MARRIAGE, COUPLE, AND FAMILY THERAPY
Theory, Skills, Assessment, and Application

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FIRST EDITION
Marriage, Couple, and Family Therapy

THEORY, SKILLS, ASSESSMENT, AND APPLICATION
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Marriage, Couple, and Family Therapy: Theory, Skills, Assessment, and Application provides a foundational basis for counselors working with couples and families. Whether you are working specifically with couples and families, in a school, private practice, or an agency setting, this text covers all the bases from theory to practical application. As an added bonus, current issues such as immigration, diverse family structures, the impact of grief and illness on the family, and parental and adolescent influences on family development are covered from a systemic, empathic, and multicultural perspective. Readers will find the case presentations, guided practice activities, and expert reflections that accompany each chapter interesting, relevant, and helpful.

The aim of Marriage, Couple, and Family Therapy: Theory, Skills, Assessment, and Application is to provide readers with a strong foundation in marriage and family therapy (MFT) history, theory, and clinical assessment that will allow them to develop the skills and competencies needed to become effective, ethical counseling practitioners in today’s diverse society. Currently, there are no textbooks on the market that have a section dedicated specifically to the role of assessment within introduction books for marriage and family counseling.

This text thoroughly prepares students by infusing the role of assessment with the theoretical knowledge and skills deemed important by national boards, organizations, and accrediting bodies. The National Association of Regulatory Boards in Marriage and Family Therapy determine specific knowledge areas are necessary for those seeking to become licensed clinicians. These topics consist of major models and theories of MFT and clinical, research, and ethical topics. The Council for the Accreditation of Counseling and Related Programs Assessment (CACREP, 2016) also aligns with the American Association for Marital and Family Therapy (AAMFT, 2014) and has established skills, practice, and knowledge domains. Each have identified the importance of having knowledge related to assessment.

Marriage and family therapy cannot adequately assist clients without proper assessment. For this reason, this text focuses on and views assessment as an integral part of
the counseling process. As part of the holistic counseling process, therapists are taught to gather and integrate information about an individual from multiple sources using multiple methods to positively impact the counseling process (Watson & Flamez, 2014, Drummond & Jones, 2016). Once this assessment process begins, therapists and clients begin to see the numerous benefits of assessment in all aspects of counseling practice from rapport building, problem identification, diagnosis, treatment planning, assessing treatment efficacy, and evaluating client outcomes. Highlighting the importance of sound assessment in the practice of counseling, previous authors have contended that it is imperative for counselors, working in a variety of clinical settings, to develop refined assessment skills (Whiston, 2016). Thus we have an entire section dedicated to assessment.

To further meet these goals our textbook is divided into four main sections. The first section will cover the history and conceptual frameworks of marriage and family counseling. The next section will focus on research, intake, assessment, and progress evaluation. The third section covers all the major schools and models of family therapy, including: transgenerational family therapies, strategic and Milan, structural, behavioral and cognitive behavioral, solution-focused, narrative, family psychoeducation and enrichment, and integrative models. The textbook comes to an end by covering special issues within marriage and family therapy such as nonnuclear families, influences on parental functioning on the family, and child and adolescent influences on the family. Each chapter includes the following:

- **Learning Objectives** based on the COAMFTE and CACREP standards.
- **4–5 Guided Practice Exercises**, which include mini case studies, tables, charts, and activities.
- **Reflections from the Contributor’s Chair**, in which authors share how they apply and use the material in their practice.
- Rich **Case Presentations** to demonstrate the applied practice of the content
- **Keystones**, which contain bulleted main summary points.
- **Additional Resources**, including readings, websites, and videos for additional study.

In addition, each chapter is written by experts in our field who have been recognized nationally for their publications and leadership related to marriage and couples therapy. Students introduced to the topics in this text have the unique and unusual advantage of exposure to not only expert knowledge but also to their personal reflections, strategies, and unique case presentations. Where else can students hear so many personal reflections and stories, and even read advice from so many top counselors in the field?

While this book covers multiple aspects of family therapy and includes up-to-date research, we realize that this text alone cannot adequately address all the issues one may come across when working with couples and families. However, we hope that exposure to
the rich, substantive, and interesting material not only increases learning but encourages students to question, research, and discuss other possibilities. As discussed in this text, questions lead to research, which leads to improved client services and outcomes. We hope you enjoy reading the many differing views and strategies in the text as much as we did!
Acknowledgments

Completing a project of this scope would not have been accomplished without the perseverance, dedication, hard work, and wonderful contributions of the contributing authors. To each of you, I extend my sincere appreciation for helping create an introduction marriage and family text that introduces the role of assessment in working with couples and families.

To my family and friends, especially my parents, Rosemary and John, I thank you for your love and support during the many hours spent on this project. Your love and encouragement is one of the greatest gifts a daughter could ever ask for.

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Each and every one of you has my sincere appreciation and gratitude.

—Brandé Flamez

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PART I

History and Conceptual Framework
As you embark on studying family therapy, there is no doubt you will realize that each family is unique. You will learn that there are a variety of approaches, techniques, and interventions; there is no “one-size-fits-all” approach; and there are many ways of offering help. As a professional it is important to have a fundamental understanding of the key concepts in family therapy.

Family therapy can trace its origins to the groundbreaking work of Alfred Adler a century ago. Though Adler’s work focused on the wellness of individuals, he recognized early on the significant role the family of origin played in an individual’s development and mental health. Early in his career, Adler was mentored by Sigmund Freud, but he soon departed from the strict views of Freud. This departure from the traditional psychoanalytical theory of the time was significant in Adler’s early work in family therapy. Adler rejected what he saw as a myopic focus on sexual themes and an overemphasis on the power of the unconscious. While he recognized these considerations as influential, Adler asserted that the more relevant aspect was how these manifested in relational dynamics. He gave value to the social context of individuals, noting direct ties between family experiences in early life and identity and worldview in adulthood. In many ways, Adler was a systemic therapist before systems theory was widely known. Adler’s foundation in the field of family therapy, combined with the popularity of general systems theory (GST) in the mid-20th century, laid the groundwork for what would eventually become family systems therapy and eventually simply family therapy. The field has evolved exponentially...
over the past 50 years, with a variety of theoretical approaches and empirically supported interventions to support its efficacy. In this chapter, we provide an overview of these theories and their application.

Before we embark on a review of key theories, we want to ensure that you have a firm understanding of the underpinnings of family therapy. Thus, in this chapter, we will review these fundamentals—including concepts, constructs, and considerations. We will also discuss some of the advantages and challenges to systems-focused counseling and provide some perspective from real-life clinical experiences with family work.

**LEARNING OBJECTIVES**

After reading this chapter, you will be able to do the following:

- Understand key concepts in the study of family therapy.
- Recognize the roots and common themes across family therapy disciplines.
- Determine the appropriateness of systems-focused interventions.
- Integrate cultural considerations and adaptations into systems-focused interventions.
- Compare and evaluate the strengths and barriers in clinical work with families.

**KEY CONCEPTS**

Though each systemic theory will have some unique elements and foci, there are many concepts that are common across disciplines. In this section, we will discuss some of those universal concepts, including relevance and application.

**General Systems Theory**

GST was first proposed by Ludwig von Bertalanffy in the early to mid-20th century. Sometimes referred to as a “general theory of systems,” Bertalanffy’s ideas forever changed the way researchers viewed and organized ideas about their respective fields. His theory shifted traditional focus from components or pieces to relationships and mutual influences. At the core of GST are the ideas that “a) circumstances and events can be evaluated and understood through analysis of dynamic interactions among influential elements, and b) all systems have shared patterns that reveal key characteristics of that system” (Scott, 2015, p. 129). The expanding popularity of GST during the 20th century significantly impacted the field of psychotherapy by transferring focus from individuals to relationships. GST was the foundation for the rapidly evolving family systems theory.
in which individuals were viewed within the context of their systemic relationships. This ecological perspective helped further advances in clinical mental health by actively integrating the role of both relationships and environment on the health and wellness of individuals (Magnavita, 2012). For the first time, the existing connections, bonds, and associations were considered vital to the treatment equation, in turn supporting the view that relationships themselves are often the “client.” Guided Practice Exercise 1.1 asks you to consider the rationale for viewing relationships instead of individuals as the major focus in counseling.

GUIDED PRACTICE EXERCISE 1.1

In family therapy, the relationship, rather than the individual, is seen as the client and each individual is viewed as being part of the family system. Why do you think this viewpoint became prevalent in family therapy? What might happen if family therapists viewed only one person in a relationship as the client? How would focusing on the relationship as client help each individual separately?

Cybernetics

Cybernetics is the study of self-regulation in systems (Smith-Acuna, 2010). The concept—applicable across disciplines and fields—provides an understanding of the processes, limitations, and mechanisms by which systems maintain themselves. A simple example of this can be seen in the temperature regulation common in modern-day households. The temperature is set by the home owner on a thermostat. The thermostat monitors the internal temperature of the home, alternately turning on heating or cooling elements to keep the temperature inside consistent. The temperature system in the home, therefore, monitors and controls itself through a feedback loop. The feedback loop is an essential part of the communication necessary to maintain a homeostasis—or steady equilibrium—in the environmental temperature. In social systems, there are “rules” that regulate acceptable behaviors within the system; such rules “which are often implicit, serve as the system’s thermostat” (Smith-Acuna, 2010, p. 69). If the behaviors deviate from the established rules, the system will respond with feedback to reestablish the system’s homeostasis.

Feedback loops in couple and family relationships—as with many other types of self-regulating systems—can be positive or negative. These terms are not reflective of the relative impact of the feedback, but rather the mechanism of action. Positive feedback loops encourage the increase of a particular behavior to maintain equilibrium, while negative feedback loops discourage certain behaviors. Either way, the system strives to maintain its homeostasis, which has been established by history and habit and is often separate from the health or wellness of the system.

In studying the cybernetics of human systems, early researchers discovered that while systems do have an overall tendency to maintain homeostasis over time, the variations in practices and the inefficacy of some feedback loops do not always support
this. Punishments, guilt, and shame are common negative feedback processes in family systems, and though designed to provide regulation to the system, they may prove to be both ineffective and destructive. For example, an adolescent who breaks household rules by staying out all night may find himself or herself on the receiving end of parental anger and punishment. This reaction is designed to bring the child back to the acceptable behavior of the system. However, the consequence may be rejected by the adolescent, who instead responds with his or her own anger and a rebellion toward the parents’ efforts. The conflict escalates, with the system experiencing a “runaway effect” in which the feedback loops fail, resulting in the system’s extended disequilibrium—perhaps even necessitating intervention or outside assistance. Still, it is important for couple and family counselors to recognize that systems are disposed toward homeostasis, regardless of whether such is healthy or unhealthy, and are generally resistant to change without concerted and collaborative efforts of all within the system (Scott, 2015).

The reality and regularity of runaway feedback loops in couple and family systems helped better explain not only the observed variations in system dynamics, but also the recognition of different levels of change. For example, in the situation above, the adolescent accepting parental consequences and changing his or her behavior to conform to the parents’ rules would be an example of **first-order change**. Such changes are more simplistic and most easily recognized by system members; they also can have a more immediate impact on restoring homeostasis to the system. A **second-order change** for this system might be a change in the behaviors concerning the rules and system regulation—such as a family meeting to discuss parents’ feelings of worry as well as the teenager’s desire to have more freedom. It is important to note that couple and family therapists work with both levels of change within the system, being careful not to impose values or personal judgment on system members, but rather to focus their efforts on promoting a healthy homeostasis in which all members flourish.

**Functionalism**

In simplest terms, **functionalism** provides an answer to the question “what purpose does this serve?” Most often applied to behaviors, this concept may also apply to overarching patterns, smaller pieces, unique characteristics, or even circumstances within a system. Functionalism became an important element in the evolution of couple and family therapy, as researchers sought to better comprehend the complexities and influences in systems. Using a functionalist perspective provided another dimension to the role and function of certain traits, behaviors, or characteristics (Morgan, 2014). For example, in the family system described above, it might be argued that the adolescent’s behavior serves a purpose; perhaps he or she is trying to assert independence as he or she moves closer to adulthood. Alternatively, perhaps the parents have a high-conflict relationship and frequently fight, which the teen finds stressful. By creating a conflict in the form of rebellion, the teen forces the parents to unite in their reaction—thereby easing (temporarily) the tension in the parental relationship.
Functionalism can sometimes be limiting or restrictive, as it often relies heavily on assumptions. Considerations of gender roles, motivations, dyadic influence, and culturally driven forces, for example, are given great weight in functionalism, though they may vary widely from one system to the next. Still, functionalism validates the potential importance of these considerations and should not be overlooked. In fact, it could be argued that functionalism is an essential aspect of family systems theory and clinical work, as it adds a depth to the understanding of problems themselves.

