FAMILY THERAPY IN THE MIDDLE ATLANTIC AND VIRGINIA DIVISIONS OF THE AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY COUNSELORS

by

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CHAPTER I.

INTRODUCTION

Statement of the Problem

The field of family therapy is growing rapidly. Guerin (1976) and Kaslow (1976) estimate it to be about twenty-five years of age. With the rapid growth, there has also been confusion. Some of the phrases used by the theorists to describe family therapy are "hodgepodge" (Zuk, 1976), "techniques in search of a theory" (Manus, 1966), "part techniques and part theories" (Zuk, 1976), "partial concepts" (Bowen, 1976), and "each therapist doing his own thing" (Olson and Sprenkle, 1976).

The researcher was first confronted with the Washington, D. C., area confusion while attempting to find a practicum situation in family therapy by making inquiries at the Middle-Atlantic Division of the American Association of Marriage and Family Counselors (AAMFC) conference in April 1976. Only one person, among those questioned at the conference, was able to name an AAMFC supervisor and he was reporting on his own pastoral counseling training program.

This apparent lack of familiarity with family therapy

in general, and training opportunities specifically, by local professionals was part of the justification for the undertaking of this project.

Purpose of the Study

This study was intended to be exploratory and descriptive. The purpose was to investigate the theoretical positions and family therapy activities of members of the Middle Atlantic and Virginia Regions of the American Association of Marriage and Family Counselors. This was done by means of a short questionnaire sent to them in April 1978. Special attention was given to several areas which the Group for the Advancement of Psychiatry (GAP) studied in 1965 and 1966. These areas were as follows:

1. professional identity according to academic discipline,
2. favorite family therapy theorists and relationship of their geographic area to the area where the respondent resides,
3. techniques employed in relation to the number of people seen in a session,
4. criteria for choice of family therapy as a modality,
5. training in family therapy,

6. the function of symptoms displayed by the "identified patient",
7. goals of therapy in relation to the individual and to the family as a whole,
8. duration of treatment, and
9. contraindications for family therapy.

Another purpose was to survey the respondents about several controversial issues which appear in the family therapy literature. Those included the following:

1. the number of therapist hours devoted to the practice of psychotherapy in general, and family therapy in particular,
2. the respondent's definition of family therapy,
3. the possibility of doing family therapy with only one family member present in sessions, and
4. whether or not the respondent would request family therapy if a member of his/her own family were in distress (Guerin, 1976).

A third purpose was to survey the respondents on two issues which are currently under discussion in the state of Virginia, due to the recent licensing law for professional counselors. Therefore, two questions were asked on the following topics:

1. respondents' desire to participate in further training in family therapy, and
2. licenses which the respondents might already possess.

Background and Need

Three studies of the practices of family therapists have been reported in the literature. In 1969, Beels and Ferber reported on the direct observations they had been making of family therapists over a period of years, classifying them in accordance with their activity during the therapeutic hour.

The Group for the Advancement of Psychiatry (GAP) surveyed therapists during 1965-66. That sample was made up of about 40% social workers and 40% psychologists and psychiatrists combined. "Among the remaining 20% are marriage counselors, clergymen, nonpsychiatric physicians, child psychiatrists, nurses, sociologists, and others from scattered disciplines" (1970, pp. 2-3).

A metropolitan Washington, D.C., consumer study (Adams and Orgel, 1976) was done which questioned psychologists, social workers, and psychiatrists. In a question related to modality preferred, some of the respondents indicated "family theory" to be a choice. This choice bore no relation to the

clinical training experience which they had reported, however. A question was also included in that study which asked if the therapist were open to seeing members of a patient's family or the spouse. There was no follow-up question as to whether this meant conjoint therapy or consultation.

A 1976 AAMFC publicity folder stated that there were over 4000 AAMFC members in various disciplines listed as "psychologists, psychiatrists, social workers, ministers, physicians, sociologists, attorneys and educators." The researcher has met public health administrators, Catholic laypersons, nuns, psychiatric nurses, dietitians, sex therapists, financial advisors, and gerontologists who are also engaged in forms of family therapy which bring them to workshops and supervisory sessions. Most of these people and the AAMFC members were not involved in the previous studies. They had not been asked to formally respond as to what it was that they were doing which made family therapy different from other forms of counseling and psychotherapy, what theories they preferred, or which techniques were useful to them.

It was with the foregoing views in mind that this study was undertaken. It is thought that the results of the study have provided some information on who in the AAMFC is prac-

ticing family therapy, what theoretical modalities are preferred, and what some of the techniques are which are found to be useful by the respondents in relation to the number of people seen in family sessions.

Definition of Terms

Identified patient. The "patient" chosen by the family as the "sick one," due to his or her symptoms of pathology.

Family. Any group of persons living under the same roof interacting as a single household.

Family systems. A very controversial concept among theorists. For purposes of this study it shall refer to the interactions of family members, and emotional interplay, conscious and unconscious, which goes on among the members.

Family therapists. Therapists who are "differentiated in practice by their concern with the total family and their emphases on concepts dealing with understanding the family process" (Olson, 1970, p. 505).

Family therapy. A search of the literature reveals that the terms "family approach," "family counseling," "family oriented therapy," "family treatment," and "family work" are used interchangeably.

Wells, Dilkes and Burchart (1976, p. 499) stated, "It

was difficult to find any consensus of a definition of family therapy," when they reviewed the literature for research in family therapy. A broad definition for family counseling is given in an editorial in the New York Association of Marriage and Family Counselors' _Journal of Family Counseling_ (Aaroz, 1973, p. 4):

> In an editorial sense, this term means any and all counseling related to the family constellation. Thus, it includes, _contentwise_, premarital, marital, and post-marital counseling and psychotherapy; _methodologically_, it embraces individual, couple, and group counseling and psychotherapy in all its forms, conjoint, concurrent, combined, collaborative, etc.; _theoretically_, it gathers the contributions of all the psychotherapy schools in the broad based spectrum between psychoanalysis and behavior therapy.

The GAP Report (1970, p. 24) uses the definition "... the treatment of two or more family members _meeting conjointly_, at least during much of the therapy, or regarding family therapy more broadly as an orientation and alertness to problems of family relationships."

Wells, Dilkes and Trivalli highlight the spectrum involved in family therapy:

> ...Jackson and Satir, and Alexander, discuss family treatment approaches ranging from working with all nuclear family members at the same time with the same therapist to approaches where family dynamics are noted but all therapeutic contact is with individual family members. Olson sees all the family therapy methods as evolving from a transactional framework in which 'the focus is on the process of

> the family as a system,' and the therapeutic units are the various natural groupings, such as the marital couple or the nuclear and extended family (1972, p. 190).

