Major Marriage and Family Therapy Models
Developed by Thorana S. Nelson, PhD and Students

STRUCTURAL FAMILY THERAPY

LEADERS
- Salvador Minuchin
- Charles Fishman

ASSUMPTIONS:
- Problems reside within a family structure (although not necessarily caused by the structure)
- Changing the structure changes the experience the client has
- Don't go from problem to solution, we just move gradually
- Children's problems are often related to the boundary between the parents (marital vs. parental subsystem) and the boundary between parents and children

CONCEPTS:
Family structure
- Boundaries
  - Rigid
  - Clear
  - Diffuse
  - Disengaged
  - Normal Range
  - Enmeshment
  - Roles
  - Rules of who interacts with whom, how, when, etc.
- Hierarchy
- Subsystems
- Cross-Generational Coalitions
- Parentified Child

GOALS OF THERAPY:
- Structural Change
  - Clarify, realign, mark boundaries
- Individuation of family members
- Infer the boundaries from the patterns of interaction among family members
- Change the patterns to realign the boundaries to make them more closed or open

ROLE OF THE THERAPIST:
- Perturb the system because the structure is too rigid (chaotic or closed) or too diffuse (enmeshed)
- Facilitate the restructuring of the system
- Directive, expert—the therapist is the choreographer
- See change in therapy session; homework solidifies change
- Directive

ASSESSMENT:
- Assess the nature of the boundaries, roles of family members
- Enactment to watch family interaction/patterns

INTERVENTIONS:
- Join and accommodate
  - mimesis
- Structural mapping
- Highlight and modify interactions
- Unbalance
- Challenge unproductive assumptions
- Raise intensity so that system must change

CHANGE:
- Raise intensity to upset the system, then help reorganize the system
- Change occurs within session and is behavioral; insight is not necessary
- Emotions change as individuals' experience of their context changes

Structural Family Therapy, Continued

<table>
<tr><td><u>Interventions</u>
• disorganize and reorganize
• Shape competence through Enactment (therapist acts as coach)</td><td></td></tr>
<tr><td><u>TERMINATION:</u>
• Problem is gone and the structure has changed (2nd order change)
• Problem is gone and the structure has NOT changed (1st order change)</td><td><u>SELF OF THE THERAPIST:</u>
• The therapist joins with the system to facilitate the unbalancing of the system
• Caution with induction—don't get sucked in to the content areas, usually related to personal hot spots</td></tr>
<tr><td colspan="2"><u>EVALUATION:</u>
• Strong support for working with psychosomatic children, adult drug addicts, and anorexia nervosa.</td></tr>
<tr><td colspan="2"><u>SUPERVISION INTERVENTIONS:</u></td></tr>
<tr><td colspan="2"><u>RESOURCES:</u>
Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.
Minuchin, S., & Fishman, H. C. (1981). Family therapy techniques. Cambridge, MA: Harvard University Press.
Minuchin, S., Rosman, B. L., & Baker, L. (1978). Psychosomatic families. Cambridge, MA: Harvard University Press.
Fishman, H. C. (1988). Treating troubled adolescents: A family therapy approach. New York: Basic Books.
Fishman, H. C. (1993). Intensive structural therapy: Treating families in their social context. New York: Basic Books.</td></tr>
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NOTES

STRATEGIC THERAPY (MRI)

LEADERS:

- John Weakland
- Don Jackson
- Paul Watzlawick
- Richard Fisch

ASSUMPTIONS:

- Family members often perpetuate problems by their own actions (attempted solutions) --the problem is the problem maintenance (positive feedback escalations)
- Directives tailored to the specific needs of a particular family can sometimes bring about sudden and decisive change
- People resist change
- You cannot not communicate--people are ALWAYS communicating
- All messages have report and command functions-- working with content is not helpful, look at the process
- Symptoms are messages -- symptoms help the system survive (some would say they have a function)
- It is only a problem if the family describes it as such
- Based on work of Gregory Bateson and Milton Erickson
- Need to perturb system – difference that makes a difference (similar enough to be accepted by system but different enough to make a difference)
- Don't need to examine psychodynamics to work on the problem

CONCEPTS:

- Symptoms are messages
- Family homeostasis
- Family rules -- unspoken
- Cybernetics
  - Feedback Loops
  - Positive Feedback
  - Negative Feedback
- First order change
- Second order change
- Reframing
- Content & Process
- Report & Command
- Paradox
- Paradoxical Injunction
- "Go Slow" Messages
- Positive Feedback Escalations
- Double Binds
- "One down" position
- Patient position
- Attempted solutions maintain problems and become problems themselves

GOALS OF THERAPY:

- Help the family define clear, reachable goals
- Break the pattern; perturb the system
- First and second order change- ideally second order change (we cannot make this happen-- it is spontaneous)

ROLE OF THE THERAPIST:

- Expert position
- Responsible for creating conditions for change
- Work with resistance of clients to change
- Work with the process, not the content
- Directive

ASSESSMENT:

- Define the problem clearly and find out what people have done to try to resolve it
- Elicit goals from each family member and then reframe into one, agreed-upon goal
- Assess sequence patterns

Strategic Therapy (MRI), Continued

Interventions
- Skeptical of change
- Take a lot of credit and responsibility for change; however, therapist tells clients that they are responsible for change
- Active

