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## Nakamura, Shin-Ichi

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### Name

Shin-Ichi Nakamura, M.D.

### Introduction

Shin-Ichi Nakamura is well known for his contributions to the field of family therapy for studying aspects of cultural diversity and cross-cultural research. He is a well-known mental health professional in Japan. More specifically, he has explored family therapy techniques within Asian populations including those from Japan, Taiwan, Hong Kong, Korea, and Mainland China. Dr. Nakamura has also been one of the main leaders who has brought forth and supported initiatives and organizations to influence the education and training of mental health professionals in Asian regions as well as studies the group dynamics within and across Asian cultures.

### Career

Shin-Ichi Nakamura is a psychiatrist who obtained his medical degree from Juntendo University, School of Medicine in 1975. He also received his Doctor of Medical Science in 1983 and became certified by the Japanese Society of Psychiatry and Neurology the same year. He became a member of the American Family Therapy Academy (AFTA) in 1990 and has been supervised by Linda Bell, Ph.D., an AFTA member, as well as Dr. Arthur Mandelbaum and Dr. Stephan Jones; the latter two are both directors of the Menninger Clinic in Topeka, Kansas. He also was a cofounder, member, and President of the Japanese Association of Family Therapy and is a member of the American Family Therapy Academy in Hong Kong. Dr. Nakamura is also a council member and Vice President of the Consortium Institute on Family in the Asian Region for Japan and Korea. He currently practices in Tokyo/Kanto area of Japan, providing therapy in both English and Japanese at the Nakamura Psychotherapy Institute, where he is also the director. He is also the general manager for the Asian Center for Therapeutic Assessment and is also connected to the Taiwan Institute of Psychotherapy. In his practice, his specializations include family therapy (children and adolescents) and help couples through sexual dysfunction, infidelity, and depression.

### Contributions to the Profession

Dr. Nakamura's work began as a part of a group of psychiatrists who wanted to promote family


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therapy in Japan. Following the works of Bateson, Whynn, Lidz, Bown, Haley, and others, he and other psychiatrists formed a group to study family pathology in schizophrenics with Asian clients. This later broadened to family therapy. Through this work, he and nine members created the Japanese Association of Family Therapy to serve the community as well as other mental health professionals. He also studied couples and found variations of couple arguments within five Asian regions that he studied. He points out that ignoring body language and only focusing on direct communication would be detrimental to couples' work. In his 2013 article, he mentions that though a therapist can assume to be very neutral with couple interactions in therapy, what a therapist observes is most often a reflection of the cultural biases of the observer. He also noted that although a therapist is a senior level clinician in terms of experience, they still won't experience couple solutions and process issues in the same manner as other couples. Additionally, relationships and arguments will take different forms regardless of the cultures involved, even if both partners are from the same cultural background in comparison to other Asian groups. He encourages therapists to not follow a prescribed list of "shoulds" and "should nots" around theory, culture, and gender and look more toward sharing the family's realities.

In addition, Dr. Nakamura wrote about the fluidity of culture and how cultures evolve from moment to moment through experience. He noted the difficulty in studying culture with measures and measurement both quantitatively and qualitatively. Further, he mentions the importance of meaning and how that can translate differently when comparing different countries (i.e., Japan and the USA), no matter how similar or different the traditions are because they aren't always on equal/similar playing fields due to language, gender, history, and/or hidden or noticeable stereotypes/categorizations. He also encourages those doing cross-cultural research to have flexibility, understanding, sincerity, and methodological rigor as well as caution, humility, and compassion. With all of these tools, cultural diversity and cross-cultural research will be enhanced and held to a higher standard.

## Cross-References


- ▶ Family
- ▶ Family Conflict in Couple and Family Therapy
- ▶ Family Therapy


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# Napier, Augustus


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## Name

Napier, Augustus

## Introduction

Augustus Napier was a respected pioneer in the field of family therapy and one of Carl Whitaker's best-known associates. His wife Margaret was also a therapist, and they founded a practice together where they did co-therapy.

## Career

Napier received his doctor of philosophy degree in clinical psychology from the University of North Carolina at Chapel Hill. He then studied with Carl Whitaker in the department of psychiatry at the University of Wisconsin. He served as part of the faculty at the university for almost 10 years after which he moved to Atlanta. Along with his wife, Margaret, he founded a treatment and training center called *The Family Workshop* in Atlanta where he served as the director. After his retirement Napier rediscovered his early interest in photography and poetry and even published a book titled *Convergence: Photographs and Poems*.

## Contributions to Profession

Augustus Napier was an experiential family therapist. He studied under Whitaker and with him published one of the best-selling and widely used books in training, *The Family Crucible*, in 1978. The book is a detailed case study of a family that Napier and Whitaker saw in therapy together as co-therapists. Napier describes how, by the experiential use of their selves, he and Whitaker supported yet provoked the family to participate and take risks in therapy. Whitaker's style of experiential family therapy was very much a product of his charismatic personality with improvisations and intuitive approaches that may be hard to replicate by budding therapists. The works of Napier, on the other hand, made experiential therapy more accessible to therapists.

Napier stressed the use of evocative techniques and the strength of therapists' own personality in creating powerful therapeutic encounters for clients in therapy. He believed in providing clients an experience in therapy that they may not have otherwise experienced in their day to day lives. He believed that these experiences will be of symbolic importance, for example, therapists are often symbolic of a parent or an authority figure. A here-and-now experience with the therapist that is real and powerful, according to Napier, can become a corrective experience for clients in working out issues that they may have had with their parents in a symbolic way. In his works, Napier wrote descriptions of interventions and techniques and explained how they served as catalysts for change to occur. He was also the one who insisted on therapists setting limits on how far they push clients in session.

