, reflect on which key concepts are most driving a particular theory. With many theories of couples and family therapy to choose from, included in this chapter are the most popular ones as well as those that are most associated with some of the major players in the history of couples and family therapy. The theories we will look at include the **human validation process model, structural family therapy, strategic family therapy, multigenerational family therapy, experiential family therapy, psychodynamic family therapy, behavioral and cognitive-behavioral family therapy, narrative family therapy, and solution-focused family therapy.**

Human Validation Process Model of Family Therapy

All of the ingredients in a family that count are changeable and correctable—individual self-worth, communication, system, and rules—at any point in time. (Satir, 1972a, p. xi)

In addition to Salvador Minuchin and Jay Haley, Virginia Satir is considered to be one of the pioneers of couples and family therapy. Her **human validation process model**, which has also been called a *communication theory* and a *change process model*, integrates many ideas from family systems theory and communication theory, while adding a sense of caring and a focus on self-esteem that is emphasized in the existential–humanistic approaches (Satir, 1972b).

Satir believed that a **primary survival triad** exists that includes parents and the child, with each child’s sense of well-being and self-esteem the result of this triad. Low self-esteem eventually leads individuals to take on one of four unhealthy universal communication patterns: (1) **the placater**, who appeases people so others won’t get angry at him or her; (2) **the blamer**, who accuses others in an effort to diffuse hurt; (3) **the computer**, who acts cool, calm, and collected in an attempt to deal with the world as if nothing could hurt him or her; and (4) **the distracter**, who goes off on tangents in an effort to treat threats as if they do not exist (Satir, 1972a). On the other hand, Satir also believed that children who had healthy parenting would grow into adults who were congruent—in sync with their feelings, thoughts, and behaviors—and could thus communicate clearly with others.

Believing that communication and behavioral patterns are a result of complex interactions among family members and the legacy from past generations, Satir felt it was important to obtain graphic information about important past events in one’s family. Thus, she would often have families complete a **family life fact chronology**, which is a history of important events within the extended family. Similar to a **genogram**, the family life fact chronology could be analyzed and reflected upon by all involved in therapy. Additionally, Satir was one of the first therapists to use **family sculpting** in an effort to bring forth blocked and unexpressed emotions (Piercy, Sprenkle, & Wetchler, 1996). This experiential work involves each family member taking a physical position that nonverbally represents how that member interacts with the rest of the family. For instance, a child who is withdrawing might stand near a door as if she were about to leave the room; a mother trying to control her son might stand over him with her finger pointed at him; and a father who is detached through drinking might sit at a table with a make-believe glass of beer in his hand.

Satir believed that a family therapist should be caring and respectful, believe in the ability of the family to heal, actively encourage the family to change, be spontaneous, and act “as a facilitator, a resource person, an observer, a detective, and a model for effective communication” (Becvar & Becvar, 2009, p. 199). By creating a trusting atmosphere that encouraged the letting-down of defenses, Satir hoped to open up communication patterns, look at past hurts, and help clients learn how to be more effective and open communicators. Ultimately, through this process, Satir hoped that individuals in couples and families could have mature relationships in which each person could (Satir, 1972a):

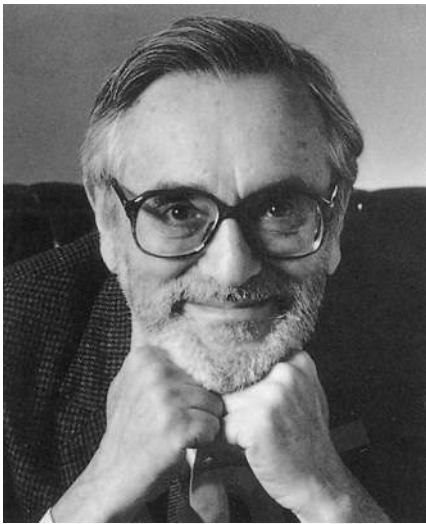
- be responsible for oneself and have a strong sense of self.
- make decisions based on an accurate perception of self, others, and the social context.



Virginia Satir

- be able to make wise choices for which one takes full responsibility.
- be in touch with one's feelings.
- be clear in one's communication.
- be able to accept others for who they are.
- see differences in others as an opportunity to learn, not as a threat. (adapted from Satir, 1967, p. 91)

Structural Family Therapy



Salvador Minuchin

Although many well-known family therapists see themselves in the structural school, certainly the most renowned is Salvador Minuchin (1974, 1981). Minuchin (1974) states that all families have **interactional** and **transactional rules** that are maintained by the kinds of boundaries in the family, as noted through the structure and hierarchy that exists. He also asserts that all families experience stress, which is handled differently by each family as a function of the existing rules, boundaries, and structure and hierarchy in the family (see p. 511). In order to make change in families, structural family therapists must join with the family, map the family, and provide interventions for restructuring.

Joining. Minuchin believes that change in the family can occur only if the therapist is able to “join” with the family.

Joining is when the counselor is accepted by the family and wins its confidence. Joining can be done in many ways, such as through empathy, being friendly, or sharing common stories with the family. Joining the family allows the counselor to understand the family's rules, boundaries, structure and hierarchy, and stress. It is only then that the counselor can begin the process of mapping and later restructuring the family.

Mapping. **Mapping** a family can be done formally or informally, and involves an examination of how the family communicates, who is in charge, rules used in the family to maintain its homeostasis, and an understanding of the structure and hierarchy of the family. Mapping is the first step toward restructuring, as one cannot make change unless one understands the current way in which the family relates.

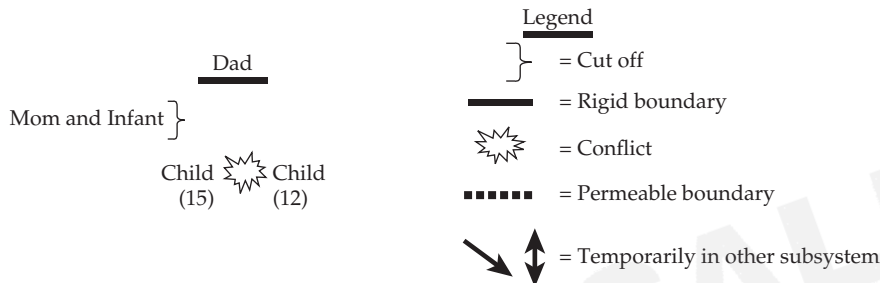
Restructuring. **Restructuring** the family occurs after the counselor has joined the family and mapped its structure. It involves creating healthier boundaries, and changing structure and hierarchy, in order to help the family deal with stress and function in a healthier manner. Restructuring can occur in numerous ways. Box 15.4 describes the restructuring of one family.