INTERVENTIONS:
- Paradox
- Directives
  - Assignments ("homework") that interrupt sequences
- Interrupt unhelpful sequences of interaction
- "Go slow" messages
- Prescribe the symptoms

CHANGE:
- Interrupting the pattern in any way
- Difference that makes a difference
- Change occurs outside of session; insession change is in viewing; homework changes doing
- Change in viewing (reframe) and/or doing (directives)
- Emotions change and are important, but are inferred and not directly available to the therapist

TERMINATION:
- Client decides when to terminate with the help of the therapist
- When pattern is broken and the client reports that the problem no longer exists
- Therapist decides

SELF OF THE THERAPIST:
- Therapist needs to be VERY careful with ethics in this model; it can be very manipulative (paradox) and a lot of responsibility is on the therapist as an expert

EVALUATION:
- Very little research done
- Do clients report change? If so, then it is effective

SUPERVISION INTERVENTIONS:

RESOURCES:

Watzlawick, P., Weakland, J., &, Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: Norton.

Fisch, Richard, John H. Weakland, and Lynn Segal (1982). *The tactics of change: Doing therapy briefly*. San Francisco: Jossey-Bass.

Watzlawick, P., J. B. Bavelas, and D. J. Jackson. (1967). P*ragmatics of human communication.* New York: W. W. Norton.

Lederer, W. J., and Don Jackson. (1968). *The mirages of marriage*. New York: W. W. Norton.

NOTES:

STRATEGIC THERAPY (Haley & Madanes)

LEADERS:
- Jay Haley
- Cloe Madanes
- Influenced by Minuchin

ASSUMPTIONS:
- Family members often perpetuate problems by their own actions (attempted solutions) --the problem is the problem maintenance (positive feedback escalations)
- Directives tailored to the specific needs of a particular family can sometimes bring about sudden and decisive change
- People resist change
- You cannot not communicate--people are ALWAYS communicating
- All messages have report and command functions-- working with content is not helpful, look at the process
- Communication and messages are metaphorical for family functioning
- Symptoms are messages -- symptoms help the system survive
- It is only a problem if the family describes it as such
- Based on work of Gregory Bateson, Milton Erickson, MRI, and Minuchin
- Need to perturb system – difference that makes a difference (similar enough to be accepted by system but different enough to make a difference)
- Problems develop in skewed hierarchies
- Motivation is power (Haley) or love (Madanes)

CONCEPTS:
- Symptoms are messages
- Family homeostasis
- Family rules – unspoken
- Intergenerational collusions
- First and second order change
- Metaphors
- Reframing
- Symptoms serve functions
- Content & Process
- Report & Command
- Incongruous Hierarchies
- Ordeals (prescribing ordeals)
- Paradox
- Paradoxical Injunction
- Pretend Techniques (Madanes)
- "Go Slow" Messages

GOALS OF THERAPY:
- Help the family define clear, reachable goals
- Break the pattern; perturb the system
- First and second order change- ideally second order change (we cannot make this happen-- it is spontaneous)
- Realign hierarchy (Madanes)

ROLE OF THE THERAPIST:
- Expert position
- Responsible for creating conditions for change
- Work with resistance of clients to change
- Work with the process, not the content
- Directive
- Skeptical of change
- Take a lot of credit and responsibility for change; however, therapist tells clients that they are responsible for change
- Active

ASSESSMENT:
- Define the problem clearly and find out what people have done to try to resolve it
- Hypothesize metaphorical nature of the problem
- Elicit goals from each family member and then reframe into one, agreed-upon goal
- Assess sequence patterns

Strategic Therapy (Haley & Madanes), Continued

INTERVENTIONS:

- Paradox
- Directives
  - Assignments ("homework") that interrupt sequences
- Interrupt unhelpful sequences of interaction
- Metaphors, stories
- Ordeals (Haley)
- "Go slow" messages
- Prescribe the symptoms (Haley)
- "Pretend" techniques (Madanes)

CHANGE:

- Breaking the pattern in any way
- Difference that makes a difference
- Change occurs outside of session; insession change is in viewing; homework changes doing
- Change in viewing (reframe) and/or doing (directives)

TERMINATION:

- Client decides when to terminate with the help of the therapist
- When pattern is broken and the client reports that the problem no longer exists
- Therapist decides

SELF OF THE THERAPIST:

- Therapist needs to be VERY careful with ethics in this model; it can be very manipulative (paradox) and a lot of responsibility is on the therapist as an expert

EVALUATION:

- Very little research done
- Do clients report change? If so, then it is effective

RESOURCES:

Madanes, Cloe. (1981). *Strategic family therapy*. San Francisco, CA: Jossey-Bass.
Madanes, Cloe. (1984). *Behind the one-way mirror: Advances in the practice of strategic therapy*. San Francisco, CA: Jossey-Bass.
Madanes, Cloe. (1990). *Sex, love, and violence: Strategies for transformation.* New York: W. W. Norton.
Madanes, Cloe. (1995). *The violence of men: New techniques for working with abusive families*. San Francisco: Jossey-Bass.
Haley, Jay. (1980). *Leaving home*. New York: McGraw-Hill.
Haley, Jay. (1984). *Ordeal therapy: Unusual ways to change behavior*. San Francisco, CA: Jossey Bass.
Haley, Jay. (1987). *Problem-solving therapy* (2nd Ed.). San Francisco: Jossey-Bass.