Another question which arises over definition involves the words "counseling" and "therapy." The researcher sees counseling as being crisis-motivated and problem oriented. Therapy is seen to be working in depth with underlying causes, unconscious motivations and complementary psychodynamic patterns within familial dyads. In clinical practice, the researcher uses both concepts; at times counseling expands into psychotherapy. Other times both concepts can be seen to be working within a single session. An example of this is noting the symbiotic needs of each client in a dyad when attempting to work at problem solving. Sporakowski and Mills speak of family therapy on different levels:

> ...the deep intensive, the inter-actional-transactional, and the educative. They are used over varying lengths of time; in general, the deeper the level, the longer the duration of treatment. The level of treatment is also determined by the nature of the problem, the ego strengths of the family, and the skill of the therapist (1969, p. 64).

The researcher desires to take into account all levels of treatment, therefore no distinction is being made between counseling and therapy.

Marriage Counseling and Family Therapy are frequently

linked under the term Marriage and Family Counseling, as in The American Association of Marriage and Family Counselors (AAMFC). Olson and Sprenkle (1976, p. 318) state: "The structural distinctions between marriage counseling and family therapy are also fading as there is increasing focus on all types of relationships including unconventional ones." For purposes of the current study, marriage or relationship counseling was considered to be a part of family therapy.

In clinical work, the researcher considers family therapy to be that therapeutic intervention which aims at changing the way family members relate to one another. The goal is the improvement of both individual and family functioning. Although dyads, triads, entire nuclear families and occasional extended family sessions are preferred, the researcher agrees with Bowen (1966) that family therapy can be done with one person.

For the purposes of this research project, the definition of family therapy was left open. One of the objectives of the current study was to survey the respondents' attitudes toward certain key elements in the various definitions of family therapy.

CHAPTER II

REVIEW OF THE LITERATURE

History and Evolution of Family Therapy

The first case of family therapy appeared in the writings of Freud in 1909 when he reported treating a case of childhood phobia in his patient, Little Hans, by seeing the father instead of the child (1955). Ackerman wrote his first article on the importance of family relationships in 1937 (Guerin, 1976), and began publishing articles about the interpersonal aspects of family life in the mid-fifties (Ackerman, 1958). Another pioneer, Bell, published his first article about treating a family group in 1953, and elaborated his theories more extensively in 1961 and 1975.

The major focus for many of the early family therapists was the work done with schizophrenogenic families in the fifties, which is when Bowen (1971) says that the movement surfaced after being underground for a number of years. Haley joined Bateson to study human communication in 1952 in California. Weakland (1960) and later Jackson (1960) joined them in their research on schizophrenia (Bateson, Jackson, Haley, and Weakland, 1956). Haley followed Jackson and Satir to the Mental Research Institute when the Bateson project terminated in 1962. He then went to work with Min-

uchin in Philadelphia, where they collaborated on the development of structural family therapy (Minuchin, 1974). Haley moved to Washington, D. C., in 1976 where he is training family therapists in strategic family therapy.

Bowen began at the Menninger Clinic, then moved to the National Institutes of Mental Health in his work with families (mothers at first) of schizophrenics (Bowen, 1960, 1965, 1966). From there he moved to Georgetown University in 1973 where he is still training psychiatric residents and other mental health professionals in family therapy. His group is also doing research in family therapy.

Others who were pioneers in schizophrenia research were Lidz, Cornelison, Fleck, and Terry (1957, 1965); Speck (1967); Boszormenyi-Nagy (1962); Wynne, Ryckoff, Day, and Hirsch (1958); Midelfort (1957); and Satir (1967). In their work with schizophrenics, the troubled family was shown to be involved in the etiology of the psychosis. Patients would improve and be sent back to their family situations, only to have mental illness recur. The concepts developed in treating schizophrenics and families having a troubled child have been explored and enlarged for the treatment of other family groups. Guerin (1976, p. 20) gives the Bateson communications project the credit for using a "...communications and

structural model to define family dysfunction."

Classifications of Family Therapists

There have been four attempts to classify family therapists. The GAP study (1970) attempted to classify family therapists according to theoretical positions using a scale ranging from A to Z. A therapists see primarily individuals, occasionally see a family, but focus on individual psychodynamics. Z therapists see only families, focusing on the group system rather than individual psychodynamics. Therapists are not located at specific points upon the scale, but issues are discussed in relation to their treatment possibilities by A, M, and Z therapists, M's being halfway between the two extremes.

Olson's (1970, p. 506-507) system is similar in that he uses five categories to indicate the focus of treatment: (1) Intrapersonal (intrapsychic primarily with an individual); (2) Interpersonal (primarily interpersonal with related individuals seen separately); (3) Quasi-interactional (focuses on interactional skills such as behavior modification); (4) Interactional (group process with unrelated individuals); and, (5) Transactional (natural family group seen together with the goal being improved family relations).

Guerin's (1976) classification categorizes family therapists into two broad groups, psychoanalytic and systems. The classifications, based upon the theoretical position of the therapist, are further subdivided into four groups in each. Systems therapists may be general (psychoanalytic, sociological, anthropological), strategic (focus on presenting symptoms), structural (strategic plus some structural characteristics of families), or Bowenian (elements of all previous categories plus Bowen's three generation approach). The psychoanalytic group is divided into individual (family members of identified patient may be seen), group (natural family group seen together), experiential (exclusively here and now with natural family group), and Ackerman (strongly tied to analytic principles).

The Beels and Ferber classification of family therapists, which organizes therapists according to the role which they play within the therapy hour, first appeared in _Family Process_ in 1969. The two broad classifications include the conductors and the reactors. The conductors lead the group, are active, issue value statements, arrange experiences, and provide goal-oriented leadership. The reactors are "...generally less compelling public personalities..." (1972, p. 175), are "...more gradual and indirect, but

eventually require that a key element in the system move the way they want it to" (p. 207).

The Theory and Practice of Family Therapy

Although there does not appear to be any accepted theory of family therapy, certain assumptions are shared by the therapists who consider themselves to be family practitioners. The GAP Report (1970) states that the symptoms which an individual family member or "identified patient" presents can be a representation of the family's pathology and that seeing the family together offers some advantages over treating the identified patient in individual psychotherapy. Satir sees the advantage as her being able to directly observe and experience a family's interaction, getting "first-hand knowledge" (1967). The following quotation shows Beels' and Ferbers' agreement with her on that issue:

> ...both the family's regulatory system - benign and pathological - and the experience which is the key to change in that system are embodied in a communication system that is only fully developed and clear when the family are in each other's presence. When they are not present to one another, but represented by verbal or symbolic traces, the system is much more difficult to read, for both them and the therapist. In this way both the 'conjoint' and 'nonverbal' aspects of family therapy are clearly related (1972, p. 207).

Previously in their article, Beels and Ferber had taken

the position that not all members of a family need to be present for all sessions, but that the therapist's "interest and allegiance" is towards the whole family, and this interest and allegiance defines family therapy, not the number of people in the room or the membership of the meeting (p. 195).

In relation to families with children, Framo (1975) agrees with Satir (1967) about focusing on the marital relationship "...once the original symptomatic children have become defocused" (p. 22). In the GAP study, sixty per cent of the respondents reported sometimes focusing on the marital pair. A majority of them sometimes preferred only a few family members, sometimes the whole family. Sixty per cent of the respondents would see an individual family member separately while seeing his or her family conjointly.