Napier was also a strong proponent of co-therapy. He acknowledged that having two therapists in a room can be expensive. However, he believed that doing family therapy was complex, and in order to prevent the therapist being sucked into the destructive patterns of the family, it was important to utilize a co-therapist. Napier also believed that the art of experiential family therapy cannot be easily taught as it is atheoretical and atechnical. There is a high focus on therapists' intuitive process. Therefore, teaching experiential theory is best done, according to Napier, in a co-therapy context.

In his tenure as a family therapist, Napier published several books and papers. He also presented workshops and seminars nationally and internationally. Besides *The Family Crucible*, another best-selling book of his is titled *The Fragile Bond*, which was a book that portrayed Napier's marriage, how they worked on their bond, and their work together as a co-therapist.



## Cross-References


- ▶ Experiential Family Therapy
- ▶ Whitaker, Carl


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# Narrative Couple Therapy

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## Introduction

From the beginning of its development, narrative therapy has found a home in couple and family therapy, although narrative practices are also used in individual and group therapy, community work, consultation, and mediation.

## Prominent Associated Figures

Michael White and David Epston (1990) were the original developers of narrative therapy, and both of them used narrative ideas in working with couples. All of the contributions to narrative work with couples (Freedman and Combs 2015; Payne 2010) are built on their original ideas.

## Theoretical Framework

Narrative therapy is based on the idea that we experience life through stories. Stories are formed through people's experiences and the meaning they make of those experiences. These meanings are not made individually. People make meaning in relation to other people, to normative cultural discourses, and to contextual and historical influences. When relationships or partners in a couple do not measure up to discourses of what a relationship or partner should be in their particular context, people often judge their relationship or their partner to be problematic. For example, when people compare their relationship to the cultural idea that partners in a relationship should be "soul mates" or should be everything to each other or that healthy couples have sex a certain number of times a week, they may evaluate their relationship as problematic. Or if a person compares their partner to a set of idealized characteristics, they may locate the problem in their partner. Discourses may also support problematic actions or power inequities (Dickerson 2013). Gender discourses and patriarchy may be particularly important to expose when intimate partner violence has occurred or is occurring (Jenkins 2009). For example, patriarchy supports men treating women and children as property, thus creating a context that recruits men to act in ways which may culminate in abuse and violence. Narrative therapists locate problems in discourses or in people's relationships with discourses. When discourses are exposed and their effects are talked about, people are in a position to change their relationship with those discourses.

Not all experiences become included in the stories that people tell of their lives and relationships. There are many experiences that people have not made meaning of, but that narrative therapists can ask questions about and that could become important stories in the life of a relationship and its partners. The purpose of narrative therapy is to engage people in the telling and experiencing of preferred stories about their relationships, themselves, and their identities. The purpose is not to help shape relationships in any particular predetermined way. Narrative therapists believe that as people engage in the retelling of preferred stories, they reexperience them. These retellings create grounds for continued experience that is in keeping with the meaning, purposes, and ethics implied by the stories.

Particularly relevant to couple therapy is the notion of identity as relational and shifting, rather than individual and essential. Narrative therapy includes the idea that people's identities change through time, shaped through relationship, culture, context, and choices that people make (Combs and Freedman 2016). Membership in a couple, then, contributes to each partner's identity (Freedman and Combs 2004).

Narrative practice is collaborative, building on the idea that people are the preferred authors of their own stories. The therapist endeavors to stay in a decentered but influential position, asking questions that provide the opportunity to deconstruct problematic stories and author preferred ones.

Narrative therapy does not include the idea that couples should have a particular kind of relationship. Therapists ask what members of the relationship find problematic and what they prefer, rather than guiding them into particular kinds of interactions or priorities or role arrangements.

## Populations in Focus

Narrative therapists generally work with whoever would like to engage in therapy. Couple therapy is often between two people who would like their relationship to be different. This often means that couples who come to consult narrative therapists consist of people in an intimate partner relationship who are in conflict, who have experienced a problem, or who are dissatisfied with their relationship. It can also include couples who want help deciding whether to stay together or couples that include one partner who would like the relationship to change or end and the other who does not. Some couples come to therapy, not because of a problem but to enrich their relationship. Narrative therapists also work with couples after they separate or divorce to help with issues such as co-parenting. Narrative couple therapy can address couples with sexual problems (Findlay 2012; Gershoni et al. 2008) and those with conflicted relationships to help prepare for separation or divorce (Madigan 2017). Ideas from narrative couple therapy can also be helpful in working with parent-child pairs, friends, and people with difficulties in work relationships. Additionally, for people involved in polyamory, narrative relational therapy may be a useful context for conversation.

## Strategies and Techniques Used in Model

### Witnessing and Positioning

Often, members of a couple come to therapy hoping that a therapist will align with them or act as a judge or perhaps a teacher, offering communication tools or assignments. Since narrative therapists have different purposes – the telling and retelling of preferred stories – it is important to create a structure that facilitates each partner listening to and understanding the others' stories (Freedman 2014). This structure is designed to engage one couple member at a time in that telling and provides space for the other member to give reflections or act as a witness and perhaps to extend the retelling. This structure fits with the way narrative therapists think of people as the privileged authors of their own stories. The therapist speaks to one member of the couple, drawing out descriptions of his or her experience while referring to the other – the witnessing partner – in the third person. At times, the therapist turns to the witnessing partner and invites reflections, taking care to keep in mind the primary purposes of deconstructing problematic stories and developing preferred ones. If the therapist asks a very general question, such as "What were you thinking as your partner spoke?", the witnessing position may be lost as the partner asserts how their partner is mistaken or how something else is more important. But if guided by the purposes of the narrative metaphor, the therapist can ask reflecting questions, such as "What did it mean to you to hear that your partner was considering your preferences in that decision?", that invite shared understanding and development of new understandings.