NOTES:

MILAN FAMILY THERAPY

LEADERS:
- Boscolo
- Palazzoli
- Prata
- Cecchin

ASSUMPTIONS:
- problem is maintained by family's attempts to fix it
- therapy can be brief over a long period of time
- clients resist change

CONCEPTS:
- family games (family's patterns that maintain the problem)
  - dirty games
  - psychotic games
- there is a nodal point of pathology
- invariant prescriptions
- rituals
- positive connotation
- difference that makes a difference
- neutrality
- hypothesizing
- therapy team
- circularity, neutrality
- incubation period for change; requires long periods of time between sessions

GOALS OF THERAPY:
- disrupt family games

ROLE OF THERAPIST:
- therapist as expert
- neutral to each family member – don't get sucked into the family game
- curious

ASSESSMENT:
- Family game
- Dysfunctional patterns (patterns that maintain the problem)

INTERVENTIONS:
- Ritualized prescriptions
- Rituals
- Circular questions
- Counter paradox
- Odd/even day
- Positive connotation
- "Date"
- Reflecting team
- Letters
- Prescribe the system

CHANGE:
- Family develops a different game that does not include the symptom (system change)
- Requires incubation period

TERMINATION:
- Therapist decides, fewer than 10-12 sessions

EVALUATION:
- Not practiced much, therefore not researched
- Follow up contraindicated

SUPERVISION INTERVENTIONS:

Milan Family Therapy, continued

RESOURCES:

Campbell, D., Draper, R., & Huffington, C. (1989). *Second thoughts on the theory and practice of the Milan approach to family therapy.* New York: Karnac.

Campbell, D., Draper, R., & Crutchley, E. (1991). The Milan systemic approach to family therapy. In A. S. Gurman & D. P. Kniskern (Eds.), *Handbook of Family Therapy (Vol. II)* (pp. 325-362). New York: Brunner/Mazel.

Cecchin, G. (1987). Hypothesizing, circularity, and neutrality revisited: An invitation to curiosity. *Family Process, 26*(4), 405-413.

Cecchin, G. (1992). Constructing therapeutic possibilities. In S. McNamee & K. J. Gergen (Eds.), *Therapy as social construction* (pp. 86-95). Newbury Park, CA: Sage.

Palazzoli, M. S., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counterparadox: A new model in the therapy of the family in schizophrenic transaction.* New York: Jason Aaronson.

Palazzoli, M. S., Boscolo, L., Cecchin, G., & Prata, G. (1978). A ritualized prescription in family therapy: Odd days and even days. *Journal of Marriage and Family Counseling, 48*, 3-9.

Palazzoli, M., & Palazzoli, C. (1989). *Family games: General models of psychotic processes in the family.* New York: W. W. Norton & Company.

NOTES:

SOLUTION-FOCUSED BRIEF THERAPY

LEADERS:

- Steve de Shazer
- Insoo Kim Berg
- Yvonne Dolan
- Eve Lipchik

ASSUMPTIONS:

- Clients want to change
- There's no such thing as resistance (clients are telling us how they cooperate)
- Focus on present and future except for the past in terms of exceptions; not focused on the past in terms of cause of changing the past
- Change the way people talk about their problems from problem talk to solution talk
- Language creates reality
- Therapist and client relationship is key
- A philosophy, not a set of techniques or theory
- Sense of hope, "cheerleader effect"
- Nonpathologizing, not interested in pathology or "dysfunction"
- Don't focus on the etiology of the problem: Solutions are not necessarily related to problems
- Assume the client has strengths, resources
- Only need a small change, which can snowball into a bigger change
- The problem is not occurring all the time

CONCEPTS:

- Problem talk/ Solution talk
- Exceptions
- Smallest difference that makes a difference
- Well-formed goals (small, concrete, measurable, important to client, doable, beginning of something, not end, presence not absence, hard work)
- Solution not necessarily related to the problem
- Clients are experts on their lives and their experiences
- Therapeutic relationships: customer/therapist, complainant/sympathizer, visitor/host

GOALS OF THERAPY:

- Help clients to think or do things differently in order to increase their satisfaction with their lives
- Reach clients' goals; "good enough"
- Shift the client's language from problem talk to solution talk
- Modest goals (clear and specific)
- Help translate the goal into something more specific (clarify)
- Change language from problem to solution talk

ROLE OF THERAPIST:

- Cheerleader/Coach
- Offer hope
- Nondirective, client-centered

ASSESSMENT:

- Assess exceptions—times when problem isn't there
- Assess what has worked in the past, not necessarily related to the problem; client strengths
- Assess what will be different when the problems is gone (becomes goal that might not be clearly related to the stated problem)

INTERVENTIONS:

- Help set clear and achievable goals (clarify)
- Help client think about the future and what they want to be different
- Exceptions: Amplify the times they did things that "worked" when they didn't have the problem or it was less severe
- Compliments:
  -"How did you do that?"
  -"Wow! That must have been difficult!"
  - "That sounds like it was helpful; how did you do that?"
  -" I'm impressed with ...."
  -"You sound like a good ...."