Structural family therapy is a deliberate and purposeful approach to working with families and relies on many of the basic principles discussed under “Key

Box 15.4 An Example of Family Restructuring

Mom and Dad have three children, aged 15, 12, and 1. Since the birth of their new child, the two oldest children have been fighting constantly and having problems at school. The husband and wife seem depressed. Assessing the situation, you find that the whole family is dealing with transitional and idiosyncratic stress. The baby was not planned, and the

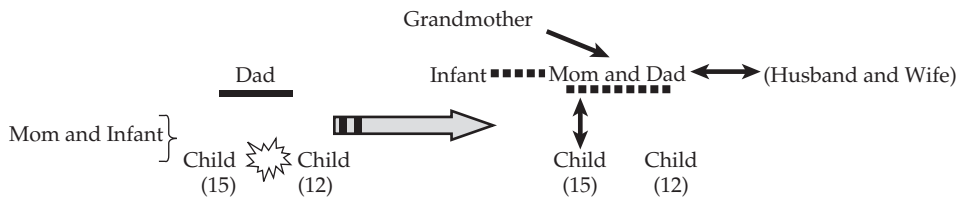
family is stretched financially. The therapist notes that the family hierarchy has changed, that the spousal subsystem is showing depression, and that the parental subsystem is not able to maintain control over the two older children. The therapist wants to strengthen the spousal and parental subsystems. The current map of the family is shown to the left of the legend.



The family therapist prescribes the following actions:

- Have the oldest child take a certification course in babysitting to assist with child care.
- Ask the grandmother to assist with child care to relieve some pressure on Mom.
- Have Dad take on some of the responsibilities related to the problems with the oldest children. He must meet with the teachers and school counselors.
- Suggest that Mom, who now has assistance with child care, take on a part-time job to relieve some of the economic stress (she has always worked in the past).
- Establish one evening a week when the grandmother or oldest child will watch the other two children so the parents can go out.

The goal is to reestablish the spousal subsystem while strengthening the parental subsystem. The grandmother and oldest child will periodically take on a position of power in the family, with their power being time-limited. The extra money and reduction of stress for Mom will result in reduced stress in the family. The family map eventually looks like the diagram below:



Concepts.” Many family therapists who are first starting out are trained in this approach, as it helps the therapist view the family from a systemic perspective.

Strategic Family Therapy

The steps involved in strategic therapy are based on an understanding of communication and systems theory; and, because unconscious motivations play



Courtesy of Dr. Sonja Benson

Jay Haley



Courtesy of Cloé Madanes

Cloé Madanes

little if any role in this type of therapy, the approach is relatively pragmatic. Relative to the therapeutic process, the strategic approach is not particularly concerned with feelings (although the therapist wants the client to end up having good feelings!). This approach is based on how individuals communicate with one another, how communication sequences can be changed to help people feel better, and how power is dispersed in the family. Power for the strategic therapist is defined in some very nontraditional ways:

Power tactics are those maneuvers a person uses to give himself influence and control over his social world and to make that world more predictable. Defined thus broadly, a man has power if he can order someone to behave in a certain way, but he also has power if he can provoke someone to behave that way. One man can order others to lift and carry him while another might achieve the same end by collapsing. (Haley, 1986, p. 53)

The therapist most associated with the strategic approach has been Jay Haley (1973, 1976), although others, like Cloé Madanes and the Milan Group, have also become well-known. Haley was greatly affected by Milton Erickson, a legend as a therapist because of his uncanny ability to induce change in clients. In Haley's 1976 book, *Problem-Solving Therapy*, he describes four stages of the first interview that lay the groundwork for the change process. Although unique to the way Haley implements strategic therapy, these stages provide a picture of how all strategic family therapists work.

Haley's Stages of The First Interview

1. *The social stage.* During this stage, the therapist invites the whole family to counseling and asks each member to introduce himself or herself. At this point, the therapist can observe where family members sit, interactions among family members, and the overall mood of the family. During this stage, the therapist should not share his or her observations with the family, and all formulations about the family should be tentative.
2. *The problem stage.* During the problem stage, each family member is asked to describe his or her perceptions of the problem. The therapist should carefully listen, as the problem is often defined differently by family members. Interactions among family members should be carefully observed, and therapist interpretations about the problem should not be shared.
3. *The interaction stage.* The interaction stage is highlighted by the therapist's attempt to get the family to interact during the session in the same manner in which they might at home. This process assists the therapist in viewing how the family is organized around the problem.
4. *Goal-setting stage.* During this stage, the family is asked to be clear about what they would like to change, and, in collaboration with the therapist, a problem is agreed upon. This problem is important and needs to be addressed;

however, it also tells us something about how the family communicates and the hierarchies in the family (Foster & Gurman, 1985; Haley, 1973, 1976). Therefore, how the therapist addresses the problem may vary based on an assessment of the structure and communication sequences in the family. Remember, the focus is on having people change the way they communicate so they will feel better, and sometimes what the family thinks they *should* do will actually make the problem worse. Thus, the role of the therapist is to help the family change based on the therapist's understanding of the communication problems and how power is used (and abused) in the family. The family need not know why the therapist is prescribing certain tasks, but the family does need to "buy into" the change process. Haley addresses this change process through the use of **directives**.

Directives

It is important to emphasize that directives can be given directly or they can be given in a conversation implicitly by vocal intonation, body movement, and well-timed silence. Everything done in therapy can be seen as a directive. (Haley, 1976, p. 50)

Directives are the kinds of instructions given to a family to foster change. If enough progress has been made, directives can be made at the end of the first session, although sometimes it may take two or three sessions. Haley (1976) identifies two types of directives: "(1) telling people what to do when the therapist wants them to do it, and (2) telling them what to do when the therapist does not want them to do it because the therapist wants them to change by rebelling" (p. 52).