In answering what it is that family therapy does, Beels and Ferber say, "...it provides a means of getting at what is happening...by bringing the happening into awareness..." (1972, p. 201). Framo paraphrases Ackerman, "...family therapy does not aim so much at merely taking something away, such as pathogenic conflicts, but often achieves a surplus, positive, actualizing sense of enrichment in family life" (1975, p. 21).

Several reasons were given by GAP respondents and family

theorists for the choice of family therapy as a treatment modality. Those included evaluation of the presenting problem (GAP, 1970), individual treatment developed into family treatment (GAP), discouragement with length of time required by traditional therapy (Kaslow, 1976), failure of other forms of treatment (GAP), and inadequacy of other methods (Olson, 1970).

Contraindications for family therapy have been offered by a number of family theorists. The writer will attempt to summarize those offered by Ackerman (in GAP 1970), Wahlroos (1976), and Sporakowski and Mills (1969) who drew upon Wynne and Shertz for their listing of contraindications. Family therapy is contraindicated in the following situations:

1. When any disablement precludes a key family member from attending sessions.

2. When a valid family secret or parental subsystem secret exists. Much is discussed in the literature about including parental sexual material, and third party involvements, criminal activities and antisocial activities.

3. When there is presence of extreme defenses in a family member, which if broken might lead to a physical or psychotic crisis.

4. When the ability of the members to communicate with-

out constant interruptions or physical assault is not present.

5. When the scheduling of a family appointment is impossible due to diverse schedules of family members.

6. When deeply rooted dishonesty in one or both parents exists which renders the usefulness of family therapy impotent.

7. When there are psychological defenses which do not permit some flexibility as the family is restructured and changed in the process of therapy, which do not permit members to be able to share one therapist, and which do not cause a member to prevent his own scapegoating by other family members.

8. When the therapist is inadequately trained or unable to practice family group therapy with the following considerations in mind:

a) It can be exhausting physically and mentally.

b) In some cases a cotherapist may be necessary.

c) One needs to be cognizant of the family as a system rather than resorting to individual methods.

d) One needs to be able to be reflective at times and capable of assertive intervention at other times.

e) One needs to control one's impulses to be dictatorial and advice rendering rather than coaching or facilitating.

f) One needs a strong theoretical education and clinical training in individual psychodynamics, group processes, and family systems.

The family therapy literature contains diverse theoretical positions ranging on a continuum from the analytic style of Ackerman to the problem solving systemic approach of Haley. Ackerman says that the approaches are different

> ...in the extent to which they deal with conscious or unconscious focus, content or affect, past or present...the degree that they emphasize intrapsychic, inter-personal, and situational factors... the degree to which they rely on re-education, manipulation, or the therapy of emotion and depth (1970, p. 123-124).

The choices of theorists by the GAP respondents were Satir, Ackerman, Jackson, Haley, Bowen, Wynne, Bateson, Bell, Boszormenyi-Nagy, and Sullivan in order as their top ten preferences. Foley (1974) did a study in 1970 finding the same top five preferences chosen by his respondents, but in a different order. He stated that this seemed to indicate that family therapists were agreed upon whose theories were most important to the field. The GAP report also stated that the choices of theorists by the respondents were related to the area in which the theorists and respondent lived, suggesting that the therapists were as much influenced by availability of a teacher as by his or her writings.

The GAP concluded that an integrative framework is needed to blend psychodynamic and family theories, that future psychiatry "...will be radically altered by a shift from individual to relational psychology as its theoretical understructure" (1970, p. 37).

Summary

Family therapy has grown from Freud to the Bateson communication project and the work with schizophrenogenic families into a form of therapy in its own right. Although no set of theories or practices has been agreed upon by family therapists, several attempts have been made to classify them according to theoretical framework, focus of treatment, and the role which the therapist plays within a session. Certain assumptions are shared by family therapists, some of those being the "identified patient" indicating the family's pathology, and the therapist's interest in the well-being of the entire family rather than of an individual. Several indications for family therapy as the treatment modality of choice are given by therapists. Those include failure of traditional methods, presenting problems, individual treatment evolving into family therapy, and the shorter time required. There are a number of contraindications for family therapy, includ-

ing some in relation to the family itself, and others in relation to the therapist's personality and training. Two studies found the same five theorists to be favored among family therapists, with a positive relationship between geographic location of theorist and therapist. The GAP concluded that there needs to be a conceptual integration of psychodynamic and family theories as psychiatry of the future will probably shift from individual to relational psychology.

CHAPTER III

PROCEDURES

Sample

The subjects for this study were the 182 clinical members of the Mid-Atlantic and Virginia Divisions of the American Association of Marriage and Family Counselors.

Instrument

A twenty-one item questionnaire was developed by the researcher. In a pretest, five marriage and family counselors were asked to respond to the questionnaire. Two of the questions required minor rewording and the category "pastoral counselor" was added to the original questionnaire.

The items in the questionnaire were chosen in several ways. Some were similar to the GAP questionnaire. Other items were selected due to disagreement in the literature over the subject matter within the question, and two questions were asked which have been topics of discussion in the profession recently due to the new licensing laws in the state of Virginia.

The questionnaire included several types of questions, including choices of listed answers, numerical ratings of the suggestions presented, write-in answers and eleven

questions to be answered according to a Likert-type rating scale from one to five.

A copy of the questionnaire is appended to this report.

Data Collection

The questionnaires were mailed with a cover letter from the researcher's major advisor introducing her to the subjects being surveyed. A self-addressed, stamped return envelope was included for the respondents' use in mailing completed questionnaires back to the researcher. Anonymity was assured to the respondents.

Analysis of Data

Of the 182 questionnaires mailed out, 104 were returned and 102 were included in the analysis. One of those discarded was returned after the cutoff date; the other is described below. The first step was to sort the returns on the basis of the professional affiliation checked in question 1. Although one choice only was requested, 29 respondents chose more than one. In those cases, the academic degree was used to determine which affiliation was most appropriate. In several cases, training and workshops were considered as well. For example, one respondent who checked 8 occupations also checked the M.Div. degree, which could be clergy or pastoral

counselor, and listed training in pastoral counseling. Therefore, the respondent was classified as a pastoral counselor.

In several cases, even after using the above criteria, two professional affiliations still seemed to fit; however, one was always marriage and family counselor. For those respondents the other affiliation was chosen because all of the respondents, as members of the professional organization under study (AAMFC), are marriage and family counselors. This choice served to leave a distinctive class of marriage and family counselors who had academic degrees and professional training only in that discipline.

Only one respondent checked "other" as his/her only affiliation. That was a sex therapist with the degree J.D., clinical training only in sex therapy, and who practiced no family therapy or psychotherapy. That questionnaire was not included in the study.

The response data were encoded on punch cards and analyzed using the Statistical Package for Social Sciences (SPSS) on the VPI computer system. The SPSS is an integrated package of computer programs which were developed at the University of Chicago in order to analyze social science data.