At times, it is difficult for people to stay in a witnessing position, particularly when conflict, anger, or hurt stand in the way. When this occurs, narrative therapists may suggest particular lenses or positions from which to listen (White 2004). Examples of such positions include a position of friendship or listening through the lens of shared hopes for the children. These positions may be set up in a variety of ways, such as through a series of questions that invite people to reaccess times that they occupied the position, through a discussion that invites people into a context in which they use the position, or simply through a suggestion.

### Asking Questions

The main practice in narrative therapy is asking questions. Narrative therapists use questions to generate experience rather than to gather information. Two important purposes in asking questions are to facilitate unpacking problems and to

facilitate developing preferred stories. In the unpacking process, discourses that support problems often become visible. Once discourses are visible, people are in a position to choose how to relate to the pulls of those discourses. Additionally, in the unpacking process, moments that stand outside of and would not be predicted by problems become visible. These moments can be starting points for developing preferred stories and for making new meaning. Narrative practitioners hope to assist people in thinking the not-yet-thought and saying the not-yet-said through questions.

Narrative therapists ask questions to assist people in telling stories and to invite people to reflect on the meaning of those stories. As they reflect on the developing stories of their life and relationship, people often appreciate what their partners give value to. This recognition contributes to their partner's identity. At other times people reflect on opportunities to know themselves in new ways that have become available in the relationship. This also can contribute to identity. Given the opportunity for these kinds of reflections, couple therapy is an ideal context for therapists to assist people in developing preferred identity conclusions. Narrative therapists ask questions inviting members of a couple to consider how they are becoming different through their relationship and how their relationship contributes to this.

### Deconstructive Questioning

Deconstructive questions (White 1991) unpack people's description of their experience with the purpose of showing how their stories are constructed, with the implication that they could be constructed in different ways. They may expose cultural stories that propose standards that couples may be comparing their partners or relationships to or that may be supporting problematic actions (White 2011). Cultural stories can also support power differences and set the stage for intimate partner violence. Unpacking people's descriptions and asking experience-near questions about each partner's expectations, beliefs, and ideas about how one should act, about communities or people supporting such actions, about gender socialization, etc. can contribute to conversations in which people become aware of possibilities that lie outside the dictates of cultural norms.

### Externalizing Conversations

Engaging in conversations with people to name problems so that people are clearly separate from those problems is a hallmark of narrative therapy (White 2007). Narrative therapists assist people in capturing what they are finding problematic in experience-near names, rather than in psychological terms. Externalizing conversations are deconstructing conversations because they unpack the psychological discourse that problems are characteristics of people. Through these conversations people describe their relationship with problems and the effects the problems are having on their life. Since members of a couple often locate the problem in each other, these kinds of conversations can be particularly important. Through externalizing conversations couples often join together to have a different relationship with a problem, rather than blaming each other or locating the problem in each other. Members of a couple may agree on what is problematic and together they can collaborate to name the problem in an experience-near way. Alternatively, each partner may name a different problem. In the second case, it usually is important for each partner to witness the other's experience of what they have named as the problem.

### The Absent But Implicit

In order for something to be discerned as a problem, it is being contrasted with something not problematic – the absent but implicit (White 2000). The absent but implicit has to do with what people treasure. Problems occur when what is treasured is not being lived out or available. Asking about the absent but implicit can completely change a conversation from one of blame to one of what is being longed for (Carey et al. 2009; Freedman 2012). To arrive at the absent but implicit, it can be helpful to ask what a member of the couple is missing or why it is important to describe the complaint in front of the partner.

### Developing Preferred Stories

The primary purpose of narrative therapy is to engage people in the telling and retelling of preferred stories. Deconstructing conversations and working with the absent but implicit are used to help people see beyond problematic stories and what those stories predict for people's lives and relationships to other experiences – experiences that would not be predicted by the problematic story line and that feature what people give value to. These experiences and values can be starting points for the telling and retelling of preferred stories. Stories are a sequence of events that happen over time according to plot. To facilitate telling preferred stories, narrative therapists ask about details of events, the people involved, the history of events, the actions taken over time, as well as the skills, abilities, and knowledge implied by the stories, the meaning the stories hold for the couple and members of the couple, and the implications for their identities.

### Naming the Problem and the Project

As people tell preferred stories, therapists often ask about whether these stories indicate a direction in life or what the couple gives value to. It can be useful for people to arrive at a name that captures what they would prefer, rather than the problem. Once a problem and project are named, these names can help organize the therapy and highlight new directions. Therapists can ask about whether particular actions or decisions fit more with the problem or the project; they can ask people to describe what is different when the project is moving forward, rather than when the problem is operating; etc. These names are helpful to organize experience for people who are coming to consult as well as for therapists who may be guided by these names in asking relevant questions.

### Documents

One of the ways that narrative therapists extend the work of the therapy conversation is through documents (Fox 2003; White and Epston 1990). Documents can take many forms, including letters that summarize a therapy conversation and pose additional questions, certificates marking achievements, decisions or turning points, and lists that enumerate knowledge, strategies, or achievements. Particular to therapy with couples are letters written to the relationship by the therapist or the couple and letters from the relationship to the couple (by the couple or by the partners separately).

Documents are one means of retelling and thickening preferred stories. They can facilitate sharing preferred stories with an audience so that couples have witnesses to their new directions and possibilities and they can serve as a way of sharing insider knowledge with others for whom it might be useful. This sharing of insider knowledge is a hallmark of narrative therapy. This practice recognizes the hard-won knowledge of people dealing with problems. It serves to help others. And those who agree to share their documents often find it very meaningful to know that they are helping others.