In the first case, a therapist can either give good advice or give a directive that changes the structure of the family. Haley admits that advice, even good advice, is rarely followed by families. Therefore, he suggests giving directives in which the family wants to participate, directives that will address both the presenting problem and also broader problems inherent in the family organization and communication sequencing. The therapist generally does not reveal to the family his or her agenda of restructuring family dynamics, as this is not generally found to expedite change. For instance, parents might identify a problem as their daughter's use of drugs. However, in therapy, it soon becomes clear that the family isolates and cuts off the daughter from the rest of the family. The therapist could give good advice, such as suggesting to the daughter that she take a drug education class. However, this would most likely be a wasteful suggestion, as it is unlikely to be followed by the rebellious daughter. Therefore, it would be more useful to offer a directive that deals with the drug use *and* the family organization—a directive in which all would participate. For example, the therapist might ask the family to include the daughter in as many family activities as possible in an effort to ensure that she is not doing drugs. The parents will appreciate this directive, as it is dealing with the problem, and the daughter will appreciate it, as she is finally being included in the family.

The second type of directive, called a **paradoxical directive**, involves asking clients to do something opposite of what might seem logical, with the expectation that the directive is likely to fail and that this failure will lead to success in therapy. Put simply, “some clients are more invested in the ‘cons’ of change, not the ‘pros’ of change” (Jack Grimes, personal communication, July 14, 2009). If clients actually do follow the directive, success is also ensured. For instance, a family has a child who is constantly angry and screaming. The therapist might reframe the situation by stating that this child is actually quite healthy in that he is expressing his feelings. The therapist suggests that listening to the child’s feelings is not likely to be helpful because the child needs to release his healthy anger. Probably, the therapist remarks, it would be helpful instead to encourage the child to scream more. Parents who rebel against this suggestion end up listening to the child. On the other hand, parents who go with the suggestion are now compliant clients who have reframed the problem into a healthy behavior and are praised at the next session for being such good clients.

Another technique to induce change of this kind is through the **use of metaphor**. Look at how Haley (1976) uses metaphor to deal with a couple’s uncomfortable feelings about talking directly to their son about his being adopted:

[The therapist] talked to the boy about “adopting” a dog who had a problem of being frightened.... When the boy said the family might have to get rid of the dog if he became ill and cost doctor bills [the boy had been ill], the therapist insisted that once adopted the family was committed to the dog and would have to keep him and pay his doctor bills no matter what. Various concerns the boy might have had about himself as well as the parents’ concerns about him were discussed in metaphoric terms in relation to the proposed adoption of the puppy. (p. 65)

Course of Treatment. Strategic therapy tends to be a short-term approach to counseling because it focuses almost exclusively on presenting problems, does not spend time dealing with intrapsychic processes, and uses directives to facilitate the change process (Carlson, 2002). Usually, directives can be made within the first few sessions, with follow-up and revision to the original directives sometimes calling for only a few more sessions.

Clearly, to be a strategic therapist takes a great deal of training and confidence in one’s ability at suggesting effective directives. It is interesting to watch some of the more well-known strategic therapists work. Criticized as manipulative by some, today’s strategic therapists stress collaboration, not manipulation (Carlson, 2002). In fact, their directives, even ones with hidden agendas, appear to come from a real and caring place for these master therapists.

Multigenerational Family Therapy

Family counselors who take on a multigenerational approach to family therapy focus on how behavioral patterns and personality traits from prior generations have been passed down in families. Therefore, many multigenerational family

counselors may encourage bringing in parents, grandparents, and perhaps even cousins, uncles, and aunts.

Although multigenerational family counselors focus on intergenerational conflicts, the way they go about this may differ. For instance, Ivan Boszormenyi-Nagy (1973, 1987) believes that families are relational systems in which **loyalties**, a sense of **indebtedness**, and ways of relating are passed down from generation to generation. Couples enter relationships with a **ledger of indebtedness and entitlements** based on their families of origin and what was passed down to those families. A couple who enters a relationship with an imbalanced ledger will invariably attempt to balance the ledger with each other. This is almost always unsuccessful, as the imbalance is a result of unfinished business from the family of origin, not from the spouse. For instance, one who felt unloved by his mother might attempt to settle up his account with her by trying to have his wife shower him with love. However, because this is unfinished business with the mother, the husband will continue to feel a sense of emptiness, even if the wife fulfills this request. Boszormenyi-Nagy believes that it is crucial for all family members to gain the capacity to hear one another, communicate with one another, and have the ability to understand their interpersonal connectedness to the current family as well as their families of origin.

When each generation is helped to face the nature of the current relationships, exploring the real nature of the commitments and responsibility that flow from such involvements, an increased reciprocal understanding and mutual compassion between the generations results. The grandchildren, in particular, benefit from this reconciliation between the generations; they are helped to be freed of scapegoated or parentified roles and they have a hope for age appropriate gratifications plus a model for reconciling their conflicts with their parents. (Friedman, 1989, p. 405)

Another multigenerational family therapist, Murray Bowen, believed that previous generations could dramatically affect one's ability to develop a healthy ego. He considered the ultimate goal of couples and family therapy to be the **differentiation of self**, which included differentiation of self from others and the differentiation of one's emotional processes from one's intellectual processes (Bowen, 1976, 1978; Guerin & Guerin, 2002). He believed that there was a **nuclear family emotional system** made up of all family members (living, dead, absent, and present), which continued to have an emotional impact upon the system. Such an emotional system, said Bowen, is reflective of the level of differentiation in the family, and is called the **undifferentiated ego mass**. Thus, previous generations could continue to have an influence on current family dynamics (Klever, 2004). Bowen used the **genogram** to examine details of a family's functioning over a number of generations. Although the basic genogram includes such items as dates of birth and death, names, and major relationships, along with breakups or divorces, the therapist will usually also ask the family to include such things as where various members are from, who might be scapegoated and/or an



Murray Bowen

Box 15.5 Who's More Dysfunctional?