Structuralism

Just as functionalism helps explain the role of conflicts and behaviors, structuralism helps to explain the position of these relative to the system and its members (Morgan, 2014). Furthermore, structuralism provides a deeper understanding of suprasystems and subsystems that influence family dynamics and patterns. According to the structural theory of family systems, clear and consistent boundaries are essential elements of healthy dynamics. Boundaries that are too weak, too strong, or simply unclear can contribute to the system becoming dysfunctional. In this view, the key to positive change in structuralism is to improve the position of the individual relative to the system; this is done through the clarification and adjustment of relational bonds. A structurally focused counselor considers how the systemic relationships impact the etiology and resolution of the presenting issues. Let’s turn to Guided Practice Exercise 1.2 and consider how structuralism might affect family behaviors.

GUIDED PRACTICE EXERCISE 1.2

Assume a teen has unclear or enmeshed boundaries with her mother in the family system. This same teen stayed out past curfew, and both parents decided to enforce boundaries together. How do you suppose this teen will react to each parent? Will the enmeshment cause more defiance toward the mother? Do you think this would affect the nature of conflict in the family system?

Structuralism was the foundation of Salvador Minuchin’s work in the 1970s and arguably had the greatest impact on the advancement of family therapy. However, it is also true that structuralism is inseparable from functionalism in a practical sense. Thus, from a foundational perspective, it is often best to consider these core concepts together as “structural-functionalism,” wherein issues, behaviors, conflicts, and other systemic attributes are considered for their purpose, role, and impact on system members—and vice versa. Critics of this view have argued that how one interprets the relative importance of these components changes over time, generally as a function of sociohistorical forces (Dickerson, 2010). You will learn more about structuralism in Chapters 2 and 11. This poststructuralist view emphasizes the importance of a broader epistemology relating to systems theory, and a move toward critical realism, which provides a truly integrative epistemological perspective (Pocock, 2015). Such deliberations are relevant to the
budding family clinician because they assist in the comprehensive understanding of the very theories that guide clinical practice, as well as how to adapt and integrate these to best meet clients’ needs.

Family

Thus far we have discussed the system of the family in rather abstract terms—but what defines a “family”? How do you define your family? It is not sufficient to understand how the family system operates; we must also describe the system in more concrete terms. Historically, family has consisted of individuals related by blood, marriage, or adoption. Other definitions have included those with economic interdependency, such as sharing a common household. More contemporary views have included those with emotional or psychological interdependency, such as domestic partners or those in long-standing committed relationships. In addition, systemic function can help define family—such as economic support, child rearing, companionship, and safety. With such varied and contextual definitions, it is important for clinicians to consider how the family system defines itself. In simplest terms, if the system members consider themselves “family,” they should be viewed as such.

Even with such broad and potentially abstract terms, there are some commonalities across differing definitions of “family.” For example, there is often a shared past and an expectation of a shared future. The family unit also generally includes economic connections, such as the rearing and support of any young within the system. Contextually, families also experience common effects of environment, such as cultural influences. Most importantly, there is an identity attached to the membership in the family and a commitment to maintaining that identity over time. Guided Practice Exercise 1.3 notes examples of simple and complex relationships; which do you consider family?

GUIDED PRACTICE EXERCISE 1.3

Consider the examples below—which do you consider “families” and why?

- A husband and wife and their children
- Divorced parents of grown children
- A 45-year-old single woman, her live-in boyfriend, and her adult daughter
- A 38-year-old single man and his cat, Zeus
- A lesbian couple and their biological children
- Two 27-year-old female best friends who have cohabited since college
- Two adult brothers living together
- Two grandparents raising their grandchild
- A widow and her deceased husband’s niece’s partner
- A gay couple and their adopted daughter
- A newly married couple in their 50s and their adult children from previous marriages
• A single adult man and his two young children
• An 80-year-old woman and her lifelong best friend
• A 30-year-old single woman, her live-in partner, and her divorced parents
• A professional football team

For further discussion: What cultural and socioenvironmental influences affect your definition of family? How can ensure that you honor the constructs and definitions of your clients?

Family Life Cycle
The concept of family life cycle evolved from a developmental perspective that asserted that families change over time in predictable ways. Though grounded in traditional definitions of family, family life cycle constructs can often be applied to less traditional, more contemporary family systems. At the core of this stage-based view are several key elements: first, that family life cycle stages are marked by the addition or subtraction of family members; second, that the developmental stages of individuals within the system impact the stages of the system; and third, that socioenvironmental influences impact the family life cycle. The purpose of this framework was to help clinicians identify and understand the developmental tasks associated with the family life cycle, as well the complex interactions between individual and systemic development. A more detailed discussion of family life cycle is provided in Chapter 3 of this text.

Family Therapy
Family therapy is a clinical approach to mental health treatment wherein the family is the primary focus, rather than the individuals who make up the family. The system itself is the “client” in family therapy, with the treatment focus being the relationships, interactions, and overall dynamics that support systemic functioning. Family therapy acknowledges the systemic influences of homeostasis and equilibrium as being powerful forces that demand attention if change and growth are to be permanent. That is, family therapy acknowledges that without change in the system, there is unlikely to be lasting change in any members of the system. Therefore, unlike individual psychotherapy, the focus of treatment in family therapy is communication, conflict resolution, and relational dynamics rather than insight, self-awareness, and personal growth (Walrond-Skinner, 2014). That is not to say that family members participating together in therapy do not experience insight, self-awareness, and personal growth, but rather that these facets occur as a consequence of family therapy rather than as the major treatment focus. Methods, interventions, and theoretical orientations in family therapy have evolved considerably over the past 50 years, the details and specifics of which are described in detail in subsequent chapters. Professional identity issues and considerations related to distinctions between family “therapy” and “counseling” have also been mentioned in the literature and are discussed in detail in Chapter 5.
Differentiation

The development of the concept of differentia tion is widely attributed to Murray Bowen (1978). You will learn more about Bowen in Chapters 2 and 9. Though his roots were firmly planted in psychoanalytic theory, Bowen was largely influenced by biology and the processes he observed in growth and development. Bowen saw a metaphoric correlation between undifferentiated cellular masses and the psychological fusion observed in family systems. He coined the phrase undifferentiated family ego mass to describe the unified emotionally driven behaviors observed in relational systems (Bowen, 1978). From Bowen’s work emerged the term differentiation, whose use is not limited to Bowenian family therapy but has found a home across disciplines. Differentiation—in simplest terms—is the relative degree to which individuals develop their own identity separate from their systemic origin. Furthermore, differentiation is reflected in and impacted by boundaries within systems, which in turn are evidenced by rules, patterns of communication, and relational dynamics.

Differentiation has been found to be directly correlated with psychological well-being (Krycak, Murdock, & Marszalek, 2012; Skowron, Stanley, & Shapiro, 2009). Furthermore, the correlation persists across both individualistic and collectivist cultures, though variations are noted in contextual environmental influences (Chung & Gale, 2009; Lohan & Gupta, 2016). An awareness of the impact of differentiation is essential to the systemic practitioner, as it provides insight into the individual’s ability to balance intimacy and autonomy in relationships. Moreover, it helps provide a deeper understanding of the self, as well as the self in relation to others (Ross & Murdock, 2014).

Attachment

If differentiation can be viewed as a contextually driven assessment of security in individual identity, then attachment can be viewed as the experiential foundation on which that identity is based. Research focusing on the characteristics of attachment bonds between parents and children was brought to the forefront by the work of John Bowlby (1958) and later expanded on by Mary Ainsworth (Ainsworth & Bell, 1970). Both researchers recognized patterns in the way parents interacted with their children, noting that the mother–child dyad was especially impactful. Further, they noted that these interactional patterns directly affected the developing child’s sense of security and autonomy. This in turn has an ongoing impact on cognitive and social development. In fact, poor attachment in childhood can have an impact that lasts throughout the life span.

The study of attachment—including its development, modification, persistence, and impact—can be a professional specialization for the systemic counselor. Interest in this essential concept of systems-based counseling may even lead to adopting the empirically based attachment-based family therapy as one’s primary theoretical orientation (Diamond, Russon, & Levy, 2016). However, at this juncture and for better understanding of topics discussed in this text, a foundational understanding of attachment will suffice. Table 1.1 shows a comparison of children and adults’ attachment styles.
### Table 1.1: A comparison of children’s and adults’ attachment styles

<table>
<thead>
<tr>
<th>Children</th>
<th>Adults</th>
<th>Relational traits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>Secure</td>
<td>Confident, adapts easily</td>
</tr>
<tr>
<td>Anxious</td>
<td>Preoccupied</td>
<td>Clingy, needy</td>
</tr>
<tr>
<td>Avoidant</td>
<td>Dismissing</td>
<td>Indifferent, detached</td>
</tr>
</tbody>
</table>

Note the correlations between the observed emotional behaviors. To understand the impact of these attachment patterns, systemic counselors should recognize that all human beings are driven to attach to others and that they desire security in those attachments. Clinical interventions designed to enhance the quality of attachment styles—and repair weaknesses where they might exist—will have a direct positive impact on both relational dynamics and individual identity (Diamond et al., 2016; Fraley, 2010; Johnson, 2009).

**Triangulation**

The concept of **triangulation** is another that was originally associated with Murray Bowen and his theory of family systems therapy but is now integrated across multiple theoretical orientations. Triangulation is simply the formation of a three-person system, which Bowen (1978) believed was the smallest stable relationship structure. He asserted that while dyads are the initial structural building block in systems, external stressors create tension and anxiety in the dyad, which responds by bringing another person into it—thus creating the triad or triangle. The energy flow across the triangle impacts the relational dynamics of individuals involved. That is, changes in attention, support, and connection in dyads within the triad alter the way the entire system functions. The alliances formed by shifts in the system’s energy may be transient or permanent; regardless, they are associated with increased anxiety and conflict (Bowen, 1978). For example, a mother may complain to her teenage daughter about her husband (the child’s father), perhaps sharing that she’s frustrated about his lack of attentiveness or engagement in the family system. Whether she is aware of it or not, she has triangulated the child by creating a situation in which the child must react with support and empathy, but in opposition to her father. This can create anxiety for the child and form an alliance with the mother in a manner that was previously absent. The change in the energy flow of this triad can give rise to further conflict and stress across the system. Triangles and triangulation will be discussed in more detail in subsequent chapters.

**Narratives**

Thus far we have looked at some of the concepts within couple and family therapy that help describe the framework of the system and its members. **Narratives**, by contrast, focus on how the family members view themselves—including their individual, systemic, and social roles. Narratives are stories, constructs, and beliefs that individuals develop
over time and which determine the way they derive meaning (Logan, Jackson, Teufel-
Prida, & Wirick, 2015). Based in social constructionism, narratives are essential to how
people define their realities and experience events. For example, in the family above in
which the mother has triangulated the daughter due to conflict with her husband, a key
element to the mother’s stress lies in her own narrative of what marriage is “supposed
to be.” She has an expectation of behavior in her husband and a belief about how much
time he should spend with her and the family. Her constructs are a result of her envi-
ronmental influences and experiences throughout her life, and they form the basis for
her marital narrative. Her narrative is not “right” or “wrong”—it just is. Similarly, her
husband has his own narrative about marriage and probably does not view his behavior
as problematic. If this couple were to seek clinical support for their marital troubles, an
eyear step for the counselor would be to understand how their individual narratives
affect their interpretations of the presenting issues and the relationship itself.

Narratives are critical elements in couple and family therapy, as they exist on both
the individual and systemic levels, impacting perceptions and behaviors. Regardless of
one’s theoretical orientation, counselors must understand the sociocultural influences
that affect their clients’ experiences and worldview. Further, they need to recognize the
role of narratives not only in the experience of current issues, but also in the revision
and construct of a new reality.