### Internalized Other Questioning

One type of interview that some narrative therapists use is called internalized other questioning (Epston 1993). Based on the idea of relational identity, the therapist asks one partner to embody their internalized version of their partner and to answer questions as the partner. After the interview there is a kind of debriefing, in which the partner who was portrayed is asked if the answers fit and what it meant to hear them. Then the witnessing partner is asked to embody their partner for an interview.

### Linking Lives Through Shared Purposes

Because narrative ideas are situated in relational identity, rather than individualism, and because local knowledge and insider knowledge are privileged over professional knowledge, finding ways to join people around shared purposes is a valued practice. This joining can be through sharing documents featuring insider knowledge, through letter writing campaigns in which people are invited to write to couples in response to particular requests, or through inviting others to witness couples' stories as outsider witnesses or members of a reflecting team.

## Case Example

When Caroline and Sophie came to therapy, they had been together a year and a half and had been living together for about 9 months. In response to initial questions about what they appreciated about their relationship, they said that they felt safe and secure together, that they had mutual values and interests, and that they had been able to shape a life together that they both thought was a good one. Caroline described hiking and travel together that she enjoyed. Sophie said that she appreciated feeling understood and supported most of the time. The partners both thought that they had a very good relationship until recently when they began arguing and not feeling understood or respected.

Caroline had previously been in a heterosexual marriage and had a 24-year-old son, Mark, who was living in Europe and rarely visited in the US and a 21-year-old daughter, Emily, who had been in college in a different city when the couple got together. Caroline had been divorced for 12 years. Although her children initially lived with her after the divorce, both had been away in school programs and other activities most of the time for more than 4 years. Their more recent time at home had been divided between Caroline and her ex-husband.

Sophie had had a number of long-term lesbian relationships and had no children. She said that she was not close to her parents who lived in another state but that she visited them occasionally.

One area of difficulty that seemed to have opened the door to what the couple initially named "the difficulties and conflict" had to do with their relationship with Caroline's 22-year-old daughter, Emily. As Caroline listened from a witnessing position, Sophie told how they had established their relationship as two women, living alone. Of course, Sophie knew that Caroline had children but she thought they would only be occasional visitors. She described an earlier 5-day visit from Emily. She said that Emily did not clean up after herself and did not respect the couple's privacy. Even worse was that Caroline seemed like a different person when Emily was around. Suddenly, Caroline was enthusiastic about doing things that hadn't interested her before. Their schedule was completely disrupted as Caroline responded to Emily's every whim to go shopping or go out to eat or go to movies. When Caroline stopped listening and began to protest that Sophie could join them, I (JF) asked her to listen from a position of friendship, almost as though Sophie was not talking about her and Emily, but as though she was a friend talking about her own life.

After Sophie filled in more details, I asked what this was like for her and she said that it was extremely upsetting, particularly because Emily had decided to move back to Chicago when she finished college at the end of this semester and Sophie was sure this meant that she would be visiting much more frequently. Caroline's delighted response to this plan led Sophie to believe that their relationship did not come first. This was a knowledge that was hard to live with and that created distance and conflict in their relationship.

Caroline seemed distressed as she was listening. Letting her know that we would also be hearing her experience, I asked what she, from a position of friendship, understood was distressing to Sophie. She described the feelings of not being important to Caroline that she thought Sophie experienced and the experience of the chaos involved in having a young person in their home. I asked Sophie what it was like to hear Caroline's understanding of her situation. She acknowledged that it was important, but that it would have been even more important to have felt understood at the time and more important than that was the issue of future visits.

I let Sophie know that I wanted to spend time talking about that, but I wasn't sure we could address it in the initial conversation. I wanted to make sure to hear from Caroline. Sophie agreed to listen to Caroline from a position of friendship.

Caroline spoke of her love for Sophie and how she wanted to spend the rest of her life with her. She also said that she felt like Sophie did not understand that she was a mother and that Sophie was asking her to act as if she wasn't. Her love for Emily did not take away her love for Sophie, but

she felt that Sophie was asking her not to act like a mother in order to prove her commitment to the relationship. She said that Sophie had asked her to ask Emily not to make a mess when she visited and to respect their schedule and not to take time away that Caroline usually spent with Sophie. Caroline said that when she imagined doing that, it felt like a betrayal of her relationship with her daughter and with herself as a mother. She described being torn between her partner and her daughter. Both were extremely important relationships for her and she didn't understand why she had to choose.

I asked Sophie if, listening from a position of friendship, she understood anything that she had not understood before. She said that it was hard to listen. She was committed to Caroline but she met her as a single woman. Her children had not been there and she hadn't recognized them as an important part of Caroline's life. She was beginning to understand that they were, but she was not happy with that understanding.

In the last quarter of the interview, I wondered how the couple had been able to move beyond the difficulty and hurts on both sides that resulted from the different experiences they had of Emily's visit. They talked about the distance and misunderstanding that had been there at first and described how they had been able to find their way back to connection. They talked about how a mutual friend called them when her partner unexpectedly ended their relationship and how they had come together to help and support and distract their friend. When I asked what this said about their relationship, they said that it showed that they were a good team and that they shared values. To help them to relive this story, I asked about details of their experience. I used the words that they had introduced for the problem – distance and misunderstandings – and wondered if their being a good team and having shared values might be important in dealing with the distance and misunderstandings. They answered affirmatively but tentatively that they might.