Bowen's belief that individuals generally find others of similar psychological health has always intrigued me. Many times, I have seen clients come for therapy, complaining and even diagnosing their lover or spouse whom they have left. At these times, I've often thought that if the partner were there, that person would likely have a comparable complaint or diagnosis. And it certainly makes some intuitive sense. After all, why would someone who is psychologically healthier

than my clients want to be with them? (Or, for that matter, why would someone psychologically healthier than you, or me, want to be with us?) And why would my clients choose to be with someone less healthy than them? (Or, why would we choose to be with those less healthy than us?) Have you ever found yourself diagnosing a person you are with or used to be with? Any thoughts about what they may have been saying about you?

identified patient, mental illness, physical diseases, affairs, abortions, and stillbirths. Such genograms are excellent tools for examining how families evolve over time and for identifying current issues in families (McGoldrick, 2005) (see Figure 15.1).

Bowen believed that individuals find others of similar psychological health with whom to form significant relationships. Therefore, an undifferentiated person will find a person with a similar level of undifferentiation, each hoping he or she will find completeness in the other. What initially seems like a perfect fit usually ends up as a major disappointment and often ends in divorce. When undifferentiated parents do not deal with their issues, which by their very nature are frequent, a **family projection process** occurs in which parents unconsciously **triangulate** their children or project their own issues onto the children. The purpose of this projection is to reduce stress within the parental relationship while maintaining each spouse's level of undifferentiation. This allows the couple to continue to avoid their issues. An unhealthy relationship obviously leads to problems with child-rearing, and ultimately the child grows into an undifferentiated self, thus continuing the cycle. This process could continue *ad infinitum* (see Box 15.5).

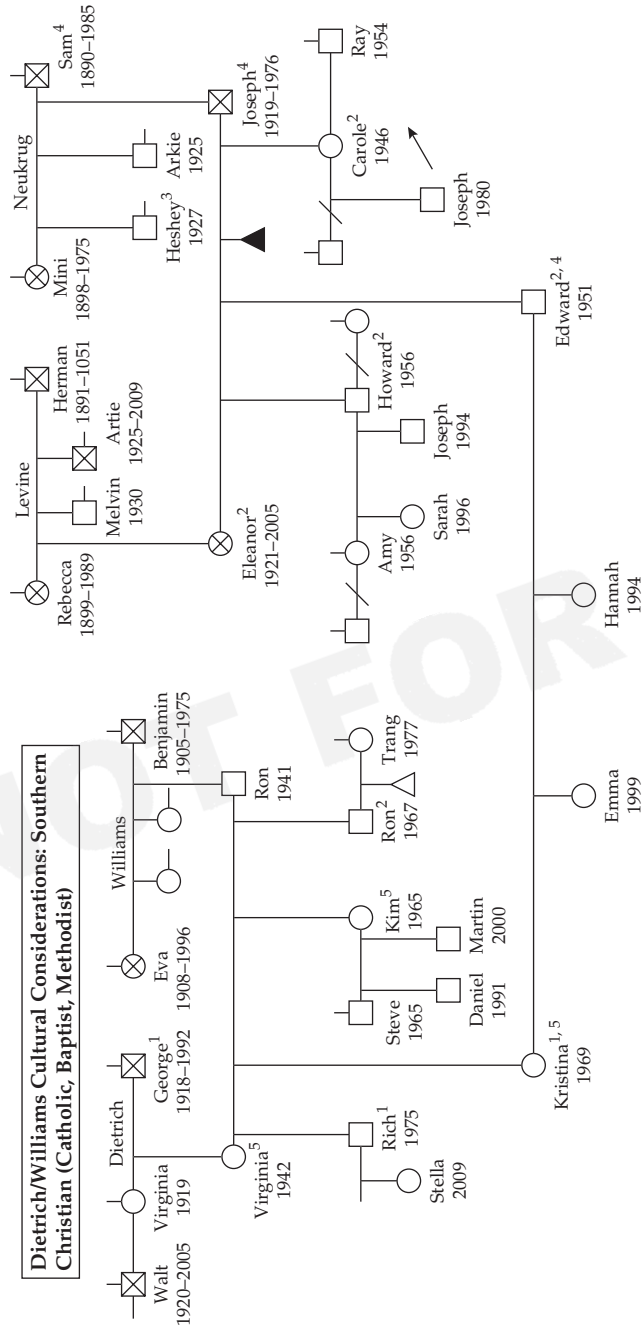
From a Bowenian perspective, therapists should be detached and take on the role of teachers and consultants, helping their clients to understand family dynamics and systems theory from an intellectual framework. Bowen mostly worked with couples, generally did not include children in the process, and kept emotionality at a minimum during the sessions by having the clients talk to and through the therapist. Bowen's goal was to help family members see themselves as they truly are and to help them move toward differentiation of self.

Experiential Family Therapy

As the name implies, **experiential family therapy** stresses the experience of self, of one another, and of the therapist within the family therapy milieu (Napier, 2002). Based mostly on humanistic and existential psychology, this type of therapy has a positive view of human nature, believes that the individual (and the family) has a natural growth tendency, and relies on the relationship between the therapist and the family to induce change. The most well-known experiential family

Levine/Neukrug Cultural Considerations: New York Jewish

Dietrich/Williams Cultural Considerations: Southern Christian (Catholic, Baptist, Methodist)



□ Male ○ Female ▲ Stillborn or Abortion △ Child in Utero | Offspring — Marriage — Separation/Divorce
 ✕ Death ↗ Physical Custody

1, 2, 3, 4, 5 = Tags. These could represent any of a number of mental health problems, disorders, or physical disorders. They should be clearly defined. (The numbers attached to my family members are randomly placed and are for demonstration purposes only). For instance, 1 = depression, 2 = anxiety disorder, 3 = substance disorder, 4 = diabetes, etc.