Identified Patient
Couple and family counselors may see multiple issues relating to differentiation, at-
tachment, and narratives in presenting family systems. However—more often than
not—a single family member is considered the identified patient. This designation
is twofold. First, the identified patient in the family is the one whom the system has
determined is “the sick one.” The system presents this person as needing the clinician’s
help to “get better,” preferably with little or no change to the homeostasis of the system
itself. “Identified patient” is a concept associated with projection, scapegoating—even
active participation and collusion—depending on the theoretical orientation of the
clinician. However, regardless of the underpinnings of treatment, the concept has a
prominent role in couple and family work, as it is vital to understanding the structure
and dynamics of the system, as well as the deeper pathologies present.

The external symptoms evident in the identified patient are viewed by the sys-
tem as the focus of treatment; however, a couple and family counselor sees these
symptoms as manifestations of internal issues within the system itself. That is, this
individual is simply the “member expressing a disturbance existing in the entire fam-
ily” (Gurman & Kniskern, 2013, p. 365). Thus, the clinician views the family as the
patient. Treatment focus is on relational dynamics and dysfunctional family patterns,
rather than on a single member’s specific behaviors. It is not uncommon for family
systems to cling to the notion that one individual is “the problem” to be defensive in
considering a more systemic view. However, with support, empathy, psychoeducation,
and a nonjudgmental approach to examining issues, couple and family counselors can help shift the family paradigm to a more systemic treatment view.

The second facet of the “identified patient” concept may initially sound contradictory to the first one but is a reality of contemporary clinical work. Though a couple and family counselor views the relationships as the focus and the system itself as the patient or client, the realities of managed care and third-party payers require one family member to literally be the identified patient—if only for reimbursement purposes. This may put the clinician at odds with his or her theoretical orientation and perhaps even undermine the progress true systemic work can do; however, the need for this designation is a pragmatic one. Clinicians can mitigate the potential negatives by educating clients on policies and procedures and keeping focus on the support and improvement of the system.

FAMILY THERAPY INDICATORS
Deciding whether family therapy or individual therapy is indicated is a multifaceted decision for therapists. In reality, both family therapy and individual therapy are important. The individual personality matters, as evidenced by years of evidenced-based research substantiating the importance of individual psychotherapy (Shechtman, 2016), as well as family therapy that asserts that the family is the natural unit for change. Therapists must consider if family therapy, individual therapy, or both family and individual therapy is warranted. In addition, there are specific indications for when family therapy is most appropriate. Similarly, family therapy must consider aspects of culture, diversity, and what therapeutic adaptations may need to be employed for treatment success.

When Is Family Therapy Warranted?
You are probably wondering, “How do I know when family therapy is appropriate or necessary?” “Is this a family or systemic issue?” “Would it be better addressed in individual counseling?” Often there is no clear answer when trying to determine whether it is “necessary” or “better” to use a systemic approach to treatment, and ultimately the answer will be associated with the therapist’s theoretical orientation. Therapists who ascribe to or practice one of the following will believe family therapy is warranted in most situations, if not all: structural family therapy, strategic family therapy, and intergenerational family therapy. Family therapy may be best as an additional therapy or cotherapy in situations of individual psychological factors, such as a person diagnosed with schizophrenia, and larger social systems that are not able to be addressed within the context of family systems.

The question remains: When is family therapy warranted? A major premise of family therapy is that most problems originate in families and can be solved within families. Systemic interventions alone or as cotherapy are considered effective for sleep, feeding, and attachment problems in infancy; child abuse and neglect; conduct problems (specifically, child behavioral problems, attention-deficit/hyperactivity disorder, delinquency, and drug abuse); emotional problems (specifically, anxiety, depression, grief, bipolar disorder, and
suicidality); eating disorders; and somatic problems (specifically, enuresis, encopresis, abdominal pain, and issues associated with controlling asthma and diabetes; Carr, 2014).

Individual Versus Family Therapy

The most obvious difference between individual and family therapy is who the identified client is. In individual counseling, the identified client is the individual, and in family therapy the identified client is the family. Many times, the difference between individual and family therapy is the focus of the therapy in a given session. In individual therapy, the focus is on the individual. In family therapy, the focus is more complex and can change. There are several people in the room during family therapy. If an individual is having an issue and is in family therapy, his or her issue may be the focus, but the family members are also there working to learn and assist in resolving the given issue with the individual. Also, family therapy can focus on issues of many family members and an issue that the entire family is addressing. It is important to recognize that family therapy typically works to alter the way an entire family system operates. Additionally, family therapy may be a variety of interactions between couples, parents and child(ren), entire families, and/or extended families.

More specifically, individual therapy tends to focus on psychopathology, individual coping, and problem solving. Often the therapist makes assessments of individuals against prescribed norms and works to address the root cause of the person’s discomfort. In most of the individual therapeutic models, the therapist remains objective to discover the individual’s emotions, cognitions, and/or disruptive behaviors. The therapist then employs a variety of interventions to improve the individual client.

Family therapy is about process. The family therapist is expected to focus on the various transactions, interactions, and exchanges that occur between persons in the family therapy session. Family therapy “involves seeing the purpose and systemic logic in what often appear to be paradoxical processes” (Bitter, 2014, p. 21).

Just as there are differences between family therapy and individual therapy, there are also similarities. Both family therapy and individual therapy can be brief, crisis or trauma focused, and treatment goal orientated. It is often the case that families and individuals enter therapy to address a certain issue or need. Both individual and family therapy serve to improve psychological wellness and often are used as adjunctive services to medical care, legal involvement, or grief and loss.

Cultural Considerations and Adaptations

Cultural and subcultural factors are an inherent part of family. Attitudes, values, and belief systems and more specifically how families define health, wellness, and mental health are associated with one’s culture. The determinations of what is an identified issue or treatment goal for therapy and the types of interventions that are appropriate for the family are all made within the context of a specific family or group’s attitudes, values, and beliefs. For example, in some intrafamilial systems, the prevailing attitude and belief regarding physical child and spouse abuse may be that these are private
family matters, with neither warranting nor requiring intervention or therapy by persons outside the family.

An additional example of how therapy goals are influenced by family attitudes, values, and beliefs is whether to vaccinate a child. While the scientific evidence supports that vaccination is safe and effective, many parents make the decision based on their religious and own personal research to not vaccinate. Outside the United States, in developing countries, other cultures are often eager to vaccinate their children and do not understand the “option” to not vaccinate. Therapists working with families often must navigate diverse issues and integrate the family’s value system into the dialogue of the family sessions. Navigating conflicting attitudes, values, and beliefs that you might have as a therapist while in session with a family is common challenge. Yet given the opportunity to work with the family, a family therapist will be able to approach a given goal from a variety of ways. There are multiple advantages and challenges in family therapy.

Advantages

**Strengths.** A systemic approach offers the opportunity to look at an issue from multiple vantage points. The systemic approach unto itself as an epistemological concept is a strength; it is unlike any other approach. As an approach, the systemic way of thinking and doing therapy challenged the “traditional” and linear cause-and-effect way of approaching therapy. Hence, the theoretical underpinnings and concepts of the approach are strengths of the systemic approach.

For example, the systemic approach would invite a family to therapy and include all perspectives in the therapeutic dialogue, and the family in conjunction with the therapist would identify areas of concern and areas that would be addressed in therapy. In individual therapy, there is often an identified “issue,” and the client seeks to address that specific goal in therapy. In family systems work, there are multiple areas or systems that can be addressed that are associated with the family and just as many ways to reach a potential goal.

Specifically, psychotherapy is dominated by approaches that are individualistic in orientation, and the systemic approach offers equality in the multiple avenues to goal achievement. Thus, **equifinality** is strength of the systemic approach—equifinality being the idea that in a system, an identified goal can be reached by a variety of ways, and thus a therapist can focus on an issue within the familial system that seems to make sense.

**CASE PRESENTATION 1.1: THE CASE OF LIU YANG AND BEN**

Liu Yang is a Chinese American mother to a 13-month-old boy named Tai. Liu Yang is married to a multiracial man named Ben who was born in United States. Liu Yang and Ben live in a progressive area of the country, and Liu Yang is responsible for caring for Tai while Ben earns the money for the family. Ben works out of the home and earns a very comfortable living. Liu Yang and Ben enter family counseling due to concern over Tai’s development (he is small for his age, and there is a family history of autism). Liu Yang is still breast-feeding Tai, and Ben disagrees with this practice. Also, Tai is sleeping in Liu Yang and Ben’s bed at
night. Tai has co-slept since he was born. Liu Yang believes in co-sleeping, whereas Ben does not believe they should continue to co-sleep. In addition to disagreements about co-sleeping, Ben and Liu Yang would like to have another baby.

As the family therapist of Liu Yang, Ben, and Tai, you note that there is an identified goal of growing the family and assessing the development of Tai. Other potential issues in therapy may center on multiculturalism, gender roles, value systems, and specifically the parenting practice of co-sleeping. A strength of the systems approach is that there are an equal number of ways to potentially reach the goals that Liu Yang and Ben hope to accomplish in therapy. The therapist could address Liu Yang’s value system, as it is associated with her parenting practice of co-sleeping, or Ben’s gender role or the multicultural and Chinese view of young male development or the potential life cycle impact of a new child. All approaches being equal would result in systemic change.

Viewing families as a system involves recognizing the various relationships between and within the family and the inherent power, behaviors, emotions, thoughts, values, and attitudes associated with the family system. The lens of a systemic approach requires a certain “systems intelligence” by which a clinician can understand and approach a clinical familial case from the standpoint of balancing between parts, content, context, and reciprocity (Sweeney & Sterman, 2007, p. 286). This “systems intelligence” is ultimately a more contemporary version of thinking about the interweavings of life, family, and problems versus the historical or organismic version of systems whereby organisms thrive or die in accordance with their openness or closeness to their environments (Bertalanffy, 1934, 1968). Ultimately, a key strength of a systemic approach is how a therapist conceptualizes the family in its entirety (wholeness) versus its individual pieces or parts.

In addition to the conceptual, albeit theoretical, strengths of equifinality and wholeness, multiple strengths of the systemic approach lie in the application of the approach in couple and family interventions. The systemic approach is unmatched in its ability to comprehend the complexities of family life. Similarly, in systems work a therapist understands and recognizes reciprocity. We are all interconnected. If an aspect of the system is changed, other systems are affected. Therapists working with the systems approach are aware of reciprocity between systems, thus strengthening their therapeutic interventions accordingly. Similarly, a systems therapist can conceptualize change, observe patterns and trends, make connections, deal with physical or symbolic ambiguity of system boundaries, and address aspects of perspective and time in therapy (Stanton & Welsh, 2012).

**Benefits.** According to Bitter, Long, and Young (2010), “Modern system therapists tend to want as many members of the family as possible in the room—often including friends and other members from the family’s community” (p. 19). There is an inherent respect for diversity and multiculturalism in a systemic approach. The systems counselor works to include, not exclude. The benefit of systems work is to address diverse family makeup and emerging forms of family in a way that is inclusive, not exclusive. Also, the systems counselor works to address interdependence and issues of influence and subjectivity that are common in the discussions of race, socioeconomic status, gender, age, sexual orientation, creed, and culture.
Beneficial to the systemic approach is the specific focus on process and crossing boundaries between systems. This approach allows for an effective client-centered experience that is based in theory and interventions (Patterson & Sexton, 2013). Rooted in process and function, the systemic approach is beneficial due to common family therapy techniques. For example, the technique joining (Haley, 1976; Minuchin, 1974) provides both structure and support for a family. By joining with a family, the therapist forms a therapeutic alliance with the family—meeting, greeting, and forming a bond in a quick but relaxed way.

Many times, clinicians using a systemic approach find that they have “more ideas about how to proceed” and clients were “better engaged” in the process of therapy (Fredman, 2014, p. 2). In a systemic approach, there is a collaborative environment. Thus, the systemic therapist works together with various systems to provide the benefit of unity and goal orientation.

Challenges

Common issues. Conceptualizing a family from a systemic approach is rich with strengths and benefits, but also laden with challenges and potential risks or barriers. Mechanistic models of systems have focused on a historical model of a family, thus excluding a contemporary definition of family and the changing view of family. In addition, traditional systemic approaches may not account for the complex interaction of factors in problem origination, continuation, or change in a contemporary family system.