Between the first and second meeting, I sent a letter to the women summarizing my understanding of each of their experiences and asking several questions:

- Even though distance and misunderstandings have entered your relationship, you were able to put those aside when a friend asked for help. How did you do that? Is there something that you might learn from this that will be helpful in other situations?
- You said that there were a number of situations characterized by distance and misunderstandings, although we only spoke of one. Are there new understandings from our conversation that also might apply to these situations?

My hope was that these questions might provoke thought between our meetings.

In the next meeting, Sophie seemed a bit more understanding about Caroline's relationship with Emily and Caroline seemed grateful but careful, not sure how much room there really was. We considered other situations in which distance and misunderstandings had taken over. The couple seemed to be developing more stories of understanding and room for each other.

In the third meeting, Sophie revisited some of the problems she talked about in the initial meeting, particularly focusing on how she entered the relationship thinking it was one of two single, unattached women forming a couple, but now Caroline no longer seemed to be an unattached woman or a woman only attached to her. In responding to deconstructing questions, Sophie spoke about friends and other lesbian couples who only had each other and friendship networks. In response to further questions, Sophie described her experience coming out more than 30 years earlier and being supported by a network of women. One of the ideas she embraced in this process was that biological ties were not important. People could choose partners and create families of choice. She believed that she and Caroline were engaging in that process but that Caroline had thrown it all aside the moment Emily came into the picture.

In response to questions about the effects of the idea of only having each other and creating a family of choice rather than biology, Sophie began to see that the way these ideas shaped her expectations left little room for Caroline to have any kind of relationship with her daughter

and still be in the relationship with Sophie. No new conclusions were reached in this conversation, but it did seem to be unsettling the status quo and opening space for more conversations about other possibilities.

Then in the fourth meeting, Caroline said that Emily was staying at their apartment while she looked for an apartment in Chicago. She feared that the understanding and room was shrinking as the days went on. It was a shame, she said, because Emily wished she could get to know Sophie. Emily loved Sophie's paintings on the apartment walls and wished she could ask her about her art. She also said that she thought she saw some things about Sophie as a person in what she painted that were interesting to her.

Sophie was very still on hearing this. When asked to reflect, she said that she was stunned and asked if this could honestly be true.

At the next meeting, Caroline announced that she was thrilled that Sophie had invited Emily to her studio and that Emily was working on an art project there. I asked how that made a difference at home. Caroline said that everything was different. Sophie was warm and relaxed and Caroline had not realized that fear was making her hesitate about doing things with Emily, but now the fear was shrinking.

Turning to Sophie, I asked what happened that allowed her to take the step of inviting Emily to her studio. She said that when she heard that Emily understood something about her through her art, she became very curious about what Emily saw. She had been seeing herself as a grouchy woman not wanting to be a stepparent, but she imagined that Emily must have seen something else, so she began watching Emily watching her and looking at her paintings. She liked the expression on Emily's face as she looked at the paintings and that helped her see Emily differently. It was a turning point, leading the way to inviting Emily to the art studio and being in a different kind of relationship with her. When the two came back to the apartment, Sophie was not sure how Caroline would feel seeing that they had had an important experience without her. Caroline, though, seemed to feel wonderful about it. That created a ground in which the atmosphere changed, and sometimes the three could be together and at other times they could be together in different pairs.

When I asked Sophie what made this so wondrous, she described a contrast with relationships earlier in her life in which she felt left out and concluded that she only did well in contexts with one other person. I pursued three lines of questions in the remainder of the interview. One was about what she thought Emily appreciated about her and what it was like being appreciated in that way. The intention of this line of questions was to create the opportunity to draw new identity conclusions. The second line of questions was about experiences of comfort and belonging with more than one person at a time. These questions helped develop and thicken stories of relationships including others. The third line of questions was about the possibility of forging a relationship that included family. Sophie brought up the idea that biological family members could also be family members of choice.

Caroline's reflections included an acknowledgment of how important it was to her to hear Sophie include Emily in her family of choice. This development gave her hope about including Mark as well.

We continued meeting for several months, developing stories of understanding and room.

## Cross-References


- ▶ Feminism in Couple and Family Therapy
- ▶ Postmodernism in Couple and Family Therapy
- ▶ Questions in Couple and Family Therapy
- ▶ Training Narrative Family Therapists


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# Narrative Family Therapy

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## Introduction

Narrative practices offer a unique nontraditional approach to psychotherapy. In this chapter, we will address the complexities and the various applications of narrative practices that are relevant when working with families. We will summarize aspects of the significant shift in paradigm that shapes the philosophy of narrative therapy particularly with families, briefly describing these key concepts and the practices that emerge from them.

## Prominent Associated Figures

The pioneering work of ▶ "Michael White" (White and Denborough 2017) and David Epston (White and Epston 1990; White 2007) is a major source and stimulus for many of the ideas expressed in this chapter. Narrative practices are located within postmodern, social constructionist and poststructuralist traditions. Authors whose ideas are commonly characterized within these theoretical orientations include Michael Foucault, Jacques Derrida, Gilles Deleuze, Mikhail Bakhtin, Arnold van Gennep, (Victor Turner 1977), and Jan Fook.

## Theoretical Framework

Narrative practices include a robust philosophical worldview about how to be with people and how people change. It is a highly respectful person-centered therapeutic approach. This makes it possible to move beyond demoralizing conversations that are laden with expert knowledge, to re-moralizing conversations, which privilege

peoples' local knowledge. These re-moralizing conversations make it possible to avoid the use of deductive questions that aim to categorize people's identities, (through normalizing language, psychiatric diagnoses, labels emerging from psychological assessment, the language of personality types, and so on, which all totalize people's identities and obscure uniqueness, resilience, and context) and instead use inductive, invitational questions that view "identity" and "family" as situated within life as an open process. There is an emphasis on people's possibilities rather than their limitations, their abilities rather than their deficits, and what is strong rather than what is wrong with people.