FIGURE 15.1 Hannah Virginia Williams Neukrug's Abbreviated Genogram



Carl Whitaker

therapist is Carl Whitaker, who prided himself on his lack of a theoretical approach: “I have a theory that theories are destructive and I know that intuition is destructive” (Whitaker, 1976, p. 154). Despite this bold statement, it is clear that when working with families, Whitaker conceptualizes families from a systems perspective:

The major problem we see in the individual approaches is they fail to take into account the powerful interdependence between family members.... The “symptom” is merely a front for the family’s larger stress. (Napier & Whitaker, 1978, pp. 270–271)

In fact, if you read any of Whitaker’s writings, it quickly becomes evident that his approach is strongly influenced by humanistic psychology with a touch of psychodynamic theory. For instance, Whitaker believes that counselors should:

- Respect each family member’s self-actualizing process.
- Respect the family’s ability to unravel itself if placed in a trusting environment.
- Create an atmosphere of oneness and nondefensiveness in order to make it difficult for the family to flee into defensive patterns.
- Assist families in resolving the pain and anger that brings them to therapy.
- Assist families in looking at their ghosts from the past.
- Be powerful enough to “invade the family” in order to be part of the family and assist in breaking roles that have become solidified over time (Whitaker, 1976, p. 163).
- Have an “I–Thou” relationship with co-therapists and the family. This real relationship models openness, the ability to dialogue and to express feeling. “Why should the family expose their tender underbelly if the therapist plays coy and self-protective?” (Whitaker, 1976, p. 164).
- Not offer any particular framework or preconceived way in which the family should operate in an effort to have the family develop their own structure.
- Model playfulness, craziness, and genuineness, in an effort to get family members to loosen up and be themselves, and ultimately push them toward individuation.
- Assist families in establishing a generation gap, or boundaries between parents and children.

Sometimes sounding strikingly like Carl Rogers, Whitaker suggests that at first, the family is defensive and closed to the therapist. As the therapist invades and then joins the family, the family begins to see him or her as a genuine person and begins to open up. This is when past inner hurts and conflicts begin to emerge, and it is at this point that the therapist can facilitate the family members’ exploration of these hurts and help the family understand how this pain has affected each member of the family. Each family member can now begin to work on his or her own problems and move toward individuation. In fact,

Napier and Whitaker (1978) note that the later stages of family counseling seem more like a number of individual sessions occurring at the same time:

At the end of therapy the family should have resolved their major relationship conflicts, and the individuals should really be individuals in a psychological sense. (Napier & Whitaker, 1978, p. 274)

Whitaker believes it is usually wise to have a co-therapist, as this will allow counselors to model the I–Thou relationship. In addition, such a “real” relationship enables therapists to discuss their understanding of the family with each other—usually in front of the family (Napier & Whitaker, 1978). Also, because of the sheer numbers of people involved in family therapy, co-therapy enables counselors to periodically attend to each member of the family. Showing his psychodynamic leanings, Whitaker also suggests that co-therapists will often be perceived as the “parents” of the family, allowing families to make analogies to their families of origin, which can then be discussed. However, co-therapists can also be perceived in other roles, allowing family members to project their issues onto them (Napier & Whitaker, 1972):

Carl can be a very big-breasted, tender mother at times and a stern, tough grandfather at others, and I myself don’t make a bad rebellious adolescent at times. It’s a lot more complicated than the simplistic way in which we often identify personality with biology. (Napier & Whitaker, 1978, p. 92)

Watch Whitaker work, and you see a master therapist who is witty, bright, reflective, real, strong, and willing to take risks. Despite the fact that he says he has no theory, you see consistency in his work, a consistency in the way he presents himself to the family that allows the family to grow, learn, deal with painful issues, dialogue, and ultimately change.

Psychodynamic Family Therapy

Family therapy, from a psychodynamic perspective, attempts to merge many of the concepts from systemic thinking with psychodynamic theory. For instance, when viewing psychoanalysis contextually, family dynamics is seen as a reflection of each family member’s personality development through the psychosexual stages. The major difference between psychodynamic family therapists and traditional, individual-oriented psychodynamic therapists is that the family therapist places great emphasis on how the client projects his or her internal world onto the family and the subsequent interactional processes that take place, whereas the individual-oriented therapist almost exclusively emphasizes the internal world of the client and projections onto the therapist (Becvar & Becvar, 2009).

Nathan Ackerman (1958, 1966) and Robin Skynner (1981) are two well-known psychodynamic family therapists. Like Ackerman and Skynner, most psychodynamically oriented therapists have generally been trained in traditional psychoanalysis methods but also saw value in



Nathan Ackerman

Courtesy of the Ackerman Institute for the Family

taking a systemic view when working with clients. Most converts to the systems approach have found that this combination offers a broader perspective that allows for direct involvement with the cast of characters. A combination such as this seems to speed up the usual slow process of most psychodynamically oriented individual approaches.

For the psychodynamic family therapist, there is generally an emphasis on how effective parents were in assisting their children through the developmental stages (Foster & Gurman, 1985). Because of this underlying assumption, unresolved issues through the developmental stages are thought to be reflected in the family in unconscious ways. Therefore, psychodynamic family therapy has as its major goal “to free family members of unconscious constraints so that they’ll be able to interact with one another as healthy individuals” (Nichols & Schwartz, 2008, p. 248).

Although strategies and techniques for the psychodynamically oriented therapist will vary, the major thrust is to have the couple or family explore their interactions and begin to understand how their behaviors result from unresolved conflicts from childhood. These conflicts may be multigenerational, in the sense that the parents pass on their conflicts to their children. It is therefore common for psychodynamically oriented therapists to encourage their clients to bring in grandparents or other extended family members for a session and to encourage clients to continue to discuss unresolved issues while at home with their immediate and extended family members.

Behavioral and Cognitive–Behavioral Family Therapy

Much like individual approaches to behavior therapy, **behavioral family therapy** is oriented toward symptom relief and does not focus on intrapsychic processes, underlying issues, or the unconscious. This approach tends to be highly structured and focuses on specific behaviors and techniques. As in individual behavior therapy, the family behavior therapist has at his or her disposal a wide array of techniques taken directly from operant conditioning, classical conditioning, and social-learning theory or modeling. Also, as in individual behavioral therapy, in recent years, there has been a trend toward the inclusion of cognitive therapy as an aspect of behavioral family therapy (Becvar & Becvar, 2009). Cognitive–behavioral family therapists believe that mediating cognitions can also affect family members and therefore should be addressed in treatment. For instance, when a parent is continually dismissive of a child, this child begins to make negative self-statements concerning his or her self-worth. Therefore, in addition to behavioral change for the parents, cognitive–behavioral family therapists believe that the child’s negative automatic thoughts also need to be addressed.