Solution-Focused Brief Therapy, Continued

Interventions

- Formula first session task: Observe what happens in their life/relationship that they want to continue
- Miracle question:
  -Used when clients are vague about complaints
  -Helps client do things the problem has been obstructing
  -Focus on how having problems gone will make a difference
  -Relational questions
  -follow up with miracle day questions and scaling questions
  -pretend to have a miracle day
- Scaling questions
- Midsession break (with or without team) to summarize session, formulate compliments and bridge, and suggest a task (tasks used less in recent years; clients develop own tasks; therapist may make suggestions or suggest "experiments"), sometimes called "feedback" (feeding information back into the therapy with a difference)
- Predict the next day, then see what happens

TERMINATION:

- Client decides

SELF OF THE THERAPIST:

- Accept responsibility for client/therapist relationship
- Expert on therapy conversation, not on client's life or experience of the difficulty

EVALUATION:

Therapy/Research:

- Simple (not necessarily easy)
- Can be perceived that therapist as insensitive- "Solution Forced Therapy"
- Crucial that clients are allowed to fully express struggles and have their own experiences validated, BEFORE shifting the conversation to strengths
- Techniques can obscure therapist's intuitive humanity
- Many outcome studies show effectiveness, but no controlled studies

Progress of therapy:

- Can clients see exceptions?
- Are they using solution talk?

SUPERVISION INTERVENTIONS:

RESOURCES:

de Shazer, S. (1982). *Patterns of brief family therapy: An ecosystemic approach.* New York: Guilford.

de Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. K. (2007). *More than miracles: The state of the art of solution-focused brief therapy.* New York: Haworth.

Berg, I. K., & Miller, S. (1992). *Working with the problem drinker*. New York: Norton.

Berg, I. K. (1994). *Family-based services: A solution-focused approach.* New York: Norton.

De Jong, P., & Berg, I. K. (2007). *Interviewing for solutions* (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Dolan, Y. (1992). *Resolving sexual abuse.* NY: W.W. Norton.

Lipchik, E. (2002). *Beyond technique in solution focused therapy.* New York: Guilford.

Miller, S. D., Hubble, M. A., & Duncan Barry L. (Eds.). (1996). *Handbook of solution-focused brief therapy.* San Francisco: Jossey-Bass.

Nelson, T. S., & Thomas, F. N. (Eds.). (2007). *Handbook of solution-focused brief therapy: Clinical applications.* New York: Haworth.

NOTES:

NARRATIVE THERAPY

LEADERS:
- Michael White
- David Epston
- Jill Freedman
- Gene Combs

ASSUMPTIONS:
- Personal experience is ambiguous
- Reality is shaped by the language used to describe it – language and experience (meaning) are recursive
- Reality is socially constructed
- Truth may not match historic or another person's truth, but it is true to the client
- Focus on effects of the problem, not the cause (how problem impacts family; how family affects problem)
- Stories organize our experience & shape our behavior
- The problem is the problem; the person is not the problem
- People "are" the stories they tell
- The stories we tell ourselves are often based on messages received from society or our families (social construction)
- People have their own unique filters by which they process messages from society

CONCEPTS:
- Dominant Narrative - Beliefs, values, and practices based on dominant social culture
- Subjugated Narrative – a person's own story that is suppressed by dominant story
- Alternative Story: the story that's there but not noticed
- Deconstruction: Take apart problem saturated story in order to externalize & re-author it (Find missing pieces; "unpacking")
- Problem-saturated Stories - Bogs client down, allowing problem to persist. (Closed, rigid)
- Landscape of action: How people do things
- Landscape of consciousness: What meaning the problem has (landscape of meaning)
- Unique outcomes – pieces of deconstructed story that would not have been predicted by dominant story or problem-saturated story; exceptions; sparkling moments

GOALS OF THERAPY:
- Change the way the clients view themselves and assist them in re-authoring their story in a positive light; find the alternative but preferred story that is not problem-saturated
- Give options to more/different stories that don't include problems

ROLE OF THERAPIST:
- Genuine curious listener
- Question their assumptions
- Open space to make room for possibilities

ASSESSMENT:
- Getting the family's story, their experiences with their problems, and presumptions about those problems.
- Assess alternative stories and unique outcomes during deconstruction

INTERVENTIONS:
- Ask questions
  - Landscape of action & landscape of meaning
  - Meaning questions
  - Opening space

CHANGE:
- Occurs by opening space; cognitive
- Client can see that there are numerous possibilities
- Expanded sense of self

Narrative Therapy, Continued

Interventions

- Preference
- Story development
- Deconstruction
- To extend the story into the future

- Externalize problems
- Effects of problem on family; effects of family on problem
- Restorying or reauthoring
  - Self stories
- Letters from the therapist
- Certificates of award

TERMINATION:

- Client determines

SELF OF THE THERAPIST:

- Therapist's ideas, values, prejudices, etc. need to be open to client, "transparent"
- Expert on conversation

EVALUATION:

- No formal studies

SUPERVISION INTERVENTIONS:

RESOURCES:

Freeman, Jennifer, David Epston, and Dean Lobovits. (1997). *Playful approaches to serious problems: Narrative therapy with children and their families.* New York: W.W. Norton.

Freedman, Jill, and Gene Combs. (1996). *Narrative therapy: The social construction of preferred realities.* New York: W. W. Norton.