As a result of this movement away from normative thinking and what is routinely thought, narrative therapeutic conversations create novel space to become permeated with curiosity about peoples' cherished values, commitments, preferences, hopes, and dreams. This poststructural curiosity helps therapists to stay focused on asking questions to which they genuinely do not know the answer. These questions that are situated in a not-knowing therapeutic posture (Anderson 1997) generate new experiences and understandings that open up an expanded range of new possibilities to reconnect people with their strongly held values, hopes, dreams, and purposes.

As it is situated in a theoretical orientation that draws primarily from philosophy, anthropology, ethnography, and critical theory, narrative family therapy is distinct from other traditional forms of family therapy. Postmodern, social constructionist, and poststructuralist theoretical backdrops inform narrative practices. These theoretical orientations offer a nonnormative pluralistic philosophy. This philosophical worldview differs from the assumptions of traditional family therapy, which is more often situated within systems theory. Narrative practices with families have moved from an understanding of systems to an appreciation for stories (Freedman and Combs 1996).

A postmodern worldview recognizes multiple realities and multiple possibilities for the performance of identity. It assumes an overall position of skepticism and distrust of master narratives. Within a framework of critical reflection, everything, including narrative therapy, is called into question. This includes a distrust of ideas such as human nature (e.g., that's just the way he is), objective reality (e.g., he has ADHD), and singular truth (e.g., all politicians are liars). In its place, it asserts that knowledge, rather than being a product of subject-object, causal-linear discovery, is created through mutual process. It asserts that claims to knowledge and truth are products of sociocultural and historical discourses and interpretations and are contextually based and constructed.

Social constructionism (▶ "Social Construction and Therapeutic Practices" by Gergen 2017; Freedman and Combs 1996) is a theory that studies the creation of mutually constructed views of the world that form the basis for shared assumptions of reality. The theory asserts that human beings make sense of and justify their experience by creating representations of their social world and then express these representations through intersubjective language. Narrative conversations both include language that is a result of lived experience and generate experience through inductive questions.

Poststructuralism (Dickerson 2014) is characteristically defined by its connection with structuralism. Structural concepts of dualism and the implied hierarchical contexts that accompany them are rejected. Dualistic ideas include binaries such as male/female, good/bad, and right/wrong. Poststructuralism also rejects the notion of the fundamental quality implied in these relationships and proposes that one way to understand these meanings and conclusions is to call them into question. This involves deconstructing the assumptions that create the impression of singular meaning.

Poststructuralism offers a way of examining how knowledge is produced and critiques thin structuralist premises, acknowledging that history and cultural conditions are subject to biases and misinterpretations. A poststructuralist approach argues that to understand a person in a family or a family itself, it's necessary to appreciate the sociocultural context in which they are situated.

## Key Concepts

### Story

Story is the central concept, the *raison d'être* in the practice of narrative therapy with families. Traversing generations since the beginning of time, diverse cultures have created numerous forms of story. However, they all contain the universal characteristics of a beginning, middle, and ending, which in many cultures are understood as rites of passage. Stories have withstood centuries of use following this time-tested pattern. This simple story form is how the meanings for understanding and living life were embraced and evolved through many different societies, communities, and families and then were passed on through generations. Stories bear and pass on lasting values that form belief systems and discourses, which families use to construct their collective meaning and navigate their lives (Duvall and Béres 2011).

The complexity and uncertainty of contemporary life challenge therapists to respond to constantly shifting cultural values and discourses that affect families. Narrative practices, with their incorporation of story, are well suited to aid therapists and families in addressing complexities and revising their stories to become more congruent with preferred realities.

The characteristics of story are highly relevant to therapeutic practice. A therapy session can be viewed as a story with a beginning, middle, and (sort of) ending. The three sequenced phases create the therapeutic process as rites of passage (van Gennep 1960) and offer a process for managing intense transitions in life. The three phases are:

1. *The separation or pre-liminal stage*. (Call to change) During this stage, there is an exploration of what is most important to understand and talk about with the family and obtain an understanding of how they are situated within their unique sociocultural context.
2. *The transitional or liminal stage*. (Quest) This stage can be understood as a journey or betwixt and between phases. During this time in the therapy session, a rich conversation between the therapist and the people who consult her takes place, and many previously hidden subordinated stories are made visible. This transitional stage involves a social collaboration with others that makes possible regeneration and renewal of knowledge.
3. *The reincorporation or post-liminal stage*. (Resolution) This final stage invites a reincorporation of identity by integrating the new learning from the middle stage with preferred values and abilities from the past. People are asked about how they would propose to take the ideas, skills, and abilities forward toward a preferred way of living their lives and relationships. This final phase includes *looking back-looking forward* temporal orientation.

The three primary elements of story provide the properties to hold a theme or plot. This bears a sense of movement by marking differences in time or going from here to there as identity is transformed through journey (White 2007). This general understanding of the story concept is congruent with commonly understood characteristics of story (i.e., narrative), which includes events in a sequence, over time to form a theme, plot, or story. When applying the metaphor of a story to a family therapy session, it can also be useful to envision a structure for the session organized by a three-act play concept (Duvall and Béres 2011).

### Critical Reflection

Evolving from postmodern orientation, critical reflection is a primary operating concept of narrative practices with families. Increasingly, therapists and the families they consult with function in a context of uncertainty, unpredictability, complexity, and imposing social discourses.

Through a working partnership, therapists constantly step back with families and reflect on their work together in ways that interrupt discourse and are structured to reflect in the conversation (as it is occurring) and reflect on the conversation (after it has occurred). Rather than an anything goes project, it's a nothing goes project. Everything is called into question.