Whereas many traditional behavioral therapists have viewed problem behaviors in a linear, cause-and-effect fashion, most behavioral and cognitive–behavioral family therapists integrate systems theory with cognitive and behavioral theory and view problem behaviors as the result of a number of feedback loops in which

the dysfunctional behavior becomes reinforced from a number of different sources, including the family (Barker, 2007; Goldenberg & Goldenberg, 2008). Because the behavioral and cognitive-behavioral family therapist is dealing with the family and not just one individual, it is particularly important to identify symptoms and target behaviors that the whole family will agree are important to change, and to understand how various behaviors are reinforced in the system:

The cognitive-behavioral approach is compatible with systems theory and includes the premise that members of a family simultaneously influence and are influenced by each other. Consequently, the behavior of one family member triggers behavior, cognitions, and emotions in other members, which in turn elicit reactive cognitions, behavior, and emotions in the original member. As this process plays out, the volatility of family dynamics escalates, rendering the family vulnerable to negative spirals of conflict. (Nichols & Schwartz, 2008, p. 284)

Although many different models of **behavioral** and **cognitive-behavioral family therapy** have been developed, some common elements that are typically identified in this approach include the following (Foster & Gurman, 1985; Gladding, 2007; Goldenberg & Goldenberg, 2008; Nichols & Schwartz, 2008):

- The importance of building a working relationship.
- Viewing therapy as an active approach that elicits the collaboration of the family.
- Believing that basic learning theory principles can be applied in a systems framework.
- Viewing therapy as brief and time-limited.
- Focusing on specific behaviors or cognitions that will be targeted in the treatment.
- Stressing the increase of positive behaviors over the elimination of negative behaviors.
- Teaching and coaching clients about the relationships among events in their lives, behaviors, cognitions, and consequences (e.g., negative or positive feelings).
- Setting goals that are clear, realistic, concrete, and measurable.
- Actively teaching and supervising the change process within the family.
- Helping families to learn how to self-manage and monitor changes in behaviors and cognitions.
- Evaluating the effects of specific techniques in an effort to measure progress.

Whereas some family therapists believe it is always important to include the whole family in the treatment, regardless of the problem (Napier & Whitaker, 1978; Satir, 1967), behavioral and cognitive-behavioral family therapists take into account what the presenting problem is and tend to include only those members who seem to be directly related to the change process (Nichols & Schwartz, 2008).

For instance, if a child is having behavior problems at home and correction of the problem involves only parenting skills training, there may be no need to include the child. Similarly, if a couple is having marital problems, although their problems will be spilling over to the children, the correction of the problem may not be directly involved with the children, and therefore they may not have to be included. In this process, it is most important for the behavioral and cognitive-behavioral family therapist to make a good assessment of the problem in an effort to determine correct treatment strategies and decide who in the family should be included in therapy (Becvar & Becvar, 2009; Nichols & Schwartz, 2009).

Narrative Family Therapy

The person or the family is not the problem; the problem is the problem. (Michael White, paraphrased)

This quote speaks to one of the newest trends in family therapy—**narrative family therapy**. Based on some of the most recent developments in the counseling field, such as **social constructionism**, **post-modernism**, and what is called **narrative reasoning** (Gladding, 2007), narrative family therapy has at its core the belief that there are no absolute truths and that it is critical to understand the stories that people and families tell in order to help them **deconstruct** how they come to understand their family. Ultimately, the goal of narrative family therapy is to recreate how the family comes to understand itself.

Two of the early founders of narrative therapy were Michael White and David Epston (White, 1995; White & Epston, 1990), both of whom decided to discard some of the rule-based procedures found in the more traditional family therapy techniques that tended to follow general systems and cybernetic theory (Nichols & Schwartz, 2009). This approach has some similarities to solution-focused therapy in that it takes an optimistic, proactive, future-oriented approach to working with people. Therapists who practice this kind of therapy tend to do the following (Fenell & Weinhold, 2003; Nichols & Schwartz, 2009):

- Show interest and develop a strong collaborative relationship with the family.
- Understand a family's history through the stories it tells and examine how the problem has been dysfunctional for the family.
- Ask questions in a nonjudgmental manner in order to understand the issues in the family and begin to help the family redefine the problem.
- Have the family **externalize the problem**. For instance, instead of defining the problem as “people in the family don’t value each other,” the problem becomes “time”—there’s not enough *time* for everyone to show each other how much they care.
- Begin to look for **exceptions to the problem**.



Photo by Jill Freedman

Michael White



Courtesy of David Epston

David Epston

- Find evidence in the family's history to show how the family has been competent and resourceful and able to combat problems such as this.
- Help the family reframe the place the problem has played in the family and help them to redefine or re-author their understanding of themselves by focusing on their existing strengths and their possibilities for the future.
- Help the family reinforce existing strengths and newfound narratives through ceremonies and other ways of acknowledging the changes the family has made.

The end goal of narrative family therapy is to help families understand how their history had defined who they were and how they interacted, and to help them find their own unique, new way of being in the world. Ultimately, the family decides what is considered a healthy way of functioning as they deconstruct their past ways of being and find new and better ways of relating.

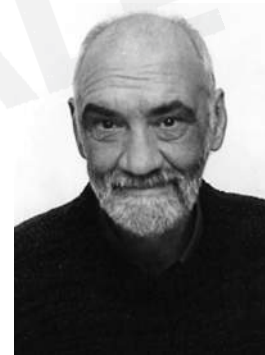


Insoo Kim Berg

Solution-Focused Family Therapy

Solution-focused family therapy is very similar to solution-focused therapy discussed in Chapter 13 and was originated by Insoo Kim Berg, Steve de Shazer, Bill O'Hanlon, and others (Berg, 1994; de Shazer, 1982). As you may remember from Chapter 13, solution-focused therapy is a pragmatic and future-oriented approach that assumes that clients can change quickly. Because the approach focuses on solutions, not problems, discussion of the past is very limited, as such discussion is believed to keep the client mired in the problem. Viewing the client as the expert, this approach believes that the client has strengths that can be expanded upon. Somewhat based on **social constructionism** and **post-modernism**, in dialogue with the counselor, the solution-focused family therapist believes that he or she can help the client create a new, **problem-free language** associated with new behaviors as he or she finds **exceptions to the problem**, develops solutions, and moves toward creating a new reality.