While the systemic approach is strong in its willingness to “include” and consider multiple perspectives, a common issue within this approach that should continue to be addressed is multiculturalism and diversity. The roles of families and couples—how to define roles in a family and the ambiguity of who is an “outsider”—remain complex. In addition, the systemic approach must continue to work to include multiple perspectives by addressing the changing landscape of family and partnership. Similarly, issues of culture and gender are a challenge that the systems approach theoretically is posed to address, yet in the therapeutic process a common issue emerges of whether the systems approach accounts for contemporary understandings of culture and gender. This is considering that in the early years of family therapy, issues of gender and culture were virtually ignored. Many of the predominant theoretical orientations under the systems approach umbrella are likely to often reflect the dominant value system and ignore the effects of oppression.

Barriers. The systems therapist must be able to establish a relationship with multiple individuals (Stanton & Welsh, 2012). There are challenges to establishing relationships and connections with multiple people. One member of the family might connect with the therapist versus another who may not, or some members of the family may or may not be able to attend all sessions. The potential barriers to connect revolve around issues of client and therapist transference and countertransference.

In addition, the establishment of a strong relationship with the family system can be threatened if the counselor overemphasizes details, making everyone happy, verbal
expression, coming to an early or too easy resolution, and dealing with one member of the family (Kalima, 2005). Similarly, there may be issues related to counselor underemphasis. Underemphasizing structure, showing care and concern, engaging family members in the therapeutic process, and letting the family work on its problems are also common barriers for family counselors (Kalima, 2005).

Issues common to therapeutic process of other approaches are also common to the systemic approach. Legal and ethical issues may arise with changing couple, family, and individual systems. The therapist would have barriers of communication and limitations of confidentiality with multiple persons. With each change in formation—couple to family, for example—the ethics of changing the relationship, informed consent, and confidentiality would need to be addressed. Similarly, termination is more complex for the systemic therapist due to the varying needs of the different people involved.

Common issues. Common issues in family therapy mirror barriers in family therapy. In addition, family therapy involves more than one person, and not all family members may show up for a given session. Client no-show or one family member being unavailable for a session is a common issue in family therapy. Families have busy schedules, and it is difficult to find a time that works for everyone’s schedule. Therapists may view no-shows for therapy and difficulty finding a time for sessions as a form of client resistance, another common issue in family therapy.

Resistance can take many forms in families. Some family members might be silent, while others will avoid talking about the issue presented for therapy. Beyond resistance, some common issues are beyond client control. Family therapy may or may not be covered by insurance. Family therapy could be needed but not offered at the agency where the client is receiving services for individual therapy. If family therapy isn’t readily available or if insurance doesn’t cover family therapy, this may deter the person from pursuing familial treatment. Part IV of the textbook is dedicated to special issues. You will have the opportunity to read about these in more detail in Chapters 18 to 20.

### Table 1.2: Advantages and Challenges of a Systemic Approach

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<thead>
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<th>Systemic Principle</th>
<th>Advantage or Challenge</th>
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<td>Wholeness</td>
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<td>Comprehending complexity</td>
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<td>Reciprocity</td>
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<td>Conceptualizing change</td>
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<td>Dealing with ambiguity</td>
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<td>Diversity</td>
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**SUMMARY**

Family therapy is a systemic approach to counseling that focuses on relationships between individuals. While it does not discount individual influences and perspectives, it does emphasize the relational dynamics of the system, as well as how these dynamics in turn affect the system members. Family systems theory has its underpinnings in general systems theory and cybernetics. Key assumptions include the system’s tendency toward homeostasis and the resistance to change due to the equilibrium of the system. In addition, the theory recognizes the role of conflicts and behaviors, as well as their relative position within the system.

In this chapter, we reviewed some of the basics foundational concepts found in family therapy, including basic definitions of “family.” Families can be defined by legal criteria, relationships, or both. The most important element in identifying a family is how the family system members define themselves; cultural and experiential influences play a significant role in the development of these constructs. Though every family is unique, there are some common elements to the experiences of the family system. All families go through a life cycle of sorts, wherein the developmental processes of the individual members affect the identity of the system. Family members also experience important developmental catalysts such as differentiation and attachment, both of which directly impact the identity development both of the individuals within the system and of the system itself. These concepts will be discussed in more detail in Chapter 3 of this text.

Family therapy can be used as a primary clinical approach or as an adjunct to individual treatment. When doing family therapy, the family itself is the “client,” although for billing and reimbursement reasons, usually one individual system member needs to be the identified client. This can sometimes create its own challenges to the process, though generally it can be managed by the clinician. Many advantages to family therapy generally outweigh the challenges, including the engagement and involvement of the entire system. The primary strength in a systems approach is the recognition of interconnectedness and the inherent dynamic influences that exist. It is an inclusive, adaptable, culturally sensitive approach to addressing issues.
KEYSTONES
Among the key points addressed in this chapter are:

- Family therapy is a systemic approach to counseling that focuses on relationships between individuals.
- Family systems theory recognizes the role of conflicts and behaviors, as well as their relative position within the system.
- Families can be defined in many terms. The most important element in identifying a family is how the family system members define themselves.
- Family therapy can be used as a primary clinical approach or as an adjunct to individual treatment.
- In family therapy, the family itself is the “client,” and the relationships in the system are the focus of treatment.

REFLECTIONS FROM THE CONTRIBUTOR’S CHAIR
I remember very clearly the day I realized I was a systems therapist. I was in my master’s program, which was designed to support my licensure as an Licensed Mental Health Counselor in Florida. It was my second term in the program, and I was taking a theories course. I found it all terribly fascinating, but I was left with this nagging feeling that there was more. For example, while I could clearly see the correlations between negative cognitions and affect, I could not deny the influence of day-to-day interactions in relationships and how these in turn affect individuals. I was also starting to figure out that my niche in the field was going to be working with adolescents, so having a firm base in family systems was essential.

Interestingly, after nearly 20 years in the field, I see elements of systems influences all around me. That is, understanding these concepts has not only helped my clinical work, it has also helped me better understand relational dynamics in extended social systems, the workplace, my community—even society as a whole. We are all interconnected. We influence those around us, and they influence us in return. Recognizing and respecting these dynamics, and learning how to positively impact them, has been key to both my professional success and my personal happiness.—Stephanie K. Scott

ADDITIONAL RESOURCES
The following resources provide additional information relating to the chapter topics.

Useful Websites
- American Association for Marriage and Family Therapy (AAMFT)
  http://www.aamft.org/iMIS15/AAMFT/
This website provides information about the AAMFT, including licensing, career, ethical codes, state resources, and more.

- American Family Therapy Academy
  https://afta.org/

This website provides information on the oldest family therapy academy in the United States, including education conferences, seminars, publications, and additional resources.

- Association of Marital and Family Therapy Regulatory Boards
  https://www.amftrb.org/

This website provides information for those interested in the marriage and family therapy field anywhere in the United States. Links to different licensure boards, as well as related groups and associations, are organized and listed by state.

- International Association of Marriage and Family Counselors (IAMFC)
  http://www.iamfconline.org/

This website provides information about the IAMFC, including ethical codes and standards, publications, resources, and more.

REFERENCES


“It is now clear to me that the family is a microcosm of the world. To understand the world, we can study the family: issues such as power, intimacy, autonomy, trust, and communication skills are vital parts underlying how we live in the world. To change the world is to change the family.”

—Virginia Satir

As Virginia Satir, who is one of the leaders and developers of marriage, couple, and family therapy (MCFT) that you will read about in this chapter, states in the quote above, we can understand our world by seeking to understand our families, and through our understanding we can effect change. I think that is also true of the MCFT profession. By understanding our profession and knowing our past and how we arrived at this place in time, we can continue to grow and perfect this profession. By learning from our past endeavors and understanding what has and has not worked, we can continue to perfect the methods by which we help couples and families. To add to what Satir stated, my own opinion is that healthy couples and families form the foundation for a healthy society. In this chapter, you will have an opportunity to learn about those individuals who came before us in this profession and how they formed the foundation on which our profession rests today.

You will also learn about the organizations and historical events that occurred and how the MCFT profession has developed around the world. In understanding this unique past, it will help guide you, as you become the leaders of tomorrow.

—Melinda Haley
As discussed in Chapter 1, the profession of marriage and family therapy has an extensive history, beginning in the early 1900s when Alfred Adler began the child guidance movement. From that time to the present, a series of important individuals have served as advocates, activists, and social change agents to develop the profession into the great benefit it is today for millions of individuals around the world (Schmidt, 2015). Over time this profession has been referred to as marriage and family counseling, marriage and family therapy, and marriage, couple, and family therapy or counseling. We will talk more about this in Chapter 5. However, in this chapter and throughout the remaining chapters, we will refer to this profession as marriage, couple, and family therapy to remain consistent in our terminology as well as to be inclusive of all people who live in systems with others, regardless of their familial or relationship status. In this chapter, we will also discuss the major events, individuals, and organizations that have helped shape the marriage, couple, and family therapy profession as we know it today.

**LEARNING OBJECTIVES**

After reading this chapter, you will be able to do the following:

- Describe the major events that have shaped the profession of marriage, couple, and family therapy from the 1930s to the present.
- Discuss the contributions of key individuals who helped develop this profession.
- Discuss the significance and importance of various organizations that have sought to serve, protect, foster, and standardize the profession (e.g., AAMFT, CACREP).
- Describe the requirements needed to become a licensed marriage, couple, and family therapist.
- Discuss the origins of evidenced-based practice and the biopsychosocial perspective.

**KEY CONCEPTS**

Family therapy evolved throughout the 20th century. The following sections discuss this evolution including key players who helped develop many of the concepts used today.

**1900s–EARLY 1950s**

In this section, we will discuss the origins of the marriage, couple, and family therapy (MCFT) profession starting with the influence of the social work movement, to Alfred Adler’s child guidance movement, to the development of the first family counseling centers by Rudolf Dreikurs. We will highlight important events and discuss the influence and contributions of major individuals who helped guide the development of the profession.
The Social Work Movement’s Influence
Before there were formalized MCFT practices, the professional social work movement sought to provide support for the disruptive influences of urbanization and industrialization on family living (Bowen, 2015). The idea behind the professional social work movement was that families needed a more formal and organized approach to help adjust to and cope with the changes and challenges of industrialization. Collectively, the Charity Organization Society and the settlement house movement began to challenge the individualist view of people experiencing problems. Instead, there was a shift to view the challenges within the confines of the family unit, the community, and the social, political, and economic environments (Bowen, 2015; McFadden, 2014).

The Charity Organization Society began its quest to build relationships with poor urban families, to help support their needs by providing in-home support (Richmond, 1917). Mary Richmond (1917), the director of organization, shifted the charity’s focus to incorporate a more systemic approach that emphasized the need for supportive counseling for individuals within the family unit. Though the Charity Organization Society did attempt to care for the concerns of the entire family, the settlement house movement placed a greater focus on the family unit (Bowen, 2015; McFadden, 2014).

The Child Guidance Movement
Initiated by Alfred Adler in the early 1900s in Vienna, the child guidance movement began the early research on the treatment of children to prevent the development of mental problems (Mansager, 2015). According to Adler, the behavioral problems of a child were related to the social context in which the behaviors occurred and in which the child may be trying to overcome feelings of inferiority (Mansager, 2015; Rasheed, Rasheed, & Marley, 2011). Therefore, Adler established that there was a need to study both the social and family dynamics that could impact the child (Mansager, 2015; Rasheed et al., 2011).

Meanwhile, in the United States in the 1920s, Rudolf Dreikurs, Adler’s associate, founded the family counseling centers. The family counseling centers were an extension of Adler’s child guidance approach that emphasized the importance of the social context related to the child’s behaviors. Therefore, the child guidance movement in the United States emphasized a team approach, which focused on treating the whole family in the clinic (Abrams, 2015).

The Groves Conference
The Groves Conference of 1934 was cofounded by Professor Ernest Groves and extended the earlier work from the social work movement to help support the foundation of marriage, couple, and family therapy (Hamon & Smith, 2014). Groves was one of the first academicians to offer a marriage and family course (Groves Conference, 2016). The major focus of the Groves Conference was to begin the development of theory and empirical
research in relationship to marriage, couple, and family counselors and to develop the profession (Groves Conference, 2016).