Most of the questions and statements requested responses

which produced nominal data. For those, the main analysis was the frequency distribution by occupation. Some of the data could be treated as continuous variable, for which several descriptive statistics were computed, such as mean and variance, range, etc. This treatment was necessary in analyzing the number of hours of psychotherapy practiced. It was also helpful in computing an index for choice of theorist and in evaluating the responses on a Likert-type scale on the last 11 statements.

For elementary correlation and relationships between the responses to several questions, cross tabulation (contingency tables) was used. The subroutine (CROSSTABS) displayed joint frequency distributions very well and provided tests of statistical significance such as chi square.

Question 6 on the survey asked respondents to cite first, second, and third choice of theorist. For analysis, on each questionnaire each theorist was coded 1, 2, 3, or 9. A check mark was counted as a first choice. In one case where all the choices were rated 1, 2, or 3, only the one marked 1 was recorded. In all cases, blanks and choices other than 1-3 were coded as 9. Then for each theorist all responses were averaged by this code, and the theorists were ranked from lowest mean to highest. A constant was subtracted from

all the means so that the lowest mean was 1.000. The resultant index, tabulated in Table I, is a measure both of frequency of citation and ranking.

Question 8 asking if respondents would request family therapy for their own families allowed only 2 choices: yes or no. Since 13 respondents (22.5%) wrote in "maybe" or a question mark, "maybe" was assigned a code as a separate response.

On question 9, where respondents were asked to choose one position, 8 respondents chose more than one. Although this was assigned a separate code as a multiple response, it was essentially unuseable and was treated as missing data.

CHAPTER IV

FINDINGS

The Therapists

In accordance with the techniques described in the analysis of data, the frequency count by occupational classification was as shown in Figure 1. The GAP study included 40% psychiatrists, 40% social workers, and 20% "others" (1970, p. 2,3). The current study included 24.5% psychiatrists and psychologists, 26.5% social workers, and 49% others. In that 49% are included 23.5% pastoral counselors and clergypersons, a group similar in size to the large groups in the GAP study.

Figure 2 shows the variety of academic degrees held by the respondents.

Favorite Theorists

The GAP study suggested "...the importance of personal availability of a teacher in a particular region as well as his more general influence through published books and articles" (1970, p. 37). Therefore it should be expected that Sullivan, Bowen, and Haley would be first, second, and third choices of theorists in relation to the amount of time they have or had been in the Mid-Atlantic and Virginia Divisions

```
Classification            N       %       Histogram
                                          I
Clergy                   11    10.8       ************
                                          I
Educator                  7     6.9       ********
                                          I
Family Counselor          1     1.0       **
                                          I
Marriage & Family        16    15.7       *****************
  Counselor                               I
Pastoral Counselor       13    12.7       **************
                                          I
Psychiatrist              2     2.0       ***
                                          I
Psychologist             23    22.5       ************************
                                          I
Psychiatric Nurse         2     2.0       ***
                                          I
Social Worker            27    26.5       ****************************
                                          I
  Totals                102   100.0       I.........I.........I.........I
                                          0        10        20        30   N
```

Figure 1. Occupational Classifications of Respondents

```
Degree                 N      %      Histogram
                                     I
Ed.D.                  5     5.6     ******
                                     I
M.D.                   3     3.6     ****
                                     I
M.Div.                12    13.5     *************
                                     I
M.S., M.A.,           28    31.5     *****************************
   Other Master                      I
Ph.D.                 31    34.8     ********************************
                                     I
Other                 10    11.2     ***********
                                     I
   Totals             89   100.0     I.........I.........I.........I
                                     0        10        20        30  N
```

Figure 2. Earned Degrees Held by Respondents

of the AAMFC. Such was not the case, as Table I illustrates.

On the basis of overall index and number of citations, the ranking was Satir, Haley, Minuchin, Bowen, Ackerman, Sullivan, and Jackson. Citations of Bell, Wynne, Bateson, Boszormenyi-Nagy, and others were far fewer; in fact, none of those "others" had more than three citations, hence were not tabulated separately.

Satir was by far the first choice, outpolling Haley by 3 to 2. It is suspected that this is because Satir often makes appearances and conducts training workshops in the geographic area under study, her most recent being in September 1977. One of the large family training centers in the Mid-Atlantic Division is the Center for the Study of Human Systems, which uses the Satir model. Many of the respondents indicated that they had received training there. Although Haley is newer to the Washington, D.C., area than Bowen, he was located in nearby Philadelphia before locating in Washington, D.C. He teaches in Baltimore, Md., as well as in Washington, which also may have given him the edge over Bowen in the present study.

In comparing the favorite theorists in the present study with those found in the GAP study (Table II), nine of the top ten were the same, the exception being Minuchin chosen in

Table I.

Family Therapy Theorists Cited as Influential (AAMFC). N = 102

Theorist	Index*	Cit**	A	B	C	D	E	F
			By Professional Affiliation					
Satir	1.000	59	1	10	15	15	4	14
			2%	17%	25%	25%	7%	24%
Haley	2.617	38	2	9	8	9	3	7
			5%	24%	21%	24%	8%	18%
Minuchin	3.206	29	2	5	8	6	1	7
			7%	17%	28%	21%	3%	24%
Bowen	3.264	28	3	4	7	7	2	5
			11%	14%	25%	25%	7%	18%
Ackerman	3.450	24	0	5	9	7	0	3
			-	20%	38%	29%	-	13%
Sullivan	3.647	22	0	4	4	7	4	3
			-	18%	18%	32%	18%	14%
Jackson	3.804	21	0	4	7	4	2	4
			-	19%	33%	19%	10%	19%
Wynne	4.892	5	0	2	1	2	0	0
			-	40%	20%	40%	-	-
Bell	4.892	5	0	1	3	1	0	0
			-	20%	60%	20%	-	-
Bateson	4.980	4	0	3	0	0	1	0
			-	75%	-	-	25%	-

A: Psychiatrists and Psychiatric Nurses
B: Psychologists
C: Social Workers
D: Clergy and Pastoral Counselors
E: Educators
F: Marriage and Family Counselors

*This index is a mean which combines both number of citations of a theorist and the ranks assigned in the citations. See Chapter III, Analysis of Data.

**Total number of times the theorist is cited, whether as first, second, or third choice.

Table II.

Family Therapy Theorists Cited as Influential (GAP). N = 127

Theorist	Cit.	By Professional Affiliation A	B	C	D
Satir	54	15	8	25	6
		27%	14%	48%	11%
Ackerman	52	16	7	25	4
		31%	13%	48%	8%
Jackson	51	21	10	15	5
		41%	20%	29%	10%
Haley	32	11	7	9	5
		34%	22%	28%	16%
Bowen	24	8	4	9	3
		33%	17%	38%	12%
Wynne	19	13	1	4	1
		69%	5%	21%	5%
Bateson	17	7	3	6	1
		41%	18%	35%	6%
Bell	15	5	3	5	2
Boszormenyi-Nagy	9	2	2	4	1
Sullivan	6	2	3	1	-

A: Psychiatrists
B: Psychologists
C: Social Workers
D: Others

the 1978 study over Boszormenyi-Nagy in the GAP study. Satir was first in both surveys. In both surveys the professional affiliations of the top ten theorists were the same: six psychiatrists, one social worker, one psychologist, one communications expert, and one cultural anthropologist.