White, Michael, and David Epston (Eds.). (1990). *Narrative means to therapeutic ends.* New York: W.W. Norton.

White, Michael. (2007). *Maps of narrative practice.* New York: W.W. Norton.

NOTES:

COGNITIVE-BEHAVIORAL THERAPY

LEADERS:
- Ivan Pavlov
- Watson
- Thorndike
- B. F. Skinner
- Bandura
- Dattilio

ASSUMPTIONS:
- Family relationships, cognitions, emotions, and behavior mutually influence one another
- Cognitive inferences evoke emotion and behavior
- Emotion and behavior influence cognition

CONCEPTS:
- Schemas- core beliefs about the world, the acquisition and organization of knowledge
- Cognitions- selective attention, perception, memories, self-talk, beliefs, and expectations
- Reinforcement - an event that increases the future probability of a specific response
- Attribution- explaining the motivation or cause of behavior
- Distorted thoughts, generalizations get in way of clear thinking and thus action

GOALS OF THERAPY:
- To modify specific patterns of thinking and/or behavior to alleviate the presenting symptom

ROLE OF THERAPIST:
- Ask a series of question about assumptions, rather than challenge them directly
- Teach the family that emotional problems are caused by unrealistic beliefs

ASSESSMENT:
- Cognitive: distorted thoughts, thought processes
- Behavioral: antecedents, consequences, etc.

INTERVENTIONS:
- Questions aimed at distorted assumptions (family members interpret and evaluate one another unrealistically)
- Behavioral assignments
- Parent training
- Communication skill building
- Training in the model

CHANGE:
- Behavior will change when the contingencies of reinforcement are altered
- Changed cognitions lead to changed affect and behaviors

TERMINATION:
- When therapist and client determine

SELF OF THE THERAPIST:
- Not discussed

EVALUATION:
- Many studies, particularly in terms of marital therapy and parenting

SUPERVISION INTERVENTIONS:

RESOURCES:

Jacobson, N. S., & Margolin, G. (1979). *Marital therapy: Strategies based on social learning and behavior exchange principles.* New York: Brunner/Mazel.

Jacobson, N. S., & Christensen, A. (1998). *Acceptance and Change in Couple Therapy: A Therapist's Guide to Transforming Relationships.* New York: Norton.

Epstein, N. B., & Baucom, D. H. (2002). *Enhanced cognitive-behavioral therapy for couples.* Washington, DC: APA Books.

Resources

Dattilio, F. M. (1998). *Case studies in couple and family therapy: Systemic and cognitive perspectives.* New York: Guilford.

Dattilio, F. M., & Padesky, C. (1990). *Cognitive therapy with couples.* Sarasota, FL: Professional Resource Press.

Beck, A. T., Reinecke, M. A., & Clark, D. A. (2003). *Cognitive therapy across the lifespan: Evidence and practice.* Cambridge, UK: Cambridge University Press.

NOTES:

CONTEXTUAL FAMILY THERAPY

LEADERS:
- Ivan Boszormenyi-Nagy

ASSUMPTIONS:
- Values and ethics are transmitted across generations
- Dimensions: (All are intertwined and drive people's behaviors and relationships)
  - Facts
  - Psychological
  - Relational
  - Ethical
- Trustworthiness of a relationship (relational ethics): when relationships are not trustworthy, debts and entitlements that must be paid back pile up; unbalanced ledger gets balanced in ways that are destructive to individuals and relationships and posterity (e.g., revolving slate, destructive entitlement)

CONCEPTS:
- Loyalty: split, invisible
- Entitlement (amount of merit a person has based on trustworthiness)
- Ledger (accounting)
- Legacy (we behave in ways that we have been programmed to behave)
- Relational ethics
- Destructive entitlement (you were given a bad ledger and it wasn't fair so it's ok to hand it on to the next person—acting out, neglecting important others)
- Revolving slate
- Posterity (thinking of future generations when working with people) this is the only model that does
- Rejunctive and disjunctive efforts

GOALS OF THERAPY:
- Balanced ledger

ROLE OF THE THERAPIST:
- Directive
- Expert in terms of assessment

ASSESSMENT:
- Debts
- Entitlements
- Invisible loyalties

INTERVENTIONS:
- Process and relational questions
- Multi-directional impartiality: Everybody and nobody feel special—all are attended to but none are more special
- Exoneration: Help people understand how they have been living out legacies and debts-ledgers—exonerate <u>others</u>
- Coach toward rejunctive efforts

CHANGE:
- Cognitive: Awareness of legacies, debts and entitlements
- Behavioral: Very action oriented—actions must change

TERMINATION:
- Never- totally up to the client

SELF OF THE THERAPIST:
- Must understand own legacies, entitlements, process of balancing ledgers, exoneration

EVALUATION:
- No empirical evaluation

SUPERVISION INTERVENTIONS:

Contextual Family Therapy, Continued

RESOURCES:

Boszormenyi-Nagy, I. (1987). *Foundations of contextual therapy: Collected papers of Ivan Boszormenyi-Nagy.* New York: Brunner/Mazel.

Boszormenyi-Nagy, I., & Krasner, B. (1986). *Between give and take: A clinical guide to contextual therapy.* New York: Brunner/Mazel.