The New York Meetings
Around the same time as Groves was developing the Groves Conference, Dr. Robert Dickerson was forming a series of meetings in New York during the winter of 1931. These meetings would help support the formation and development of the MCFT profession (Cole & Cole, 2012). Dickerson collaborated with other important pioneers in the field that spanned the Northeast: Emily Mudd from Philadelphia; Lester Dearborn from Boston; and Drs. Abraham and Hannah Stone, Dr. Valerie Parker, and Dr. Robert Laidlaw from New York (Cole & Cole, 2012).

Emily Mudd and Lester Dearborn would be the linkage between the Groves Conference and the New York meetings, thus bridging the two major forces of the MCFT field together during this time. As a direct result of the connection, the group of academicians and physicians founded the American Association of Marriage Counseling (AAMC) in 1942, which changed its name to the American Association for Marriage and Family Therapy (AAMFT) in 1979 (Cole & Cole, 2012).

First Institutes of Professional Marriage, Couples, and Family Counseling (1930s)
During the 1930s, marriage, couple, and family therapy continued to grow across the country. As the conversations increased regarding the need to support and treat families, the first two institutes opened in the United States, each on opposite coasts (Popenoe, 1975). In 1930 Paul Popenoe opened the first marriage counseling center, the American Institute of Family Relations, in Los Angeles, California (Popenoe, 1975). Researchers have identified Popenoe (1975) as the individual who brought the term marriage counseling to the forefront of discussion.

Meanwhile, just two years later, in 1932, Abraham and Hannah Stone opened their institute in the New York Labor Temple (McGeorge, Carlson, & Wetchler, 2015). As the need for education and training support for marriage, couples, and family therapy grew, Emily Mudd opened a third center, the Marriage Council of Philadelphia, in 1932 (McGeorge et al., 2015). Distinctly different from the other two institutes, Mudd’s institute was the first of its kind to focus on the need for research to enhance the profession (McGeorge et al., 2015).

Following the development from the Groves Conference and the New York meetings, the AAMC accredited three institutes in the United States: the Marriage Council of Philadelphia, the Menninger Foundation, and the Merrill–Palmer Institute (Cole & Cole, 2012). Over time, these institutes have continued to grow across the country. In 1969 the Family Institute of Chicago opened to offer courses and supervision to therapists who had an understanding that in addition to the relationship between the therapist and client, there was a critical need to explore the family as well (Rampage, 2014). Throughout
the 1960s and 1970s, more family institutes continued to open across the country to help the development of marriage, couple, and family therapists, or MCFTs (Rampage, 2014).

Kurt Lewin and Small Group Dynamics
Some of the earliest ideas throughout the institutes and meetings of marriage, couples, and family therapy are connected to Kurt Lewin’s (1947) work on group dynamics. Through his work on field theory, Lewin influenced MCFTs to recognize that the whole of a group was greater than the sum of its parts (Erickson, 2015; Lewin, 1946). By exploring the entire family unit, MCFTs could emphasize Lewin’s notion that change can occur more readily than exploring each person separately.

Lewin’s emphasis shifted the focus in marriage, couple, and family therapy, whereas therapists began to put greater emphasis on the ways families discuss their problems instead of focusing on the specificity of the problems. Furthermore, MCFTs needed to gain competence in group dynamics to fully understand and work effectively with the family unit (Erickson, 2015; Rasheed et al., 2011). Ultimately, Lewin’s work began the major shift of examining the interrelated parts of the family system (Rasheed et al., 2011).

Nathan Ackerman
Nathan Ackerman is often thought of as the father of family therapy (Weinstein, 2013). Ackerman was one of the first therapists to work with the whole family. In 1938 he illuminated the importance of viewing the family as a single unit, instead of multiple individual aspects. While Ackerman understood that the family might appear to be united, he also believed that each member of the unit might have opposing views that can create conflict (McGeorge et al., 2015). Therefore, for the first time, MCFTs would work with the entire family at the same time (McGeorge et al., 2015).

Through his emphasis on the intrapsychic phenomena, Ackerman utilized his personality to help families identify new ways of relating (McGeorge et al., 2015). His work continued to resonate with his students; specifically, Salvador Minuchin, who utilized the Ackerman’s foundation to articulate structural family therapy (McGeorge et al., 2015). Ackerman went on to establish the Family Institute in New York City in 1960 to enhance the training and supervision of MCFTs; it would change its name to the Ackerman Institute in 1971 (Rampage, 2014).

Frieda Fromm-Reichmann
Building on the works of Ackerman, Frieda Fromm-Reichmann published an article entitled, Notes on the Development of Treatment of Schizophrenia by Psychoanalytic Psychotherapy, in the 1940s, in which she explored the mother–child dynamic and its impact on the onset of schizophrenia (Fromm-Reichmann, 1948; Johnston, 2013). She coined the term schizophrenogenic mother to connect the attributes of a mother with the onset of schizophrenia in the child (Fromm-Reichmann, 1948). Fromm-Reichmann’s
term schizophrenogenic mother would be one of the most disapproved of in early marriage, couple, and family research, and researchers would later discredit it (Harrington, 2012).

Though researchers discredited the schizophrenogenic mother, Fromm-Reichmann was one of the first people to assert the relationship between members of the family unit and the importance of exploring the impact of interactions of the members in a family (Johnston, 2013). Fromm-Reichmann's work would lay the foundation for future MCFTs to explore the interaction between mother and son. Fromm-Reichmann's work caught the interest of Murray Bowen, who would later go on to research and implement Bowen systems theory (Bowen, 1978).

Theodore Lidz
When Fromm-Reichmann highlighted the mother’s impact on her child's development, Theodore Lidz took notice and began to question the severity of such an impact (Lidz, Parker, & Cornelison, 1956). Instead, Lidz emphasized the role of the father’s influence on the child, further suggesting the role each member plays in the family unit (Lidz et al., 1956). However, Lidz elaborated on his initial thoughts and hypothesized that the interaction between the parents could impact the child’s behavior (Lidz et al., 1956; McGeorge et al., 2015).

Therefore, Lidz’s work further explored the connection between mother and father and the marital relationship’s contribution to the development of the child (or children); specifically, Lidz highlighted marital schism and marital skew (Lidz et al., 1956). Within the family unit, a marital schism exists when the parents are focusing on their problems. Therefore, the parents have internal conflict and compete for their child’s attention without assessing the needs of the child. Meanwhile, in a marital skew, children are torn between parents as one parent dominates and the other is more passive (Lidz & Lidz, 1949).

John Bowlby
John Bowlby’s work at the Tavistock Clinic on the core human need for attachment further supported the premise of MCFTs that parental interaction can impact a child’s behavior (Bowlby, 1949). Marriage, couple, and family therapists often use attachment theory as a foundation to explore processes related to parental influences on a child’s future relationships (Hall, 2015). Bowlby urged that the importance of the family unit was to be a secure base from which the child could explore his or her environment and suggested that MCFTs should assess for this during therapy (Schwartz, 2015). See Chapter 1 for more discussion about attachment theory.

Don Jackson
In 1954 Don Jackson, who was one of the members of a group participating in the study of schizophrenia also known as the Palo Alto Group, began to lay the foundation for strategic family therapy (Rampage, 2014). Jackson and his group wanted to gain a greater understanding of how feedback loops control information-processing systems (Breulin
Therefore, those in the group explored cybernetics to guide their research studying family communication patterns of people diagnosed with schizophrenia. Cybernetics emphasized systems theory and highlighted the importance of exploring behaviors together so that MCFTs could gain a deeper understanding of how individual family member behaviors affected each family member (Hale & Frusha, 2016; Phipps, 2014). See Chapter 1 for more information on cybernetics, first-order change, and second-order change.

MID-1950s TO MID-1960s
The 1950s and 1960s were considered pivotal decades in the emergence of the MCFT profession. The 1950s yielded a framework from which family therapy became rooted in connectedness, and collaboration of professionals as a newly growing profession began to transpire (Lebow & Sexton, 2016). The cultivation of a new perspective changed how mental health providers perceived treatment, thus integrating a more holistic, inclusive perspective giving attention to a systemic foundation. The development of family therapy was evident in the work and collaboration of researchers such as Gregory Bateson, who was a contributor to evidence-based practices and studies of the dynamics of families (Lebow & Sexton, 2016). Additionally, during this time frame, individuals such as John Bell and other mental health professionals, including Jay Haley, Don Jackson, and John Weakland, contributed to family therapy through utilizing the dynamic of family group therapy and studies of patients diagnosed with schizophrenia (Lebow & Sexton, 2016).

Major Contributors
In this section, we will discuss the major contributors to MCFT for this time period. These will include the contributions of John Bell and John Weakland. We will also discuss some of the major theories or discoveries that helped shape how practitioners worked with families, including the double bind

John Bell. Bell (1913–1995) was a practicing psychologist in the 1950s who began to shape the dynamics of traditional therapy when he began working with families on his own accord, independently contributing to the family therapy movement (Bell, 1983). Initially, his work with families emerged from an identified gap in the appropriateness of adult therapies with adolescents (Bell, 1983). The framework that shaped his approach included a view of family as a unit for problems; therefore, Bell's premise was that the interactions and problems of the individual may be related to communal or family contexts, rather than solely an individualistic perspective (Bell, 1962, 1983).

John Weakland. Along with Bateson, Jackson, and Haley, Weakland was a contributor to the research study and subsequent article, Toward a Theory of Schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956; Weakland, 1960). In addition to this, Weakland was also instrumental in developing family-oriented brief therapy and made other substantial contributions to many of Gregory Bateson's projects (Ray, 2015; Ray & Schlanger, 2012). Further, Weakland (2010) suggested that due to the interactive context in relationships,
a behavioral change may result in the disruption of a pattern, thus ultimately impacting the entire unit.

Double Bind
The double bind theory was influential in a variety of ways, as it set a foundation for a deeper level of understanding of families and communicative interactions. From an anthropological framework, Bateson led this research and other projects that heavily influenced family therapy (Lawley, 2013). *Toward a Theory of Schizophrenia* was a pivotal research publication (Bateson et al., 1956). The study on schizophrenia yielded the groundwork for research studies pertaining to communication within the family unit (Mental Research Institute [MRI], n.d.c). This study led Bateson and contributors Jackson, Haley, and Weakland to broach the concept of the double bind theory, which ultimately pioneered a multifaceted examination of communication while drawing from the concept of cybernetics (Bateson et al., 1956; MRI, n.d.c).

The double bind theory is a concept that was derived from an examination of patients diagnosed with schizophrenia and a research focus to examine the communication styles between the patient, familial, and systemic contexts of the family unit (Bateson et al., 1956). From the communication standpoint, a double bind occurs when there are regularly present and occurring incompatible and opposing messages given to an individual (Bateson, Jackson, Haley, & Weakland, 1963). The overall message received by a person yields a conflict in the individual’s reality, thus creating conflict and incongruence (Bateson et al., 1963). Thus, Bateson, Jackson, Haley, and Weakland were instrumental in laying the groundwork for studies that were fruitful in comprehension of the process communication in the dynamics of the family unit (MRI, n.d.a). For a list of important people who were integral in the development of the MCFT profession in the United States, please review Table 2.1.

Study Centers
The research on the double bind did more than study communication patterns in the family context. The key contributors were instrumental in launching training and continued research. Founded in 1958, the Mental Research Institute (MRI) of Palo Alto was developed in response to the studies led by Bateson and his team (Institute Gregory Bateson, 2015b; MRI, n.d.b). Don Jackson gave a lecture at the VA hospital in 1954 on family homeostasis and Gregory Bateson was in the audience. This fortuitous meeting resulted in a collaboration that led to the formation of the Mental Research Institute (MRI, n.d.b).