Question 2 pertaining to training and workshops was asked in order to determine the geographic location of the experience. The response is tabulated by frequency in Table III. Eighty-nine per cent of the respondents reported training experiences in family therapy. Geographic proximity of the workshops or training did seem to have some influence as nearly 38% reported experiences in or near the area under study. It is difficult to ascertain from the statistics how many experiences were in proximity to the respondents' residences, as categories four and five were not broken down, nor was any allowance made for the respondent having moved from one area of the country to another.

The respondents were asked to rate the following statement (Item 20) on a Likert-type scale: "I would like to participate in more training opportunities available in the area of family therapy." The results are tabulated in Table IV. Conclusion: There was a favorable inclination and a recognized need for more training opportunities in family therapy by

Table III.

Geographic Location of Training Experience

	Code and Region	Count	%
1.	Local (Md., Pa., D.C., Va., Del., W. Va.)	19	18.6
2.	East (Above plus N.Y., Phila.)	20	19.6
3.	Distant (other than above)	17	16.7
4.	All over	19	18.6
5.	Too many to list	13	12.7
6.	No answer or none	14	13.7
	Total	102	100.0

Table IV.

Frequency Analysis: "I would like to participate in more training opportunities available in the area of family therapy."

	Scale Rating	N	%
1.	Strongly Agree	49	47.6
2.	Mildly Agree	27	26.5
3.	Undecided	6	5.9
4.	Mildly Disagree	7	6.9
5.	Strongly Disagree	6	5.9
	No Answer	7	6.9
	Total	102	100.0

Mean Scale Rating = 1.884

the AAMFC respondents.

Practice of Therapy

The amount of psychotherapy the respondents reported practicing weekly varied greatly, from none to 60 hours. The mean number of hours practiced by all respondents was 21. Table V lists the means broken down by occupational classification, and also the mean hours of family therapy as a subset of the hours of psychotherapy. Pastoral counselors (whose mean was twice that of clergypersons) were closely followed by psychiatrists, psychologists, and psychiatric nurses in number of therapy hours practiced per week.

The two psychiatric nurses included in the population averaged the most family therapy done (mean 22.5 hours/week). Both saw all therapy as family therapy, and had had training with Bowen as well as others. They were followed by the two psychiatrists (mean 16.5 hours/week). One of those identified himself by name and the fact that he is one of the teacher-supervisors at Bowen's center. All of his therapy hours were listed as family therapy in the survey. Psychologists were the only other occupational group who practiced more than ten hours (mean 10.2) of family therapy per week. The mean of the entire sample was 8.2 hours, with standard deviation 7.9 hours.

Table V.

Hours of Therapy Practiced

Occupational Classification	Psychotherapy N	Psychotherapy Mean Hours Weekly	Family Therapy N	Family Therapy Mean Hours Weekly
Clergy	11	14.0	11	7.5
Educator	7	10.9	7	7.0
Family Counselor	1	5.0	1	3.0
Marriage & Family Counselor	16	16.4	16	5.6
Pastoral Counselor	11	28.4	10	4.5
Psychiatrist	2	27.5	2	16.5
Psychologist	23	27.0	23	10.2
Psychiatric Nurse	2	25.0	2	22.5
Social Worker	25	21.5	24	8.7
Entire Population	98	21.2	96	8.2

Licensing

The respondents were asked if they possessed any state licenses. Nearly 74% reported a license in some jurisdiction, 16.7% reported none, and 10% gave no answer or irrelevant answers (such as listing professional organizations).
Table VI shows licensing by occupational group. Psychiatrists, nurses, psychologists, and social workers have been required by law to possess licenses (yet 3 psychologists and 1 social worker did not list them). The statistics for those other professionals who have not in the past had licenses required are encouraging.

Pastoral counselors possessed licenses at a far lower frequency than clergy. This may be because those clergypersons who are in church positions tend to do pastoral counseling in a private practice setting where the licenses are required in some states. According to the Atlantic representative of the American Association of Pastoral Counselors (AAPC), their members are discouraged from seeking licensure. Hagedorn (1978) stated that this is to encourage states to pass licensing laws which differentiate pastoral counselors from other professional counselors as social workers and psychologists are differentiated. New Hampshire is the only state which has a specific license for pastoral counselors,

Table VI.

Frequency Analysis of Licensing

Occupational Classification	N	Licensed Yes	Licensed No
Clergy	10	6 60%	4 40%
Educator	5	4 80%	1 20%
Family Counselor	1	0 0%	1 100%
Marriage & Family Counselor	14	12 86%	2 14%
Pastoral Counselor	8	3 38%	5 62%
Psychiatrist	2	2 100%	0 0%
Psychologist	23	20 87%	3 13%
Psychiatric Nurse	2	2 100%	0 0%
Social Worker	27	26 96%	1 4%
Total Population	92	75 82%	17 18%

and it is the only license which the AAPC approves.

Criteria for Choice of Family Therapy and Position as a Family Therapist

Definitions of counseling, therapy, and family therapy were intentionally omitted from the questionnaire in order to ascertain the respondents' theoretical positions in relation to family therapy.

One of the ways in which the researcher attempted to measure theoretical positions and personal commitments to family therapy was by asking the therapists to check as many criteria as applied from the list tabulated in Table VII.

Almost half said all therapy is family therapy. When the results were cross tabulated with professional affiliation there was an even distribution of this opinion. Essentially no one opposed it, either in the sense of its being a last resort or in not using it at all. Very few used it if a family requested it, perhaps because it is still such a relatively new concept that few families make such a request. A large percentage connected family therapy *per se* with the problem appearing in a child; and over one-fourth used family therapy if the family interfered with treatment of an individual. An equivalent proportion had some other criterion.

Many indicated the other consideration to be an evaluation of the presenting problem.

When comparing criteria, Table VII shows that 48% chose "...all therapy as family therapy." Later, in Item 10, they were asked to indicate the strength of their commitment to that position on a Likert-type scale. The cross tabulation for the 49 respondents from Table VII is shown in Table VIII. The frequency count for the entire population is also shown. There is some inconsistency shown in that 6 respondents, having chosen the criterion "all therapy is family therapy", later disagreed when asked to rate the same statement. The general conclusion is that while two-thirds agree to some extent, one-fifth strongly dissent.

The response to Item 10 (All therapy is family therapy) was also cross tabulated with question 9, wherein the respondents were asked to choose the one position which most closely identified them as family therapists. The results are shown in Table IX.

The chi square test applied to the data summarized in Table IX indicates that the relationship between position on family therapy and attitude toward family therapy is only weakly correlated. Looking at the replies to the question on position, almost half of the respondents would use

Table VII.