Hargrave, T. D., & Pfitzer, F. (2003). *The new contextual therapy: Guiding the power of give and take.* New York: Brunner-Routledge.

van Heusden, A., & van den Eerenbeemt, E. (1987). *Balance in motion: Ivan Boszormenyi-Nagy and his vision of individual and family.* New York: Brunner/Mazel.

NOTES:

BOWEN FAMILY THERAPY

LEADERS:

- Murray Bowen
- Michael Kerr (works with natural systems)
- Edwin Friedman

ASSUMPTIONS:

- The past is currently influencing the present
- Change can happen—individuals can move along in the process of differentiation
- Differentiation: ability to maintain self in the face of high anxiety (remain autonomous in a highly emotional situation)
    - Change in experience of self in the family system
    - Change in relationship between thinking and emotional systems
- Differentiation is internal and relational—they are isomorphic and recursive
- Anxiety inhibits change and needs to be reduced to facilitate change
- High intimacy and high autonomy are ideal
- Emotions are a physiological process—feelings are the thoughts that name and mediate emotions, that give them meaning
- Symptoms are indicators of stress, anxiety, lower differentiation
- Anyone can become symptomatic with enough stress; more differentiated people will be able to withstand more stress and, when they do become symptomatic, recover more quickly

CONCEPTS:

- Intimacy
- Autonomy
- Differentiation of Self
- Cutoff
- Triangulation
- Sibling position
- Fusion (within individual and within relationships)
- Family projection process
- Multigenerational transmission process
- Nuclear family
- Emotional process
- 4 sub-concepts (ways people manage anxiety; none of these is bad by itself – it's when one is used to exclusion of others or excessively that it can become problematic for a system):
    - Conflict
    - Dysfunction in person
    - Triangulation
    - Distance
- Societal emotional process
- Undifferentiated family ego mass

GOALS OF THERAPY:

- Ultimate—increase differentiation of self (thoughts/emotions; self/others)
- Intermediate—detriangulation, lowering anxiety to respond instead of react
- Decrease emotional reactivity—increase thoughtful responses
- Increased intimacy one-on-one with important others

ROLE OF THERAPIST:

- Coach (objective)
- Educator
- Therapist is part of the system (non-anxious and differentiated)
- Expert—not a collaborator

ASSESSMENT:

- Emotional reactivity
- Degree of differentiation of self
- Ways that people manage anxiety/ family themes
- Triangles
- Repeating intergenerational patterns
- Genogram (assessment tool)

Bowen Family Therapy, Continued

INTERVENTIONS:

- Genogram (both assessment and change tool)
- Plan for intense situations (when things get hot, what are we going to do – thinking; process questions)
- Process questions-- thinking questions: "What do you think about this?" "How does that work?"
- Detriangulating one-on-one relationships, one person with the other two in the triangle
- Educating clients about the concepts of the model
- Decrease emotional reactivity—increase thoughtful responses
- Therapist as a calm self and calm part of a triangle with the clients
- Coaching for changing own patterns in family of origin

CHANGE:

- Reduced anxiety through separation of thoughts and emotions – cognitive
- Reduced anxiety leads to responsive thoughts and actions, changed affect, changed relationships
- When we think (respond), change occurs (planning thinking) -- when you know how you would like to behave in a certain emotional situation, you plan it, it makes it easier to carry through with different consequences

TERMINATION:

- Ongoing—we are never fully differentiated

SELF OF THE THERAPIST:

- Important with this model; differentiated, calm therapist is main tool
- We don't need to join the system
- We must be highly differentiated so we can recognize and reduce reactivity
- Our clients can only become as differentiated as we are; we need coaching to increase our own differentiation of self

EVALUATION:

- Research suggesting validity: not much, not a lot of outcome
- Did not specify symptom reduction
- Client report of different thoughts, actions, responses from others, affect is evidence of change

SUPERVISION INTERVENTIONS:

RESOURCES:

Bowen, M. (1978). *Family therapy in clinical practice.* New York: Jason Aaronson.

Friedman, E. (1987). *Generation to generation: Family process in church and synagogue.* New York: Guilford.

Kerr, M. E., & Bowen, M. (1988). *Family evaluation: An approach based on Bowen theory.* New York: W. W. Norton and Company.

NOTES:

PSYCHODYNAMIC FAMILY THERAPY (OBJECT RELATIONS)

LEADERS:
- Freud
- Erik Erikson
- Nathan Ackerman
- Several others who were trained, but their models were not primarily psychodynamic: Bowen, Whitaker, etc.
- Object relations: Scharff & Scharff
- Attachment theory: Bowlby

ASSUMPTIONS:
- Sexual and aggressive drives are at the heart of human nature
- Every human being wants to be appreciated
- Symptoms are attempts to cope with unconscious conflicts over sex and aggression
- Internalized objects become projected onto important others; we then evoke responses from them that fit that object, they comply, and we react to the projection rather than the real person
- Early experiences affect later relationships
- Internalized objects affect inner experience and outer relationships

CONCEPTS:
- Internal objects- mental images of self and others built from experience and expectation
- Attachment- connection with important others
- Separation-individuation- the gradual process of a child separating from the mother
- Mirroring- When parents show understanding and acceptance
- Transference-Attributing qualities of someone else to another person
- Countertransference – Therapist's attributing qualities of self onto others
- Family Myths- unspoken rules and beliefs that drive behavior, based on beliefs, not full images of others
- Fixation and regression-When families become stuck they revert back to lower levels of functioning
- Invisible loyalties- unconscious commitments to the family that are detrimental to the individual