The key members involved in the beginnings of the MRI include key founder and director Jackson, as well as Weakland, Fisch, and Watzlawick (Institute Gregory Bateson, 2015a; MRI, n.d.b). Bateson also contributed by serving as a consultant with the MRI (n.d.b). Other key contributors included Virginia Satir, Jay Haley, and Jules Riskin (MRI, n.d.a).
The contributing members of the MRI have been influential in contributing to research pertaining to the study of family systems and the individual within the family unit (Jackson, 1965). Through the MRI, researchers have been able to contribute to over 60 projects in areas of family and family specializations, family and medical concerns, culture as related to family and communities, and mental disorders (MRI, n.d.a). Today the MRI continues to provide mental health counseling services to individuals and families, conducts research, and provides education and training (MRI, n.d.a). Let’s turn for a minute to our Guided Practice Exercise 2.1 and explore the MRI website.

**GUIDED PRACTICE EXERCISE 2.1**

Please go to the MRI’s web page at http://mri.org/. Read the descriptions related to strategic family therapy and brief family therapy, both of which are offered at the MRI clinic. If you were going to avail yourself of therapy at this clinic, which approach would most appeal to you? What intrigues you about the approach you chose?

**International Family Therapy**

The advent of family therapy was also seen on global scale. As early as the 1950s, mental health hospitals in India began to incorporate families into the therapeutic process. One of the first examples of this was the vital contributions by Vidya Sagar, who influenced how families were treated in therapy while working at the Amritsar Mental Hospital (Chadda & Deb, 2013). This trend continued into the 1960s, and during this time there was an increase in families being treated within programs (Chadda & Deb, 2013). Following similar trends, family therapy became more visible in England as independent practitioners such as Robin Skynner and John Howells began to work with the family within a social context and in practices such as translating group work and applying those techniques with the family unit (Stanton, Harway, & Vetere, 2013). In the early 1960s family therapy was also emerging in Mexico, as Raymundo Macias brought the concept of family therapy to the educational setting through teaching (Kaslow, 2000). Also in the 1950s and 1960s, the presence of family therapy was also seen in South Africa, Yugoslavia, and Argentina (Hill & Perkel, 2014; Kaslow, 2000).

**MID-1960s TO MID-1970s**

Though formalized family therapy initially emerged in the United States in the late 1940s and early 1950s, there was an explosion in the use of family therapy in the 1960s that continued over the next few decades (Gladding, 2014; Lev, 2015). Beginning in the 1960s, a more robust transition from individual counseling to family systems–based counseling was observed.

In 1965, family services programs affiliated with church organizations were emerging in major cities such as Philadelphia, New York, Boston, and Buffalo (Gladding, 2014).
During all this, the focus of marriage, couples, and family (MCF) counseling shifted to a more systemic or circular approach, in which family therapists placed emphasis on problem patterns and behaviors, belief systems, and predisposing factors within the family system; a practice that required multiple active participants rather than just individuals (Lambert, Skinner, & Friedlander, 2012). During this period, general systems theory founded by Ludwig von Bertalanffy served as the foundation for most family therapy models (Gladding, 2014).

Review of Family Therapists From the 1950s
Several family therapists played significant roles in the development and progression of the practice of family therapy, both in the decade before and the decade after the 1960s (Gladding, 2014). Though Bateson, Bowen, Erickson, Ackerman, and Jackson made their primary contributions in the 1950s, each therapist also continued to influence other family therapists into the 1960s and beyond.

**Gregory Bateson.** Bateson was the father of Batesonian therapy. As previously mentioned, Bateson was closely connected with Jay Haley, who was a therapist and influential leader in the 1960s (Gladding, 2014). Though Bateson emerged in the 1950s, his work continued into the early 1960s until his group disbanded in 1962, though his work was continued at the MRI in Palo, Alto, California (Gladding, 2014). Bateson also served on the editorial board of the *Family Process* journal and published *Steps to an Ecology of Mind* in 1972. Bateson's last book, *Angels Fear*, though based on his work, was written and published by his daughter in 1987 (Beels, 2011).

**Murray Bowen.** Bowen was a psychiatrist and family therapist and was the father of Bowen family systems theory, or simply Bowenian family therapy (Kott, 2014; Bowen Center for the Study of the Family, 2017). The Bowenian approach to family therapy involves awareness of expectations of family members (MacKay, 2012). Bowen's family systems therapy, and its focus on triangular relationships, is considered to be one of the most comprehensive additions to marriage and family therapy (Berg-Cross & Worthy, 2013). Bowen was an integral component of the family therapy movement (Kott, 2014).

**Milton Erickson.** Erickson was a strategic family therapist specializing in psychiatry and hypnosis at the University of Wisconsin. Erickson founded the American Society of Clinical Hypnosis (“Milton Hyland Erickson,” 2011; Milton H. Erickson Foundation, n.d.). Erickson was credited with creating strategic family therapy and was responsible for creating the paradox, reframing, and going with resistance techniques (Nash, 2012). Erickson's work served as a precursor for Jay Haley and other strategic family therapists (Gladding, 2014).

**Nathan Ackerman.** Ackerman was one of the pioneers in involving young children in the family therapy process (Weinstein, 2013). Ackerman’s approach to family therapy involved incorporating cultural mores of the era in his practice and as a means to affirm widely accepted social practices. Ackerman founded *Family Process*, the first family therapy journal, in 1961 in collaboration with Don Jackson. Ackerman headed up the Family Institute of New York, also known as the Ackerman Institute for the
Family, in the late 1960s (Ackerman Institute for the Family, 2014; Gladding, 2014). One of his most recognized works is *Treating the Troubled Family*, published in 1966.

**Donald (Don) Jackson.** Jackson was a cofounder of *Family Process*. Jackson founded the MRI in Palo Alto, California, in 1958 and served as the institute’s first director. He is considered the founder of interactional theory and conjoint family therapy. Jackson’s family therapy focus was on family homeostasis, with the goal of stability seeking, and focuses on the reparation of the “problematic” family member. Jackson’s identification of therapeutic double binds, or multilevel messages, was one of the most prolific additions to marriage and family therapy (Charny, 2014; Ray, Stivers, & Brasher, 2011).

**Family Therapists From the 1960s**

Preceded and aided by the continued work of Gregory Bateson, Murray Bowen, Milton Erickson, Nathan Ackerman, Don Jackson, and others, some of the most influential individuals credited with the continued rise of family therapy during the 1960s included Jay Haley, Salvador Minuchin, Virginia Satir, and Carl Whitaker (Gladding, 2014; Lev, 2015). We will detail those contributions in further detail in the following paragraphs. For a list of important events that helped shape the MCFT profession, please review table 2.2.

<table>
<thead>
<tr>
<th>Table 2.1 Important people in the development of MCFT in the United States</th>
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<td>Ackerman, Nathan</td>
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<td>Adler, Alfred</td>
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<td>Baker Miller, Jean</td>
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<td>Bateson, Gregory</td>
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<td>Bell, John</td>
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<td>Bertalanffy, Ludwig von</td>
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<td>Bowen, Murry</td>
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<td>Dreikurs, Rudolf</td>
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<td>Erickson, Milton</td>
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<td>Fromm-Reichmann, Frieda</td>
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<td>Gilligan, Carol</td>
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Table 2.2 Important events in the development of MCFT in the United States

<table>
<thead>
<tr>
<th>Event</th>
<th>Description</th>
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<tr>
<td>The social work profession's response to the needs of families during industrialization</td>
<td>re: the Charity Organization Society and the settlement house movement</td>
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<td>The child guidance movement</td>
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<td>The Groves Conference</td>
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<td>The New York meetings</td>
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<td>The development of professional organizations and centers</td>
<td>devoted to the practice of the MCFT profession</td>
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<td>The development of cybernetics and systems theory, including the</td>
<td>double bind, family homeostasis, and Kurt Lewin's small group dynamics</td>
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<tr>
<td>The recognition of MCFTs as mental health professionals eligible for</td>
<td>specialized training in family therapy as well as federal grants, solidified</td>
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<td>The influence of the feminist movement</td>
<td>by the Public Health Service Act, Title III, Section 303 (d)(1)</td>
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<td>The development of licensure, program accreditation, and a code of</td>
<td>ethics</td>
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<tr>
<td>The development of study centers such as the MRI and the Institute</td>
<td>for Family Studies in Milan, Italy</td>
</tr>
<tr>
<td>The emergence of evidence-based practice and the biopsychosocial</td>
<td>approach</td>
</tr>
<tr>
<td>The spread of MCF therapy worldwide</td>
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**Jay Haley.** Haley was a member of the MRI in Palo Alto, California, along with other family theoreticians such as John Bell, Virginia Satir, and Gregory Bateson (Beels, 2011; Bloom, 2015). Haley’s primary contributions stemmed from Milton Erickson’s work, as did many strategic family therapists of this time (Beels, 2011; Bloom 2015). One of Haley’s early writings on family therapy, *Strategies of Psychotherapy*, had several chapters dedicated to family therapy that discussed the shift from individual counseling to relationship counseling, and the logical next step, which was family counseling. Haley (1963) explored therapeutic paradoxes present in family therapy. As part of his work as a strategic family therapist, Haley conducted family therapy in Philadelphia at the Child Guidance Clinic under Salvador Minuchin (Gladding, 2014).

**Salvador Minuchin.** Minuchin developed structural family therapy, in which the therapist strives to understand the rules within the family system by becoming directly involved and helping the family identify and explore alternative ways of relating and developing healthier patterns of interaction with one another (Norflet, 2014). Minuchin wrote several books, the most famous among them being *Families and Family Therapy* and *Psychosomatic Families* (Gladding, 2014). Though he officially retired in 1996, he continues to be involved in family therapy and publish with peers and students (Stagner, 2012; Wylie, 2013). One of his latest publications is *The Craft of Family Therapy* (Minuchin, Reiter, & Borda, 2013).
Virginia Satir. Satir was responsible for the development of Satir Transformational Systemic Therapy, or simply Satir therapy (Banmen & Maki-Banmen, 2014). Satir’s model, sometimes referred to as Satir family reconstruction, is a form of therapy that emphasizes the use of self of the therapist (Novak, 2012). Reportedly, Satir saw her first family of clients in 1951 and spent four decades honing her unique approach to family therapy (Banmen & Maki-Banmen, 2014). Satir, a social worker with her own practice in Chicago, was the only woman among the numerous family therapy founders, which contributed to her impact on the family therapy field (Gladding, 2014). Perhaps her most famous work, Conjoint Family Therapy, was published in 1964 (Gladding, 2014). Satir taught courses at the MRI, and in 1976 she began the Satir Family Camp, which was a training camp targeted at educating family therapists (Banmen & Maki-Banmen, 2014).

Carl Whitaker. Whitaker’s approach was known as symbolic-experiential family therapy, which was sometimes known for implementation of outlandish techniques in session but also included experience and symbolism as its main tenets (Cag & Acar, 2015). Whitaker was a large proponent of cotherapy and live supervision. He became chair of the department of psychiatry at Emory University in 1946 and coauthored The Roots of Psychotherapy. Whitaker contributed to the literature on family therapy with The Involvement of the Professional Therapist (Whitaker, Warkentin, & Malone, 1959) and published works such as I Had to Learn Because I Wasn’t Being Taught (Whitaker, 1990).

International Family Therapy in the 1960s
During the 1960s, family therapy was also experiencing a renaissance of sorts internationally. While there is limited research on the introduction of family therapy in Mexico, Nathan Ackerman traveled to the country in the 1960s to help pioneer family therapy in the region (de Millán, 2015). Raymundo Macias, who was credited as being the first lecturer to focus on family therapy at the National University of Mexico, prompted the establishment of graduate programs in family therapy at Mexican universities, leading to higher rates of family-focused therapy in the 1970s and beyond (Kaslow, 2000).

In the United Kingdom, there were family therapy pioneers parallel to those in the United States, among them Robin Slynner, John Howells, and John Byng-Hall (Kaslow, 2000). This collective group of family therapists’ approach to therapy began because of group psychotherapy and eventually shifted to conceptualizing families as their own groups (Kaslow, 2000). Though first introduced in the 1920s, it was during the 1960s that marriage, couple, and family practice became more widely utilized, and the United Kingdom began establishing institutions dedicated to this form of therapy, with the London Institute of Family Therapy and the Family Therapy Project among them (Stratton & Lask, 2013).