Like narrative therapy, but unlike most other forms of family therapy we examined in this chapter, solution-focused family therapy does not rely on the assumptions of general systems theory, cybernetics, boundary or information flow, or many of the other theoretical underpinnings listed at the beginning of this section of the chapter (Nichols & Schwartz, 2009). In fact, solution-focused family therapists question the "truth" of those who rely on such theory and do not view problems as being inherently caused by flaws in the family's structure. Instead, they believe that language and perception of problems is related to the development of problems. Therefore, solution-focused family therapists have clients examine alternative ways of viewing themselves and focus solely on helping clients find solutions to their problems based on their existing strengths. Since each member can do this on his or her own, solution-focused therapists do not need to see



Steve de Shazer

Photos courtesy of the Brief Family Therapy Center



Bill O'Hanlon

Courtesy of Bill O'Hanlon

the whole family in therapy, but rather only those who want to work on their own solutions. Underlying assumptions of this type of therapy were listed in Chapter 13 and are repeated, in brief, here:

- Change is constant and inevitable.
- The client is the expert on his or her experience.
- Clients come to us with resources and strengths.
- If it ain't broke, don't fix it.
- If it works, do more of it; if it's not working, do something different.
- Small steps can lead to big changes.
- There is not necessarily a logical relationship between the solution and the problem.
- The language for solution development is different from that needed to describe a problem.
- No problems happen all the time; there are always exceptions that can be used.
- The future is both created and negotiable.

As you may remember from Chapter 13, solution-focused therapy can be viewed through a series of six stages that included pre-session change, forming a collaborative relationship, describing the problem, establishing preferred outcomes, problem-to-solution focus, reaching preferred outcomes, and ending therapy. With therapy occurring rapidly, the therapist enters the initial session asking if any pre-session changes were noted, and takes an **ambassador** position with the client in which he or she is curious, respectful, and accepting. Using listening and empathy skills and being tentative in his or her approach, the solution-focused therapist forms a collaborative relationship and slowly moves the client from a description of the problem toward the establishment of **preferred outcomes**. Solutions are eventually determined through the use of a number of **questioning techniques** that include asking preferred outcome questions, evaluative questions, coping questions, exception-seeking questions, and solution-oriented questions. In addition, therapists will also reframe client responses to view them in a positive light, amplify exceptions, compliment clients around solutions that work, and help clients assess progress through the use of **scaling**, where clients subjectively rate their progress on a scale from 0 to 10. With solution-focused family therapy being very similar to solution-focused therapy, you can refer to Chapter 13 for a more in-depth look at this approach.

SOCIAL, CULTURAL, AND SPIRITUAL ISSUES

Any comprehensive attempt to understand personal or family functioning must take into account the fundamental influences of gender, culture, and ethnicity in shaping the lives and experiences of men and women. These issues have assumed center stage for family therapists in recent years, extending their thinking beyond observing internal family

interaction processes to include the impact of the outside social, political, and historical forces in the belief systems and everyday functioning of family members. (Goldenberg & Goldenberg, 2008, p. 54)

Regardless of the couples and family therapy approach being applied, when working with families from diverse cultures and religious orientations, a number of issues should be considered (Goldenberg & Goldenberg, 2008; Hines, Petro, McGoldrick, Almeida, & Weltman, 2005; Ho, Rasheed, & Rasheed, 2004; McGoldrick, Giordano, & Garcia-Petro, 2005). The following highlights but a few of the major concerns:

- Racism, poverty, and lower-class status are widespread for many diverse clients and can dramatically affect how families feel about themselves and their relationship to the counselor.
- Language used by the dominant culture is often covertly or overtly oppressive of culturally and ethnically diverse families and affects how others see the family, how the family sees itself, and how the family sees and lives in society.
- Many culturally and ethnically diverse families are bicultural, and all families face issues surrounding, conflicting value systems between their culture of origin and the larger culture.
- Language differences may cause problems of miscommunication and even misdiagnosis for clients in families.
- Clients from culturally and ethnically diverse families may be less likely to attend counseling and more likely to end therapy early. Therefore, therapists need to be particularly vigilant about reaching out to such clients and ensuring that they are treating them effectively.
- Gender role issues play an increasingly large role in families from all cultures.
- Sexual orientation plays an increasingly large role in families from all cultures.
- Religion, religious values, and spirituality play significant roles in many cultures, and it behooves the effective family therapist to understand the impact of religion and spirituality has on the family.
- Families may differ dramatically around a number of key elements, including how the family dresses and value appearances, embraces specific beliefs and attitude, relates to family and significant others, plays and make use of leisure time, learns and uses knowledge, communicates and uses language, embraces certain values and mores, uses time and space, eats and uses food in its customs, and works and applies themselves.

The astute cross-cultural family counselor needs to have the knowledge necessary to work with different kinds of families, the awareness of his or her cultural biases, and the unique skills needed to work with couples and families from diverse backgrounds.

Finally, a quick word about the title of this chapter. You'll notice that the title was "Couples and Family Therapy," not "Marriage and Family Therapy." This is because the term *marriage therapy* excludes all of those thousands of gay

and lesbian couples who still cannot become married in this country. Thus, I have used a more inclusive term that is in sync with the American Counseling Association's, American Psychological Association's, and National Association of Social Worker's stands on the normalization of homosexuality. One has to wonder why the AAMFT and IAMFC have continued to use titles that are exclusive of a substantial portion of our population.

EFFICACY OF COUPLES AND FAMILY THERAPY

Research on the effectiveness of couples and family therapy has not been overabundant; however, meta-analyses of the research that has been conducted found some interesting results (Carr, 2004, 2005; Fenell & Weinhold, 2003; Shadish & Baldwin, 2003). Summarizing some of the major findings, this research suggests the following:

- Couples and family therapy seems as effective as individual therapy.
- Couples and family counseling is clearly more effective than no treatment.
- Couples and family therapy is as good, and in some cases better than, other forms of treatment (e.g., individual counseling).
- Although no one approach to couples and family therapy is particularly better than another, there are some approaches that work more effectively with specific problems.
- The ability of the therapist to build a relationship with the family is one of the key factors in successful outcomes.
- Rates of deterioration in couples and family therapy are about the same as those in individual therapy.
- Couples therapy is better than each partner's seeing a clinician separately.
- Brief therapy is as effective as open-ended therapy.
- When fathers are in therapy with the family, treatment outcomes improve.
- Co-therapy does not seem to be more effective than one therapist seeing the family.
- When an individual in a couple or family has been diagnosed as having a severe psychological problem, successful outcomes are less likely.
- Interaction styles of a family and family demographics are not related to outcomes in treatment.