GOALS OF THERAPY:
- To free family members of unconscious constraints so that they can interact as healthy individuals
- Separation-Individuation
- Differentiation

ROLE OF THERAPIST:
- Listener
- Expert position
- Interpret

ASSESSMENT:
- Attachment bonds
- Projections (unrealistic attributions)

INTERVENTIONS:
- Listening
- Showing empathy
- Interpretations (especially projections) Family of origin sessions (Framo)
- Make a safe holding environment

CHANGE:
- Change occurs when family members expand their insight to realize that psychological lives are larger than conscious experience and coming to accept repressed parts of their personalities
- Change also occurs when more, full, real aspects of others are revealed in therapy so that projections fade

Psychodynamic Family Therapy (Object Relations), Continued

TERMINATION:

Not sure how therapy is terminated

EVALUATION:

SUPERVISION INTERVENTIONS:

RESOURCES:

Sander, F. (2004) Psychoanalytic Couples Therapy: Classical Style in Psychoanalytic Inquiry Issue on Psychoanalytic Treatment of Couples ed. By Feld, B and Livingston, M. Vol 24:373-386.

Scharff, J. (ed.) (1989) Foundations of Object Relations Family Therapy . Jason Aronson, Northvale N.J.

Slipp, S. (1984). *Object relations: A dynamic bridge between individual and family treatment.* Northvale, NJ: Jason Aronson.

NOTES:

EXPERIENTIAL FAMILY THERAPY

LEADERS:
- Carl Whitaker
- Virginia Satir

ASSUMPTIONS:
- Family problems are rooted in suppression of feelings, rigidity, denial of impulses, lack of awareness, emotional deadness, and overuse of defense mechanisms
- Families must get in touch with their REAL feelings
- Therapy works from the Inside (emotion) Out (behavior)
- Expanding the individual's experience opens them up to their experiences and helps to improve the functioning of the family group
- Commitment to emotional well being

CONCEPTS:
- Honest emotion
- Suppress repression
- Family myths
- Mystification
- Blaming
- Placating
- Being irrelevant/irreverent
- Being super reasonable
- Battle for structure
- Battle for initiative

GOALS OF THERAPY:
- Promote growth, change, creativity, flexibility, spontaneity, and playfulness
- Make the covert overt
- Increase the emotional closeness of spouses and disrupt rigidity
- Unlock defenses, enhance self-esteem, and recover potential for experiencing
- Enhance individuation

ROLE OF THE THERAPIST:
- Uses their own personality
- Must be open and spontaneous, empathic, sensitive, and demonstrate caring and acceptance
- Be willing to share and risk, be genuine, and increase stress within the family
- Teach family effective communication skills in order to convey their feelings
- Active and directive

ASSESSMENT:
- Assess individual self-expression and levels of defensiveness
- Assess family interactions that promote or stifle individuation and healthy interaction

INTERVENTIONS:
- Sculpting
- Choreography
- Conjoint family drawing
- Role playing
- Use of humor
- Puppet interviews
- Reconstruction
- Sharing feelings and creating an emotionally intense atmosphere
- Modeling and teaching clear communication skills (Use of "I" messages)
- Challenge "stances" (Satir)
- Use of self

CHANGE:
- Increasing stress among the family members leads to increased emotional expression and honest, open communication
- Changing experience changes affect; need to get out of head into emotions; active interventions change experience, emotions

Experiential Family Therapy, Continued

TERMINATION:

- Defenses of family members are broken down
- Family communicating openly
- Family members more in touch with their feelings
- Members relate to each other in a more honest way
- Openness for individuation of family members

SELF OF THE THERAPIST:

- Through the use of humor, spontaneity, and personality, the therapist is able to unbalance the family and bring about change
- The personality of the therapist is key to bringing about change

EVALUATION:

- This model fell out of favor in the 80s and 90s due to its focus on the emotional experience of the individual while ignoring the role of family structure and communication in the regulation of emotion
- Emotionally Focused Couples Therapy (Sue Johnson) and Internal Family Systems Therapy (Richard Schwartz) are the current trend
- Need to assess in-therapy outcomes as a measure of success due the fact that they often result in deeper emotional experiences (and successful sessions) that have the potential to generalize outside of therapy

SUPERVISION INTERVENTIONS:

RESOURCES:

Satir, V. (1967). *Conjoint family therapy*. Palo Alto, CA: Science and Behavior Books.
Satir, V. (1972). *Peoplemaking*. Palo Alto, CA: Science and Behavior Books.
Napier, A. Y., & Whitaker, C. A. (1978). *The family crucible*. New York: Harper & Row.

NOTES:

EMOTIONALLY FOCUSED THERAPY

LEADERS:
- Susan Johnson
- Les Greenburg

ASSUMPTIONS:
- "The inner construction of experience evokes interactional responses that organize the world in a particular way. These patterns of interaction then reflect, and in turn, shape inner experience" (Johnson, 2008, p. 109)
- Individual identity can be formed and transformed by relationships and interactions with others
- New experiences in therapy can help clients expand their view and make sense of the world in a new way
- Nonpathologizing, not interested in pathology or "dysfunction"
- Past is relevant only in how it affects the present.
- Emotion is a target and agent of change.
- Primary emotions generally draw partners closer. Secondary emotions push partners away.
- Distressed couples get caught in negative repetitive sequences of interaction where partners express secondary emotions rather than primary emotions.