Family Therapy Legacy of the 1960s
During the 1960s several institutions devoted to family therapy were founded, some of which still exist today. The MRI in Palo Alto, the Family Institute in New York, the Albert Einstein College of Medicine in New York, the Child Guidance Clinic in Philadelphia,
the Family Institute of Philadelphia, the Boston Family Institute, and the Institute for Family Studies in Milan, Italy (Gladding, 2014). Additionally, many publications named after these early family therapists, or stemming from the family therapy movement of the 1960s, are still in print today; *Satir Journal* and *Family Process* are two examples among many (Maki-Banmen, 2012; Novak, 2012). Furthermore, 1963 was also the year the first licensure law, sanctioned by the state of California, regulated family counselors as a separate mental health entity (Gladding, 2014).

Family Therapy in the 1970s
The family therapy movement in the 1970s was very much an extension of the progress in the 1960s, only with a larger audience and a stronger influence. Despite this, another shift in the 1970s was also taking place. Up to this time, women in family therapy were disregarded and historically viewed in traditional gender roles (Lebow, 2014). The feminist movement, discussed later in this section, aimed to challenge that tradition.

In the first part of the 1970s, few novel family therapists or family theories emerged. Rather, the work of Haley, Minuchin, Satir, and Whitaker were developing into more widely distributed and used forms of therapy. Furthermore, the focus of the first part of the 1970s was more on organizational change and establishment, rather than on new treatment modalities (Lebow, 2014). During this decade, theories that had been developed in the previous years were refined and utilized more widely, the practice of which was facilitated by workshops, presentations, and publications (Lebow, 2014).

In the 1970s there were significant increases in membership of many previously established family therapy organizations, including the AAMFT and the American Family Therapy Academy (Gladding, 2014). New divisions of organizations devoted to family therapy also emerged during this time, such as divisions of the American Psychological Association’s Division of Family Psychology and the International Association of Marriage and Family Counselors (IAMFC), which later became an American Counseling Association division. Additionally, the *Journal of Marital and Family Therapy* published its first issue in 1974 (Gladding, 2014).

International Therapy in the 1970s
Brazil was introduced to family therapy in the 1970s as an alternative to psychoanalysis, prompted by psychiatrists with disdain for the current system, such as Lindemberg Rocha in Rio de Janeiro. Rocha was director of the Family Sector of the Pedro Ernesto Hospital at the State University of Rio de Janeiro, where he was instrumental in promoting the teaching and use of family therapy and the eventual development of programs specifying education and training in family therapy in the 1980s and beyond (Picon, 2012).

In Germany the development of family therapy paralleled that of the United States in that psychoanalysts also played an important part in introducing and advocating for a systems approach. Virginia Satir was known to have participated in workshops and conferences, and she was an influential force in the training of family therapists in Germany (Retzlaff, 2013).
Mara Selvini-Palazzoli is credited with engineering the Milan systemic approach in the early 1970s (Gladding, 2014; Luciano et al., 2012). Selvini-Palazzoli was a psychoanalytic therapist and head of the Milan Group in Milan, Italy. She emphasized a circular approach with triadic questioning and was responsible for the expansion of strategic family therapy (Gladding, 2014).

In the 1970s Scandinavia experienced interest in family therapy (Jensen, 2013), facilitated by Hans Jurgen Holm, medical director of an inpatient psychiatric facility near Oslo, Norway. Holm and his colleagues initiated the first family-centered form of therapy in the region, offering families extended stays in the cottages on the facility grounds. From Norway the family therapy movement spread into Finland, Sweden, and Estonia, where workshops and trainings based on the work of Haley and strategic family therapy were the primary influence (Jensen, 2013); Additionally, publications focusing on family therapy began to appear in the area in the 1970s; the Norwegian Journal of Family Therapy was the most notable at the time (Jensen, 2013).

Though family therapy was initially introduced to South Africa in the 1960s, it was not until the 1970s that the practice of marriage, couple, and family therapy became publicized at the South African Congress of Psychiatry. This was followed by workshops and symposia conducted by Donald Bloch at the University of the Witwatersrand and the University of Cape Town (Hill & Perkel, 2014; Kaslow, 2000).

Family therapy first emerged in South Korea in the 1970s via practitioners who studied in other countries and brought the practice back home (Lee et al., 2013). From that initial introduction, an initiative for training, education, credentials, and the incorporation of family therapy in various settings was witnessed.

In the 1970s, family systems therapy in Yugoslavia was introduced (Kaslow, 2000). The family and social network therapy of alcoholism was pioneered by psychiatrist Branko Gacic, Dr. Pavel Kastel, and social worker Jovica Potrebic in 1973 at the Institute for Mental Health. The approach instituted by these therapists viewed alcoholism as a multigenerational family problem that required participation from multiple family members (Kaslow, 2000). Let’s turn our attention to Guided Practice Exercise 2.2 in order to practice reviewing international literature.

GUIDED PRACTICE EXERCISE 2.2

Choose any country other than the United States. Do a brief literature review and find five articles or book chapters related to the history of the MCFT profession in your chosen country. What were the similarities and differences in the development of the MCFT profession between the United States and your chosen country? What surprised you regarding what you read?
LATE 1970s TO MID-1980s

During the latter part of the 1970s, the feminist movement was born, which sparked a never-before-seen emphasis on female-centered approaches in family therapy (Gladding, 2014). This signified the beginning of the feminist theory stronghold led by activists such as Rachel Hare-Mustin, Jean Baker Miller, Carol Gilligan, and other strong female leaders of the time who imagined an egalitarian and gender-equal form of family therapy (Gladding, 2014; Lebow, 2014). Because of this, many, but not all, of the family therapists emerging during this time were connected to, or influenced by, feminist approaches.

**Rachel Hare-Mustin.** Hare-Mustin published “A Feminist Approach to Family Therapy” in 1978 in the *Family Process* journal, an article which has been credited with challenging the historical approach to family therapy and facilitating the feminist approach to family therapy (Gladding, 2014). Among her other publications echoing feminist themes include “Resource Collaboration, Feminist Therapy, and Models” (Hare-Mustin, 1984), and “Family Change and Gender Differences: Implications for Theory and Practice” (Hare-Mustin, 1988).

**Jean Baker Miller.** Miller was the first director of the Stone Center for Developmental Services and Studies at Wellesley College and published *Psychoanalysis and Women* in 1973 and *Toward a New Psychology of Women* in 1976 (Jordan, 2011; Vermes, 2017). Miller’s involvement in feminist family therapy was prompted by witnessing her clients’ involvement in feminist groups. The crux of Miller’s approach emphasized a woman’s experience and the impact of relationships in human growth from a female perspective. Though Miller died in 2006, the Jean Baker Miller Training Institute at the Stone Center was dedicated in memoriam to her (Jordan, 2011; Stewart, 2007).

**Carol Gilligan.** Gilligan experienced reservations about the male-centered approaches to therapy (Women’s Intellectual Contributions, n.d.). Gilligan published perhaps her most famous work in 1982, *In a Different Voice: Psychological Theory and Women’s Development* in which she outlined her observations on traditional approaches to development (Gilligan, 1993; Women’s Intellectual Contributions, n.d.). Gilligan is also a founding member of the collaborative Harvard Project on Women’s Psychology and Girls’ Development (Gilligan, 1992). While not primarily a family therapist, Gilligan’s work has influenced the incorporation of feminist undertones in many forms of family therapy practiced today.

Family Therapy in the 1980s

In the 1980s, family therapy continued its upward projection in terms of attention, practice, research, organizational membership, and publications (Gladding, 2014). During the 1980s a heavier focus on research was emphasized, as evidenced by the *Journal of Marriage and Family* and *Journal of Family Issues*, both publishing about research methodology within family therapy. Perhaps, most importantly, it was also during this decade that family therapists became recognized as mental health professionals eligible for specialized training in family therapy as well as federal grants, solidified by the Public Health Service
Act, Title III, Section 303 (d)(1) (Gladding, 2014). It was also during the 1980s that multisystemic therapy was developed. This is a collective combination of approaches from the behavioral, cognitive, and other family therapies designed to address both familial and interpersonal aspects of treatment. Practitioners used this as a community approach for adolescents at risk and juveniles with antisocial tendencies (Gladding, 2014).

International Family Therapy in the 1980s
Family therapy continued to expand in international markets during this time. Argentina embraced marriage, couple, and family therapy in the 1980s in response to the focus on family and marriage counseling in other countries. The Argentine Systemic Federation was created in the mid-1980s, and training centers dedicated to MCFT approaches were founded and embraced (Herscovici, González, Label, Vega, & Chong Garcia, 2013).

Marriage, couple, and family therapy in China did not begin to emerge until the early 1980s. Even then, the utilization of systemic forms of therapy were slow to be incorporated, and training was limited (Deng, Lin, Lan, & Fang, 2013). Though the desire to learn about family systems was present, it was not until the 1990s that family therapy began to thrive in terms of training, the foundation of family therapy-oriented organizations emerged, and in the 2000s, publications targeting family therapy began circulation (Deng et al., 2013). For a list of important organizations that have helped guide the MCFT profession, please review Table 2.3.

| Table 2.3 Important organizations in the development of MCFT in the United States |
| American Association for Marriage and Family Therapy |
| American Association of Marriage Counseling |
| American Family Therapy Academy |
| American Psychological Association’s Division of Family Psychology International |
| Association of Marital and Family Therapy Regulatory Board |
| Commission on Accreditation for Marriage and Family Therapy Education |
| Council for Accreditation of Counseling and Related Educational Programs |
| International Association of Marriage and Family Counselors |
| Palo Alto Group and the Mental Research Institute |

MID-1980s TO PRESENT
Through growth and development, MCFT history has become common practice among practitioners throughout the world (International Association of Marriage and Family Counselors [IAMFC], 2016). According to the AAMFT (2017), “Since 1970 there has
been a 50-fold increase in the number of marriage and family therapists. At any given
time, they are treating over 1.8 million people” (para 10). Overall in the United States,
there has been an impending growth in the specialty of marriage, couples, and family
therapy, which examine the levels of competency among professionals and have attended
to common trends in licensing statewide (Gladding, 2014). The focus has evolved from
competency and training to a heightened cognition of the need for evidence-based
practices as the profession has continued to advance in a culmination of effectual and
need-based interactions (Gladding, 2014). We will discuss evidenced-based practice later
in this chapter.

Competencies and Standards
Marriage, couples, and family therapy has evolved in the United States as a known and regulated
profession. According to the AAMFT (2014b), between 1986 and 2009, there has been an in-
crease in states that govern the MCFT profession through licensure or credentialing. During
this timeframe, there has been a growth from 11 states that required licensure to practice to all
50 states requiring licensure (AAMFT, 2014b). Currently, both the state licensing boards
and the AAMFT are dually in place to provide standards and structure in the MCFT
profession; however, as the profession has evolved, state licensure boards have taken on
an increased responsibility in the governance of licensing and regulation (West, Hinton,

The AAMFT is committed to ensuring ethical practice, as evidenced by the develop-
ment of the AAMFT’s code of ethics. The AAMFT’s code of ethics (AAMFT, 2015)
attends to numerous facets of the MCFT profession and is effectual in guiding the deci-
sion-making processes in application to clients, conduct, and working with the individual
or group, and helping the practitioner avoid harm to the client, couple, or family. These
ethical codes attend to areas that include mandatory professional expectations, guidelines
for decisions and choices, as well as ethical practice, professional standards, responsibili-
ties, research guidelines, and conduct for supervision, education, and client relationships
(AAMFT, 2015).

Through the progression of the growth, associations, and structured clinics, training
programs began to emerge to further strengthen the profession’s roots. Reinforcing these
trends, the American Counseling Association incorporated a division, the IAMFC, in
1989, to help bring unification, cultural awareness and competency, and a set of standards
that will help bring increased competency (IAMFC, 2015). Similarly, the IAMFC (2015)
developed a certification that demonstrated a standard for training, thus increasing the
accountability and integrity of the profession and division via the National Credentialing
Academy. The IAMFC has just published an update to its ethical code. Ethical codes are
dynamic documents that are periodically revised to address new issues that arise as we
evolve as a society (e.g., social media; IAMFC, 2017).