In this way, critical reflection helps us to constantly improve our work with families by making meaning from experiences as they occur. Both the professionals and the families they serve have to constantly adapt to changing conditions, developing knowledge that is seen as useful and relevant, making and remaking themselves in response to uncertainty (Giddens 1991; Fook and Gardner 2007).

Critical reflection addresses how our work together with families actually creates knowledge and learning. This forms the foundation for practice-based evidence. It makes it possible to constantly improve practice by learning from experience and engages in a process of examining the fundamental assumptions that are implicit in that experience. This includes transformed thinking and practices that result from the new awareness as it happens. In this way, it is a trial and error, heuristic approach. Rather than theory controlling practice, this mutually generated knowledge can be fed back into theory, thereby informing and expanding it.

### Therapeutic Posture

The posture of a narrative practitioner expresses an attitude that is informed by poststructuralist sensibilities. They are respectful and welcoming much like a skilled host and assume a nonexpert, not-knowing position. Narrative practitioners assume that people are the experts about the details of their own lives. Through a decentered position and influential posture, narrative therapists bring facilitation skills that help to open up space for conversations that generate new experiences and possibilities.

This collaborative engagement results in greater shared participation and makes possible preferred outcomes in the therapeutic process. Conversations with families are transparent and open, including writing practices (Young 2008). Summary notes of sessions are created in collaboration with the family members in the session, as well as other documents such as certificates, drawings, and letters to "the problem" or to persons not in attendance. The upshot of this type of partnership with people is a person-centered, culturally accountable, and ethically based therapeutic practice. Narrative therapeutic conversations are coauthored and can be understood as a "journey" or "rites of passage" metaphor in which therapists travel with people as they experience movement. They are aimed at helping people to distance themselves from limiting, taken-for-granted, problem-saturated experiences to delimiting novel experiences that lead to new possibilities. The therapist facilitates scaffolding the therapeutic conversation and works to engage with people in thinking outside of what is routinely thought. In doing so, the conversation becomes situated away from what are taken-for-granted, problem-saturated stories to listening with the intention of thickening and expanding subordinated stories.

### Externalizing Worldview

Narrative practices acknowledge that problems are contextual and often introduced through difficult life transitions, thus the mantra that "the person is not the problem, the problem is the problem" (White and Epston 1990). The concept of identity is important in narrative therapy. As identity is understood as primarily a social achievement, then it can be influenced by the interactions people have with others and the choices they make. Identity stories are narrated between people in families and are shaped by dominant cultural discourses that often invite a view of the person as the problem.

Externalizing conversations encourage people to consider their relationships with problems and with each other. Externalizing a problem means to "recast" the problem as its own separate character in a person's story. This can be extremely helpful in reducing the experience of blame, shame, and hopelessness, as it helps people realize that they themselves are not their problems. Instead of *having* a problem or *being* a problem, the therapist encourages the person to think of himself or herself as struggling against a problem. Narrative therapists also seek to change the paradigm by which family members and other important people in the family's life view the family and the problem as well. Problems tend to create disconnection in people's relationships. Externalizing conversations make it possible for a person in the family, who up to now has been "cast" as the

problem, to be seen as a person being affected by the problem. This reduces interpersonal blame, amplifies empathy and understanding, and assists people to reconnect. The problem is no longer a person but something that is influencing that person and influencing how family members see and interact with each other. Now the so-called strengths or positive attributes can be named and described as the person "reappears" outside of the problem.

Narrative therapists seek to help people enlist support, identifying people in the family's life who can "team up against the problem." Family members can now be enlisted to interact and support one another in a way that "defies" the problem. Therapists see themselves as just another member of this "anti-problem team," intentionally avoiding taking a hierarchical "expert/patient" stance and instead working alongside the family, collaborating as equals in overcoming problems, and reconstructing more empowering narratives.

### Subordinate Stories

As stories about the problem unfold, therapists can employ "double listening" (White 2007) throughout. Family members will begin to tell their stories in "the usual" ways, but as we listen carefully and ask questions about some of the more neglected but potentially significant events of their lives, the meaning of these events can be developed. The therapist's questions draw people's attention to the gaps in the storylines of their lives. Delving into the inevitable gaps that exist in the problem, storylines open up space for realizations, choice, and creativity. These subordinate storylines include peoples' knowledge, skills, abilities, language, cultural beliefs, hopes, dreams, commitments, and preferences. The therapist asks questions to develop details of these stories, and what had previously been a subordinated storyline will begin to shift into a story of more prevalence in the family's life.

Attending to the absent but implicit (White 2007; "▶ Absent But Implicit in Narrative Couple and Family Therapy" by Cramer 2017) within people's words and expressions assists the therapist to notice and ask questions about the implicit values, preferences, hopes, and commitments that are reflected within them. For example, as family members express frustration regarding conflict between them, when listening is shaped by the absent-but-implicit lens, the therapist will not only hear the problem of conflict but also the as yet unspoken hopes and preferences for more loving, caring, or peaceful relations. This way of listening assists the therapist to attend to both stories and develop the backstories, present influences, and future possible impacts of these values and commitments on family life and relationships.

### Audiences and Witnesses

As stated previously, narrative therapists understand identity as a social and relational achievement. It is in the telling and retelling of stories to one another that makes it possible for our lives to become more richly known to ourselves and to one another (▶ "Witnessing in Narrative Couple and Family Therapy" by Denborough 2017 and ▶ "Narrative Couple Therapy" by Freedman and Combs 2017; White 2007). In the therapeutic context, people can be offered the option of having a conversation that is structured to create the opportunity for family members to be witnesses to each other's preferred identity claims, hopes and dreams, journeys, and movements. This is an example of critically reflective practices as they reflect within the therapeutic conversation. These are the "away from the problem" stories or subordinate stories that are hidden by the dominant problem storyline that is currently having most influence over the family.