Frequency Analysis: Choice of Criterion for Choosing Family Therapy as a Modality

N = 102

Criterion Statement	Count Chosen	%
I see all therapy as family therapy.	49	48
I use it only when other methods fail.	0	0
I use it when family members are interfering with the process of individual therapy.	28	28
I use it when the presenting problem is a symptomatic child or adolescent.	42	41
I use it only when a family requests it.	7	7
I do not use family therapy.	1	1
Other (Please specify)	26	26

family therapy in combination with marital or individual therapy. In the GAP study, most of the respondents indicated that individual therapy developed into family therapy. The GAP researchers stated "...this pluralistic approach of the respondents, using both individual and family therapy, indicates a period of transition and experimentation in therapeutic practices" (1970, p. 11).

The middle column of Table IX reveals the same inconsistency displayed in Table VIII. Only 75% of the respondents whose position was a preference for family therapy for all psychotherapy agreed with the statement that all therapy is family therapy, while 21% (6 respondents) disagreed. Perhaps these inconsistencies could be due to the interpretation by the respondents that what they do personally is family therapy, but not all therapy done by others is family therapy.

In a third way of attempting to measure the respondents' commitment to family therapy, the researcher took Guerin's suggestion (1976) and asked: "If a member of your family were in emotional distress, would you request family therapy for the entire family?" The results are shown in Table X.

Since 63% answered "Yes" to that question, it was expected that there would be a strong positive response to the statement (Item 17): "Symptoms displayed by an individual

Table VIII.

Frequency Analysis on Statement 10:
"All therapy is family therapy"

	Scale Rating	Subgroup from Table VII* N	Subgroup from Table VII* %	Total Population N	Total Population %
1.	Strongly Agree	21	42.9	24	23.5
2.	Mildly Agree	20	40.8	41	40.2
3.	Undecided	2	4.1	5	4.9
4.	Mildly Disagree	2	4.1	9	8.8
5.	Strongly Disagree	4	8.2	21	20.6
	Total	49	100.1	100	100,0

Mean scale rating in total population = 2,620

*This column shows the response of the subset of respondents who chose the first criterion listed in Table VII: "I see all therapy as family therapy."

Table IX.

Cross Tabulation of Personal Position of Therapist and the Statement "All therapy is family therapy"
N = 82, % of total shown

Scale Rating (All therapy is family therapy)	Personal Position of Therapist* II	III	IV
1. Strongly Agree	0 0%	12 15%	9 12%
2. Mildly Agree	3 4%	9 11%	21 26%
3. Undecided	1 1%	1 1%	3 4%
4. Mildly Disagree	1 1%	3 4%	4 5%
5. Strongly Disagree	1 1%	3 4%	11 13%
Totals	6 7%	28 34%	48 59%

Chi square = 9.6785, df = 8, p = .288

*Positions:

I. Family therapy is a viable option, but one with which I prefer not to work.

II. I will refer families with symptomatic children to a colleague who practices family therapy.

III. I prefer family therapy as the method of choice for all psychotherapy.

IV. I use family therapy only in combination with marital or individual therapy.

No respondent chose position I.
Multiple choices were omitted as well as no answer.

Table X.

Use of Family Therapy for Your Own Family.

Response	N	%
Yes	64	62.7
No	23	22.5
Maybe	13	12.7
No answer	2	2.0
Totals	102	100.0

are indicative of family dysfunction." The response is tabulated in Table XI. As expected, 82% agreed to some extent. However, crosstabulation of the responses to the two questions shown in Tables X and XI did not reveal a significant relationship (chi square = 6.553, df = 8, p = .6).

In summary, the AAMFC respondents were fairly committed to family therapy as a modality, although twice as many preferred to use it in combination with individual and/or marital therapy as would use it exclusively. Almost half agreed with the attitude that all therapy is family therapy. Many respondents connected family therapy *per se* with a problem appearing in a child, and 82% agreed that symptoms appearing in one family member are indicative of family dysfunction. As reinforcement, a significant 63% stated that they would request family therapy if an individual in their own family displayed symptoms of emotional distress.

Mechanics of Therapy

It has been suggested that family therapy is defined more by the number of bodies in the room than by any theoretical orientation (Beels and Ferber, 1972, p. 195). Four statements were listed in the AAMFC questionnaire pertaining

Table XI.

Frequency Analysis on Statement 17:
"Symptoms displayed by an individual are indicative of family dysfunction."

	Scale Rating	N	%
1.	Strongly Agree	35	35
2.	Mildly Agree	47	47
3.	Undecided	7	7
4.	Mildly Disagree	6	6
5.	Strongly Disagree	5	5
	Total	100	100

Mean Scale Rating = 1.990

to the number of people involved in family therapy sessions, and respondents were asked to rate them on a Likert-type scale. The statements were:

11. Only therapy which has all family members present at every session is family therapy.

12. Family therapy can be done with individuals.

13. Family therapy can be practiced with any combination of family members according to the decision of the therapist.

14. Individual sessions with the family therapist can be scheduled for family members involved in family therapy.

The results are shown in Table XII. There was quite clear agreement that not all family members need to be present in sessions, that family therapy can be practiced with combinations of family members at the therapist's discretion, and that individual sessions can be scheduled for family members involved in family therapy. However, there was a two to one polarization on whether family therapy can be done with individuals. As a followup on this point, for the seven most frequently cited influential theorists, the percentage of respondents who agreed with the statement that family therapy can be done with individuals is shown in Table XIII. The percentage was highest for Bowen.

Sixty per cent of the GAP respondents reported sometimes focusing on the marital pair. Respondents in the current

Table XII.

Frequency Analysis on Statements on Mechanics of Therapy

	Scale Rating	Statement No.* 11	12	13	14
1.	Strongly Agree	8	32	57	55
2.	Mildly Agree	11	36	29	32
3.	Undecided	0	4	3	2
4.	Mildly Disagree	32	17	10	7
5.	Strongly Disagree	49	13	3	6
	No answer	2			
	Total N = 102				
	Mean Scale Rating	4.030	2.441	1.755	1.794

*Statement No.:

11. Only therapy which has all family members present at every session is family therapy.

12. Family therapy can be done with individuals.

13. Family therapy can be practiced with any combination of family members according to the decision of the therapist.

14. Individual sessions with the family therapist can be scheduled for family members involved in family therapy.

Table XIII.

Cross Tabulation of the Statement
"Family therapy can be done with individuals"
by Theorist

Theorist Cited	N Agree*	%**
Satir	42	71
Haley	24	63
Minuchin	18	62
Bowen	22	78
Ackerman	15	63
Sullivan	15	68
Jackson	15	71

*Number of respondents who agreed with the statement and chose the corresponding theorist.

**Percentage of number of citations listed in Table I represented by the number in column under N of this table.

study gave no consensus on the statement (Item 15): "Once the presenting problem situation with a child has settled, therapy concentrates on the parental dyad (or single parent)." The results are shown in Table XIV. It might have been interesting to repeat the statement changing the word "parental" to "spousing" to ascertain any difference of opinion as to whether symptomatic children are indicating dysfunctional parenting or a dysfunctional marriage.