CONCEPTS:
- Attachment needs exist throughout the life span.
- Negative interactional patterns
- Primary and secondary emotions
- Empathic attunement
- Cycle de-escalation
- Blamer softening
- Withdrawer re-engagement

GOALS OF THERAPY:
- Identify and break negative interactional patterns
- Increase emotional engagement between couple
- Identify primary and secondary emotions in the context of negative interactional pattern
- Access, expand, and reorganize key emotional responses
- Create a shift in partners' interactional positions.
- Foster the creation of a secure bond between partners through the creation of new interactional events that redefine the relationship

ROLE OF THERAPIST:
- Client-centered, collaborative
- Process consultant
- Choreographer of relationship dance

ASSESSMENT:
- Assess relationship factors such as:
  - Their cycle
  - Action tendencies (behaviors)
  - Perceptions
  - Secondary emotions
  - Primary emotions
  - Attachment needs
- Relationship history, key events
- Brief personal attachment history
- Interaction style
- Violence/abuse/drug usage
- Sexual relationship
- Prognostic indicators:
  - Degree of reactivity and escalation- intensity of negative cycle
  - Strength of attachment/commitment
  - Openness – response to therapist – engagement
  - Trust/faith of the female partner (does she believe he cares about her).

Emotionally Focused Therapy, Continued

INTERVENTIONS
- Reflection
- Validation
- Evocative questions and empathic conjecture
- Self-disclosure
- Tracking, reflecting, and replaying interactions
- Reframe in an attachment frame
- Enactments
- Softening
- Heightening and expanding emotional experiences

TERMINATION:
Therapy ends when the therapist and clients collaboratively decide that the following changes have occurred:
- Negative affect has lessened and is regulated differently
- Partners are more accessible and responsive to each other
- Partners perceive each other as people who want to be close, not as enemies
- Negative cycles are contained and positive cycles are enacted

SELF OF THE THERAPIST:
- Accept responsibility for client/therapist relationship
- Expert on process of therapy, not on client's life or experience of the difficulty
- Collaborator who must sometimes lead and sometimes follow

EVALUATION:
Therapy/Research:
- Difficult model to learn
- When using the EFT model, it is important to move slowly down the process of therapy. This can be difficult to do.
- Learning to stay with deepened emotions can sometimes be overwhelming, but the therapist must continue to reflect and validate.
- Empirically validated, 20 years of research to back up.

CHANGE:
- Change happens as couples have a new corrective emotional experience with one another.
- When couples are able to experience their own emotions, needs, and fears and express them to one another and experience the other partner responding to those emotions, needs, and fears in an accessible, responsive way.

SUPERVISION INTERVENTIONS:

RESOURCES:

Johnson, S. M. (2004). *The practice of emotionally focused couple therapy* (2nd ed.). New York: Brunner-Routledge.

Johnson, S. M., Bradely, B., Furrow, J., Lee, A., Palmer, G., Tilley, D., & Wolley, S. (2005). *Becoming an emotionally focused couple therapist: The workbook.* New York: Routledge.

Johnson, S. M. (2008). Emotionally focused couple therapy. In A. S. Gurman (Ed.), *Clinical handbook of couple therapy* (4th ed., pp. 107-137). New York: Guilford.

Johnson, S. M., & Greenburg, L. S. (1994). *The heart of the matter: Perspectives on emotion in marital therapy*. New York: Brunner/Mazel.

Emotionally Focused Therapy, Continued

Notes:

Gottman Method Couple Therapy

LEADERS:
- John Gottman
- Julie Gottman

ASSUMPTIONS:
- Therapy is primarily dyadic
- Couples need to be in emotional states to learn how to cope with and change them
- Therapy should be primarily a positive affective experience
- Positive sentiment override and friendship base are needed for communication and affect change

CONCEPTS:
- Negative interactions (four horsemen) decrease acceptance of repair attempts
- Most couples present in therapy with low positive affect
- Sound marital house
- Softened startup
- Love maps

GOALS OF THERAPY:
- Empower the couple
- Problem solving skills
- Positive affect
- Creating shared meaning

ROLE OF THE THERAPIST:
- Coach
- Provide the tools that the couple can use with one another and make their own

ASSESSMENT:
- Four horsemen are present and repair is ineffective
- Absence of positive affect
- Sound marital house

INTERVENTIONS:
- Sound Marital House
- Dreams-within-conflict
- Label destructive patterns
- Enhancing the Marital friendship
- Sentiment override

CHANGE:
- Accepting influence
- Decrease negative interactions
- Increase positive affect

TERMINATION:
- When couples can consistently develop their own interventions that work reasonably well

SELF OF THE THERAPIST:
- Not discussed

EVALUATION:
- Theory is based on Gottman's research

SUPERVISION INTERVENTIONS

RESOURCES:

Gottman, J. (1994). *Why marriages succeed or fail.* New York: Simon & Schuster.
Gottman, J. M. (1999). *The marriage clinic.* New York: Norton.

Gottman Method Couple Therapy, continued

NOTES