SUMMARY

This chapter began with a brief history of the development of couples and family therapy. We started with a discussion of how Charity Organization Societies and "friendly visitors" were some of the first to view the systemic nature of problems

in families and communities. We pointed out that these early approaches to helping the poor led to the development of social casework from a systemic perspective.

We noted that Alfred Adler was one of the first to include the family when treating individuals, although family members were usually in separate rooms from the client. We also noted that the hold psychodynamic approaches had on the individual perspective of doing therapy was strong, and that early family therapy approaches tried to adapt this individual approach to working with the family. We noted that the shift toward family therapy being acceptable was probably related to the impact of those who worked at Palo Alto. It was here that communication in systems was researched, and a number of individuals who worked and consulted at Palo Alto became some of the most well-known family therapists.

The original work at Palo Alto, as well as the subsequent research at MRI, influenced the development of a number of family therapy approaches, including strategic family therapy, structural family therapy, and the human validation process model. At around the same time, other approaches to family therapy evolved, including multigenerational family therapy and experiential family therapy. A few years after MRI was founded, the Brief Family Therapy Center at Palo Alto was formed and became the impetus for the development of solution-focused family therapy. Other approaches to family therapy that later took hold included behavioral and cognitive-behavioral family therapy, and narrative family therapy.

As the chapter continued, a number of important concepts that underlie most approaches to couples and family therapy were examined. These included general systems theory, which examines the unique properties of many systems, including family systems; cybernetics, or control mechanisms in systems, which has been used to explain the regulatory process in systems and includes positive and negative feedback loops; boundaries and information flow in systems; the importance of rules and hierarchy in systems; the development of communication theory in the understanding of interpersonal relations; how individuals are scapegoated and become identified patients; how families deal with stress; developmental milestones through which families typically pass; and an understanding of social constructionism and how some recent family therapists have adopted this new and somewhat different way of understanding the family.

We examined some of the more popular approaches to couples and family therapy in this chapter, including the human validation process model, which was made popular by Virginia Satir; strategic family therapy used by Jay Haley, Cloé Madanes, and the Milan Group; structural family therapy, which was popularized by Salvador Minuchin; multigenerational family therapy, as practiced by Murray Bowen and Ivan Boszormenyi-Nagy; experiential family therapy, as popularized by Augustus Napier and Carl Whitaker; psychodynamic family therapy, such as that offered by Nathan Ackerman and Robin Skynner; behavioral and cognitive-behavioral family therapy; narrative family therapy of White and Epston; and solution-focused family therapy as popularized by Berg, de Shazer, and O'Hanlon.

This chapter examined issues related to multicultural counseling within a family context. It was stressed that family counselors need to understand their

own values and biases and the unique worldviews of the families with whom they work. Also, helpers must be able to apply appropriate intervention strategies as a function of the family's cultural background. In addition, it was stressed that family counselors should be aware of a number of unique issues related to families and how they might affect family treatment.

The chapter concluded with a discussion of the efficacy of couples and family therapy, and noted that overall, couples and family therapy seem as efficacious or more efficacious than many other approaches. Other specific issues related to its efficacy were discussed.

KEY WORDS

- | | | |
|-------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------|
| ambassador | experiential family therapy | interactional rules |
| American Association of Marriage and Family Therapy (AAMFT) | externalize the problem | joining |
| behavioral family therapy | family life fact chronology | ledger of indebtedness and entitlements |
| boundaries | family projection process | loyalties |
| Brief Family Therapy Center (BFTC) | family sculpting | mapping |
| Charity Organization Societies | friendly visitors | Menninger Clinic |
| cognitive-behavioral family therapy | general systems theory | Mental Research Institute (MRI) |
| contextual family therapy | genogram | Milan Group |
| covert rules | Haley's Stages of the First Interview | multigenerational family therapy |
| communication theory | hierarchies | narrative family therapy |
| cybernetics | homeostasis | narrative reasoning |
| deconstruct | Hull House | National Institute of Mental Health (NIMH) |
| developmental issues/milestones | human validation process model | negative feedback loop |
| differentiation of self | idiosyncratic rules | nuclear family emotional system |
| diffuse boundaries | idiosyncratic stress | overt rules |
| directives | indebtedness | paradoxical directive |
| double-bind theory | identified patient | Philadelphia Child Guidance Clinic |
| Eastern Pennsylvania Psychiatric Institute (EPPi) | information flow | positive feedback loop |
| exceptions to problems | International Association For Marriage And Family Counselors (IAMFC) | post-modernism |
| | | preferred outcomes |

primary survival triad	scaling	transactional rules
problem-free language	semi-permeable	triangulate
problem-saturated	boundaries	the blamer
stories	settlement movement	the computer
psychodynamic family	social constructionism	the distracter
therapy	solution-focused family	the placater
questioning techniques	therapy	undifferentiated ego
(solution-focused	strategic therapy	mass
therapy)	stress	universal rules
restructuring	structural family therapy	use of metaphor
rigid boundaries	subsystem	
rules	suprasystem	
scapegoating		

KEY NAMES

Ackerman, Nathan	Epston, David	Napier, Augustus
Addams, Jane	Erickson, Milton	O'Hanlon, Bill
Alfred, Adler	Fisch, Dick	Satir, Virginia
Bateson, Gregory	Fry, William	Skynner, Robin
Berg, Insoo Kim	Haley, Jay	Watzlawick, Paul
Boszormenyi-Nagy,	Jackson, Don	Weakland, John
Ivan	Madanes, Cloé	Whitaker, Carl
Bowen, Murray	Minuchin, Salvador	White, Michael
de Shazer, Steve		

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