Role of the AAMFT. As the name suggests, the American Association of Marriage and
Family Therapy is the association that was created to support and promote the integrity of
the field of marriage, couples, and family therapy and promotes the professional identity
of MCFTs (AAMFT, 2014a; West et al., 2013). This association has been instrumental in the growth of the MCFT profession and evolutionary changes as the field has developed (West et al., 2013). The AAMFT serves as a platform for the foundation of standards, competencies, and ethical practices, while enhancing the profession with a focus on development and research to deeply root the field in evidence-based practices. The AAMFT assumes a role in the MCFT profession that advocates and promotes wellness, awareness, social justice, and advocacy as needs emerge for populations, society, and the profession and professionals based on legal and ethical components (Bordoloi, O’Brien, Edwards, & Preli, 2013).

The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). The COAMFTE was developed to accredit graduate-level marriage, couple, and family therapy training programs and to provide program standards and competencies that must be met, thus ensuring consistency in training and development among MCFTs who seek licensure (COAMFTE, 2014). The aim of the accreditation is to encourage the practice of programmatic-based self-evaluation and educational growth to continue to ensure a graduate program’s level of competency and standard of excellence in training and educating MCFT students in their professional development (COAMFTE, 2014). While the space constraints of this chapter prevent us from going into depth about these standards and competencies, a link has been provided to this document under the heading “Additional Resources” below.

Programs that are accredited by the COAMFTE (2014) are upheld by an expectation and standard that is measurable and evaluative. The COAMFTE (2014) accreditation is useful to support students, administrators, and training programs with a standard of quality in education, licensure preparation, class transferability, program consistency, level of measurable status, attention to diversity and ethical practice, and adequate preparation. Accreditation attends to standards of education, competency, ethical codes, licensure, and examination criteria (COAMFTE, 2014).

The Council for Accreditation of Counseling and Related Educational Programs (CACREP). Recognized as an independent specialty, CACREP standards have established a set criterion for competency in marriage, couples, and family counseling programs. These competencies extend beyond the core structure of counseling and into specialty-specific themes that include attention to various facets of counseling in the context of marriage, family, and couples in relation to foundations, diversity and advocacy, assessment, research, and evaluation (CACREP, 2016). These standards require that counselors demonstrate competency and knowledge in capacities such as crisis and trauma, prevention, intervention, cognition to addiction, and legal and ethical arenas (CACREP, 2016).

Additionally, MCFTs must be able to exhibit competency in human sexuality counseling, multicultural contexts and complexities, and understand the individual as part of a cyclical unit within the family or couple (CACREP, 2016). Furthermore, CACREP (2016) standards attend to the familiarization with familial dynamics as related to violence, aging, sexuality, and trauma. A competent marriage, couple, and family program should also educate on program assessment, evaluation, and research (CACREP, 2016).
Again, while length constraints prevent us from discussing these standards in detail, a link to these standards can be found under the header “Additional Resources.” Let us turn our attention to Guided Practice Exercise 2.3, where we will compare the standards and competencies of the COAMFTE and CACREP.

GUIDED PRACTICE EXERCISE 2.3

Please go to the websites of the COAMFTE and CACREP (see a link to these documents under the heading “Additional Resources.”) Pull up both organization’s documents related to the competencies and standards required by each for accreditation of MCFT programs. Compare and contrast these two documents. What similarities and differences between these two documents do you notice?

Licensing exams. Licensure standards provide a framework for which state licensing boards can measure and evaluate candidates for the counseling licenses (Association of Marital and Family Therapy Regulatory Board [AMFTRB], 2017a). To qualify for licensing, candidates must meet a variety of components, including academic course work, intern hours, and passing a licensure exam. The Association of Marital and Family Therapy Regulatory Board (AMFTRB) created an exam as a standard for cumulative measurement of knowledge to be used as a means of qualification for the Marriage and Family Therapy License (AMFTRB, 2017b). The marriage and family therapy exam is a computerized exam that consists of questions that evaluate candidates in areas pertaining to assessment, treatment, systemic therapy, crisis, ethics and standards, and treatment evaluation and termination (AMFTRB, 2017b).

International Family History

As previously noted, trends in family therapy began to emerge on a global scale around the 1950s and further expanded throughout the course of the decades. Family therapy was seen in countries such as Poland and India, where hospitals began to treat individuals from family contexts (Chadda & Deb, 2013; Józefik, Barbaro, Iniewicz, & Namysłowska, 2013). In Poland this profession emerged in several contexts ranging from contributors such as Maria Orwid and team to the Family Therapy Outpatient Unit that was established 1983 (Józefik et al., 2013). Family therapy also appeared in South America., Specialized family therapy training was offered at the Psychiatry Institute of the Federal University of Rio de Janeiro (Kaslow, 2000). Further, family therapy became more visible in China during 1980s and continued to emerge as journal articles were published and family therapy became a field of study in education, particularly at the Institute of Psychology in Chinese Academy of Sciences (Deng et al., 2013). The expansion of family therapy on a global scale continues to emerge, as this specialty has become more visible, recognized, and regulated. For a list of people who are important to the development of the MCFT profession internationally, please see Table 2.4.
Table 2.4 Important people in the development of MCFT globally

<table>
<thead>
<tr>
<th>Person</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bloch, Donald</td>
<td>Orwid, Maria</td>
</tr>
<tr>
<td>Byng-Hall, John</td>
<td>Potrebic, Jovica</td>
</tr>
<tr>
<td>Gacic, Branko</td>
<td>Rocha, Lindemberg</td>
</tr>
<tr>
<td>Holm, Hans Jurgen</td>
<td>Selvini-Palazzoli, Mara</td>
</tr>
<tr>
<td>Howells, John</td>
<td>Sagar, Vidya</td>
</tr>
<tr>
<td>Kastel, Pavel</td>
<td>Skyinner, Robin</td>
</tr>
<tr>
<td>Macias, Raymundo</td>
<td></td>
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</tbody>
</table>

Research and Trends

As an established profession, MCFT necessitates research to further establish it from a framework of evidence-based practices (Oka & Whiting, 2013). In this vein, researchers have conducted studies on a variety of topics. An example of this includes an examination of trends in MCFT regarding supervisors who serve as gatekeepers to the profession in training (Sampson, Kelly-Trombley, Zubatsky, & Harris, 2013). Other trends include attention to areas that may need advocacy, particularly in the context of underserved populations and sociocultural differences (Bordoloi et al., 2013). You will learn more about research and trends in Chapter 6, which focuses on couples and families research.

Evidence-based practice. Evidence-based practice was formulated in the early part of this century due to the desire of some practitioners to form clinical practices based on what the research confirmed was effective (Smith, 2014). This approach has been somewhat controversial, with some practitioners in favor of such an approach, while others prefer to rely on their own clinical expertise and experience sans official research confirmation (Fraser, Solvey, Grove, Lee, & Greene, 2012; Smith, 2014). Many such practitioners believe that their vast clinical experience and success rates are proof enough that their approach works (Dattilio, Piercy, & Davis, 2014). A part of this controversy centers on two camps: those who believe in a common factors approach to explain why therapy works, and those who propose a specific factors approach (Fraser et al., 2012). In other words, it is the specific interventions, assigned in a specific way, that explain the success of an approach (Fraser et al., 2012). However, evidence-based approaches are continuing to gain in popularity because they are favored by insurance companies and other third-party payers (Dattilio et al., 2012). The MCF profession is also advocating more research education for students currently studying to join the profession. Many in the MCFT profession are calling for better trained scholar-practitioners due to this growing call for more evidence-based practices (Dattilio et al., 2012).

A biopsychosocial perspective. Marriage, couple, and family therapists often integrate a biopsychological or biopsychosocial approach with other theories to treat mental health issues within the couple or the family (Negash & Hecker, 2010). The biopsychological approach was developed by Engel (1977). This model was adopted
by the MCF profession due to many MCF therapists’ collaborations with the medical community within the field of family medicine (Howe, 2011; Pereira & Smith, 2006). The biopsychological approach is a strengths-based, holistic model that recognizes that human beings are biological, social, and psychological entities (Miller, Christenson, Glunz, & Cobb, 2016). Therefore, more than just the psychological wellness of an individual, couple, or family is considered. This approach is also very adaptable to many different cultures, because it considers the cultural relativism of the individual, or the family, across the age span (Howe, 2011).

SUMMARY
In this chapter, we discussed the origins and development of the marriage, couples, and family counseling profession from its earliest influences through the child guidance and social work movements to current-day developments such as recognizing and honoring the importance of couple relationships that do not fall neatly into a “married” package; hence the gradual shift from referring to marriage and family therapy to marriage, couple, and family therapy. In Chapter 3 you will learn more about the core principles and paradigms in the MCFT profession.

KEYSTONES
Among the key points addressed in this chapter are:

- Many individuals have made substantial contributions to the development of the marriage, couple, and family counseling profession, including but not limited to Nathan Ackerman, Gregory Bateson, John Bell, Murray Bowen, John Bowlby, Milton Erikson, Frieda Fromm-Reichmann, Carol Gilligan, Jay Haley, Rachel Hare-Mustin, Don Jackson, Kurt Lewin, Theodore Lidz, Jean Baker Miller, Salvador Minuchin, Virginia Satir, Mara Selvini-Palazzoli, Carl Whitaker, and John Weakland. Each brought unique contributions related to theory or process that has led the profession to how it is practiced today.

- There have been many key events that have helped shape the profession, such as the Groves Conference, the New York meetings, Kurt Lewin’s small group dynamics, the influence of the social work profession, the development of family systems theory, and the spread of marriage, couples, and family therapy worldwide.

- While the early development of the profession was mostly led by men, during the 1970s and with the influence of the feminist movement, many prominent women made substantial contributions to how marriage, couples, and family therapy is practiced today. The 1970s has
been viewed as a boom time for the development of MCFTs, and since then there has been a proliferation of practitioners in this profession (Schmidt, 2015).

- The MCFT profession is regulated by several organizations (e.g., AAMFT, COAMFTE, CACREP) that have set competencies and standards for the training of practitioners and who help oversee the professional development graduate-level educational and training programs. Currently all 50 US states require those wishing to practice MCFT to be licensed through their respective states boards.

- The MCFT profession is moving more toward evidenced-based practices and incorporating a biopsychosocial lens to the work practitioners do with couples and families.

REFLECTIONS FROM THE CONTRIBUTOR’S CHAIR
Melinda Haley

I have found that it is always important to understand the history of a profession to understand its progression and development and to where it is headed in theory and in practice. As an educator, I have found no greater pleasure than to engage in scholarship with my current and former students. Collaborating on this chapter was truly a labor of love, and it is thrilling to realize that soon, my students will be mentoring their own students in scholarship. The MCFT profession has progressed and grown in much the same way, with one generation mentoring the next; and we too pass on the torch of knowledge, discovery, and passion to those of you reading this chapter, who will go on to participate in the wellness of individuals, couples, and families. Enjoy your journey of discovery!

ADDITIONAL RESOURCES
The following resources provide additional information relating to the chapter topics.

Useful Websites

- American Association for Marriage and Family Therapy
  http://www.aamft.org/iMIS15/AAMFT/

This website provides information about the profession of MCFT, building your career, when conferences will be held, and how to find a therapist or a supervisor.

- Association of Marital and Family Therapy Regulatory Boards: State Licensure Comparison Chart
This website provides information regarding the requirements for licensure within each state.

- Commission on Accreditation for Marriage and Family Education: Accreditation Standards

This website provides the accreditation standards for the COAMFTE.

- Council for Accreditation of Counseling and Related Educational Programs: 2016 CACREP Standards
  http://www.cacrep.org/for-programs/2016-cacrep-standards/

This website provides the accreditation standards for CACREP.

READINGS


This publication is a guideline for how to practice the profession of MCFT ethically and honorably within the United States. This document includes topics such as how to honor the public trust, the need to engage in social change and advocacy, how and when to seek consultation and engage in ethical decision making and resolve complaints.


The authors of this edited book discuss different models of how to use yourself as a therapeutic tool to help families and couples.


The author of this chapter discusses the history of marriage and family throughout time as well as from the perspective of different cultures.


This document provides the most updated ethical code governing the profession of MCFT worldwide.

VIDEOS

https://www.youtube.com/watch?v=QRBjvCxeBeg&list=PLaByyx03ueSpAjpfxQ3JZTNXL_UGVtmBJ
This video will give you an overview on systemic therapies, particularly those of the MRI and the Milan approach.

https://www.youtube.com/watch?v=31EgvvbXS6M

This video will provide you with an overview of the benefits of marriage, couples, and family therapy.

REFERENCES