Some of the definitions for family therapy in the literature alluded to the fact that the family therapist keeps the interest of the family as a whole as his/her primary point of interest. The therapists in the current study responded to that thought in Statement 19 as shown in Table XV. On the whole, 81% agree to some extent, while 13% disagree. A cross tabulation of opinion with occupational category revealed that the disagreement was not confined to any particular discipline, but scattered rather evenly.

The therapists were polled as to whether family therapy is contraindicated in some cases (Item 18). The results are shown in Table XVI. While one in six disagreed to some extent, four times as many agreed. Cross tabulated with professional discipline, pastoral counselors, psychologists, and social workers largely agreed; educators, psychiatrists,

Table XIV.

Frequency Analysis on Statement 15:
"Once the presenting problem situation with a child has settled, therapy concentrates on the parental dyad (or single parent)."

	Scale Rating	N	%
1.	Strongly Agree	13	12.7
2.	Mildly Agree	25	24.5
3.	Undecided	14	13.7
4.	Mildly Disagree	31	30.4
5.	Strongly Disagree	17	16.7
	Total	100	100.0

Mean Scale Rating = 3.140

Table XV.

Frequency Analysis on the Statement:
"The interest of the family as a whole is of primary importance to the family therapist."

	Scale Rating	N	%
1.	Strongly Agree	55	53.9
2.	Mildly Agree	28	27.5
3.	Undecided	4	3.9
4.	Mildly Disagree	8	7.8
5.	Strongly Disagree	6	5.9
	No Answer	1	1.0
	Totals	102	100.0

Mean Scale Rating = 1.832

Table XVI.

Frequency Analysis on the Statement: "There are some cases in which family therapy is contraindicated."

	Scale Rating	N	%
1.	Strongly Agree	40	39.2
2.	Mildly Agree	33	32.4
3.	Undecided	11	10.8
4.	Mildly Disagree	10	9.8
5.	Strongly Disagree	5	4.9
	No Answer	3	2.9
	Totals	102	100.0

Mean Scale Rating = 2.061

and psychiatric nurses tended to disagree; marriage and family counselors were evenly divided.

Table XVII shows response to the statement (Item 16): "Family therapy is always short term therapy." There was clearly disagreement.

In summary, regarding the mechanics of family therapy, it can be stated that a majority of the respondents in the current study agreed that if a family is in therapy, sessions can be held with various combinations of family members, or individual members, or exclusively with individuals, and that all members need not be present at all sessions. There was, however, no clear consensus on whether, if the problem situation presents itself in a symptomatic child or adolescent, once the problem situation is settled, therapy should focus on the parental pair or single parent. The majority agreed also that the interest of the family as a whole was of primary importance to the family therapist, that family therapy was contraindicated in some cases, and that family therapy was not always short term therapy.

Summary of Findings

The current study is a survey of 102 marriage and family counselors in the Mid-Atlantic Division and Virginia Di-

Table XVII.

Frequency Analysis on the Statement:
"Family Therapy is always short term therapy."

	Scale Rating	N	%
1.	Strongly Agree	0	0.0
2.	Mildly Agree	12	11.8
3.	Undecided	5	4.9
4.	Mildly Disagree	39	38.2
5.	Strongly Disagree	46	45.1
	Totals	102	100.0

Mean Scale Rating = 4.167

vision of the AAMFC, classified into 9 occupational categories or disciplines.

Asked to choose or cite those theorists who are important in the field, with one exception the respondents' top ten choices were the same as in the GAP study twelve years ago. Satir was the first choice in both studies.

Eighty nine respondents reported having had training experiences in family therapy, and a majority would like more training. Nearly 74% possessed a state license. As a group, respondents practiced an average 21 hours of psychotherapy per week, 8 of which hours were family therapy.

The AAMFC sample was fairly committed to family therapy as a modality, although twice as many preferred to use it in combination with individual and/or marital therapy as preferred it as the method of choice for all psychotherapy. A large majority would request it for their own families, a fact which was somewhat correlated with the attitude that symptoms in an individual are indicative of family dysfunction. Almost half of the respondents saw all therapy as family therapy, and many connected it with problems appearing in a child or adolescent.

The respondents in the current study and the GAP study appeared to be flexible in relation to the number of people

seen in family sessions, from individuals to combinations to whole families. The majority agreed that the interest of the family as a whole is of primary interest to the family therapist. There was no clear consensus among respondents as to whether the therapeutic focus should be on the parental dyad or single parent once the problem situation with a child has been settled. They did agree that family therapy is not always short term, and that it may be contraindicated in some cases.

CHAPTER V

IMPLICATIONS AND RECOMMENDATIONS

Limitations

The primary limitation of the present study is its brevity. It is limited to 21 items on a questionnaire, many of which are very broad in scope. For example, question 9 asks participants to choose one of four choices to indicate personal position in relation to family therapy. It is probable that if a written definition had been requested for family therapy that the responses would have been even more vague. A large number of questions could have been asked in order to pinpoint the parameters of the respondents' positions in relation to question 9 and others. However, the limitations would be that such a questionnaire would be lengthy, perhaps then drawing a low rate of return. One respondent indicated that he receives 3 or 4 professional questionnaires per week, so is limited as to which ones he is able to return. A lengthy questionnaire would also require calibration through trial with very small samples.

A second limitation is the sample population, both in size and opportunities. Many training opportunities, professional workshops, and approved AAMFC supervisors exist in and near the Mid-Atlantic and Virginia Divisions of the

AAMFC. Respondents in a geographic area which does not have abundant training opportunities might not respond in the same way as those in the present study.

Implications

One of the most important implications is related to the high response rate for this survey: 104 of 182. This sample might be a good one to use for future more detailed research. It is assumed that as members of the AAMFC they are qualified marriage and family counselors who are practicing family therapy (at a higher mean hours of practice per week than the GAP respondents).

It is also implied that since the respondents generally desire more training, perhaps more could be offered by agencies and the AAMFC.

Recommendations

The GAP researchers recommended an integration of the family and psychodynamic theories "...into a comprehensive, balanced framework in which the relationship between the two is clarified" (1970, p. 37). The current researcher recommends the same, since the theorists chosen by the AAMFC practitioners were nearly the same as those chosen by the GAP respondents.

The researcher recommends that AAMFC and the state licensing boards draft some position paper on the definition of family therapy and how it differs from other forms of therapy. It is suspected that if the respondents in the current study were to enter dialogue that much clarification and definition of position would have to be done by each member in the dialogue.

The respondents in this study were not questioned as to whether their work was evaluated in any way or if they were involved in research. Of the GAP sample, only 3% indicated that they were involved in research. One of the AAMFC respondents indicated that he was involved as a researcher with Bowen. Another respondent reported that his/her family was involved with Bowen at NIMH in his early studies. Some of that person's written responses included: "...At the present time we have had so much 'family therapy' that it is not the method of choice (for my own family)... I prefer family therapy as the method of choice for all psychotherapy, but with restricted commitment." The respondent chose Bowen as the favorite theorist, but did not see all therapy as family therapy. Licensed in California as a marriage and family counselor, he/she is not practicing any therapy at this time and strongly disagreed with the

statement about participating in more family therapy training.

In reviewing the literature, the lack of research and evaluation of family therapy was obvious. That issue has been discussed by Wells, Dilkes and Trivalli Burchart (1971, 1976); Olson (1976); Zuk (1976); Russell (1971); Winter (1971); Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971); and NIMH (1974). It is recommended that research and evaluation be done with the family therapy that is practiced today, that the results of the research be analyzed, published, and hopefully, integrated into some formal family theory to be used in the future.

As an incentive for therapists to become active in research, continuing education units could be given for their participation. Possibly AAMFC could require part of their members' continuing education units to be earned in this manner.

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APPENDIX

COLLEGE OF HOME ECONOMICS

VIRGINIA POLYTECHNIC INSTITUTE AND STATE UNIVERSITY

Blacksburg, Virginia 24061

DEPARTMENT OF MANAGEMENT, HOUSING AND FAMILY DEVELOPMENT (703) 951-6163

March 30, 1978

Dear Fellow A.A.M.F.C. Member:

This letter is to introduce Ellen Mason Luce, student A.A.M.F.C. member and one of my thesis advisees. She has recently completed a two-year clinical psychotherapy program and all of the academic class work required for the Master of Science Degree in Management, Housing and Family Development at VPI & SU. She would like to enlist your help in furnishing data for her thesis on the activities of marriage and family counselors in the Mid-Atlantic and Virginia Regions of A.A.M.F.C.

Ellen will appreciate your taking the time to complete the enclosed questionnaire. No name or identification is expected. It will be most helpful to her for the questionnaire to be returned within a week's time.

About September 1, 1978, a summary will be available to those participating in the project. You may receive your free copy by sending a request to Ellen Luce at the address on the return envelope.

Thank you for your time and cooperation.

Sincerely,

Michael J. Sporakowski, Ph.D.
Professor, Family Development

MJS/bc

QUESTIONNAIRE ON FAMILY THERAPY

1. Please check the professional affiliation in each column which most accurately describes you as a professional.

___Clergy
___Educator
___Family Counselor
___Marriage Counselor
___Marriage & Family Counselor
___Pastoral Counselor
___Physician
___Psychiatrist
___Psychologist
___Psychiatric nurse
___Social worker
___Other (Please specify)___________________________

___Ed.D.
___M. D.
___M. Div.
___M. S., M. A. in_________
___Ph. D. in______________
___Other (Please specify)
____

2. Please specify any Family Therapy clinical training and/ or workshops in which you have participated. Also specify location of those programs.

3. Please indicate the professional licenses you possess, and in which jurisdictions.

4. How many hours per week are you engaged in the practice of psychotherapy?______________________

5. How many of those hours are devoted to family therapy?

6. Which of the following theorists are most closely related to your thinking? Please indicate first (1), second (2), and third (3) choices if you have more than one.

___Ackerman
___Bateson
___Bell
___Boszormenyi-Nagy
___Bowen
___Haley

___Jackson
___Minuchin
___Satir
___Sullivan
___Wynne
___Other (Please specify)
____

7. What are your criteria for the choice of family therapy as a method? Check as many as apply.
___I see all therapy as family therapy.
___I use it only when other methods fail.
___I use it when family members are interfering with the process of individual therapy.
___I use it when the presenting problem is a symptomatic child or adolescent.
___I use it only when a family requests it.
___I do not use family therapy.
___Other (Please specify):

8. If a member of your family were in emotional distress, would you request family therapy for the entire family?
___Yes ___No

9. Which <u>one</u> of the following positions most closely identifies you in relation to family therapy?
___Family therapy is a viable option, but one with which I prefer not to work.
___I will refer families with symptomatic children to a colleague who practices family therapy.
___I prefer family therapy as the method of choice for all psychotherapy.
___I use family therapy only in combination with marital or individual therapy.

Please read each statement and circle the number which most clearly represents your position on the issue.

1. Strongly agree (SA)
2. Mildly agree (MA)
3. Undecided (U)
4. Mildly disagree (MD)
5. Strongly disagree (SD)

	SA	MA	U	MD	SD
10. All therapy is family therapy	1	2	3	4	5
11. Only therapy which has all family members present at every session is family therapy.	1	2	3	4	5
12. Family therapy can be accomplished with only one family member present.	1	2	3	4	5
13. Family therapy can be practiced with any combination of family members according to the decision of the therapist.	1	2	3	4	5

	SA	MA	U	MD	SD
14. Individual sessions with the family therapist can be scheduled for family members involved in family therapy.	1	2	3	4	5
15. Once the presenting problem situation with a child has settled, therapy concentrates on the parental dyad (or single parent).	1	2	3	4	5
16. Family therapy is always short term therapy.	1	2	3	4	5
17. Symptoms displayed by an individual are indicative of family dysfunction.	1	2	3	4	5
18. There are some cases in which family therapy is contraindicated.	1	2	3	4	5
19. The interest of the family as a whole is of primary importance to the family therapist.	1	2	3	4	5
20. I would like to participate in more training opportunities available in the area of family therapy.	1	2	3	4	5

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FAMILY THERAPY IN THE MIDDLE ATLANTIC AND VIRGINIA DIVISIONS OF THE AMERICAN ASSOCIATION OF MARRIAGE AND FAMILY COUNSELORS

by

Ellen Mason Luce

(ABSTRACT)

A committee of the Group for the Advancement of Psychiatry (GAP) surveyed family therapists in 1966. Those respondents consisted mostly of psychiatrists, psychologists, and social workers. Since that time, the number of therapists from other affiliations has increased. Those professionals had not previously been surveyed as to their theories and practices. A sample of 102 American Association of Marriage and Family Counselors (AAMFC) included clergy, educators, marriage and family counselors, pastoral counselors, and psychiatric nurses as well as psychiatrists, psychologists and social workers. The AAMFC members were in agreement as to the theorists who were the most influential in their field, Satir having been the first choice.

Although the AAMFC therapists practice an average of only eight hours of family therapy per week, usually in combination with other therapies, they are fairly committed to it as a treatment modality, even to the point of considering it for their own families if an individual member were

in distress. Many connected family therapy with problems appearing in children or adolescents and many saw all therapy as family therapy.

The respondents were flexible in relation to the number of people seen in and apart from family sessions, in relation to duration of treatment, and in relation to the idea that family therapy can be contraindicated in some cases. The majority agreed that the interest of the family as a whole is of primary concern to the family therapist.

It was recommended by the GAP researchers and the current researcher that a theory of family therapy be developed integrating family and psychodynamic theories, that a definition for family therapy be formulated, and that continued clinical research be done in the area of family therapy.