## Practices

### Witnessing Practices

The development of subordinate storylines is greatly assisted by locating people as witnesses to each other in conversation with the therapist and then enquiring into the effects of this conversation on the witnessing person. For example, a parent may listen while the therapist "interviews" the child or youth and then be invited to reflect on what stood out for them, what they heard that was unexpected, important, meaningful, or useful to

them, and why. Then the child or youth may be asked about what they heard from their parent's reflections that pleased, interested, or surprised them and why. This process was developed as a variation on concepts about outsider witnessing as described by Michael White (2007). It is a practice that interrupts the usual back and forth responses between family members, making a different sort of reflective listening possible for them. This structure for conversation is particularly useful in family therapy as people often come in immersed in misunderstandings, conflict, and blaming of the other. They are often having difficulty really appreciating each other's experience and are trapped in hearing and experiencing each other in the same usual ways. This witnessing structure creates the possibility for the therapist to spend enough time with one person to ask questions that can expand present understandings and develop new appreciations of situations, events, and one another.

When people are having significant struggles to listen to each other differently than what the problem would require, we can use a repositioning practice (White 2004). It can be very difficult for families who are in high conflict, captured by arguing, to disengage from routine and habitual responses to each other. The problem ("the conflict," "the battling") requires them to continue listening to and responding to one another in particular ways that serve or cooperate with "it." The therapist can assist in the disengagement from these habitual responses by inviting one person at a time to distance from a sense of listening as themselves and instead be repositioned to listen as someone else would listen – someone that they have experienced as a caring, acknowledging, and compassionate listener. They can then be interviewed about what that compassionate listener would have noticed. They can speak "as if" they are that person. This makes it possible for previously hidden storylines to be noticed and then richly developed.

### Externalizing Practices

The externalizing worldview (▶ "Externalizing in Narrative Therapy with Couples and Families" by Carey 2017) earlier described is reflected in practice with families as the therapist introduces language that separates persons in the family from problems. The language of "it" and "the" is introduced as important shifts in meaning regarding the problem. Parents introducing "our son Billy has ADHD" will begin to shift away from Billy being the problem and Billy having ADHD as the therapist asks questions such as: How long has the ADHD been around? How has the ADHD been affecting Billy and everyone in the family? How does "it" have the family seeing and treating Billy? And so on. The problem of ADHD now has become relational, between Billy and "it" and between family members. This makes it possible for the family to unite in ways that reduce the influence of the problem on everyone, supporting Billy and each other to not cooperate, for example, with the rules that ADHD may have for the family.

### Practices to Develop Subordinate Storylines

As the therapist listens for the absent but implicit, this opens up possibilities for questions that answer what does this action or expression reflect about what this person and this family value or stand for. Early in a family therapy session, the therapist may ask the family's permission to get to know them away from the externalized problem, such as: Would it be ok with you if I get to know your family? What do you as a family value, or care about, before we talk about the problem? Or, if the family identifies 8-year-old Billy as the problem, for example, he has ADHD, the therapist can check if it is ok to get to know Billy away from the struggles with ADHD.

Throughout the session, the therapist will look for and listen for openings into subordinate storylines. This might create questions such as: What does it suggest about hopes, preferences, and values that this family attended the session? As family members describe frustration with a situation, event, or person, what does their frustration reflect about wishes for how else it might be? As the family describes the problem, the therapist can wonder how they have managed to not allow the problem to completely dominate their lives and relationship.

## Theory of Change

In narrative practices, we work with people to find new preferred meaning in their lives. Narrative ideas propose the notion that peoples' identities are created from numerous possible stories. Many of these stories lie within the shadowy yet untold aspects of their lives that are located outside the dominant story. When individuals and families first engage in therapy, they are often engrossed in a thin, problem-saturated, dominant story about themselves or others. These stories are often expressed through totalizing identity statements such as "I'm depressed," "He has ADHD," and "She's stubborn." Over time and through repetitive tellings, these dominant stories harden, reinforced by cultural narratives, and people and families experience them as real and true.

Nevertheless, other subordinated storylines lie outside the thin dominant storyline and often appear as traces through the therapeutic conversation. Through rich and generative conversations, these subordinated stories can be thickened and encouraged to breathe (Frank 2010), thus facilitating a way for people's identities to break free from the clutch of thin problem-saturated stories. This makes it possible for experiences to become visible that wouldn't otherwise be predicted by the problematic story. These subordinated storylines serve as temporal maps, making it possible to speak to complex, ever-changing, day-to-day lived experiences, creating space for the reconsideration of identity as people journey through life. In this way, narrative practices can also be considered an ethnographic, social justice approach to therapeutic conversations, seeking to challenge dominant cultural discourses and master narratives that have negative effects on people's lives and relationships.

## Populations in Focus

The examination and critique of knowledge brings into question what is understood as "family" in contemporary culture (Erera 2002). Rather than remaining with the term, narrative family therapy, we prefer to conceptualize our work in pluralistic terms, such as narrative practices with families. This makes it possible to avoid narrow definitions of family and instead explore the many possibilities for what establishes inclusion into the contemporary diverse forms of "family."

Issues that are connected to the various definitions of contemporary family include the following: Do family members necessarily need to be connected through blood relations? Does a bond, level of intimacy, trust, or respect legitimate inclusion in a family? What are the politics and cultural significance of the various diverse forms of family? What are the effects of inclusion or marginalization on diverse forms of family? What master narratives are imposed on various family forms? All of these issues present the diversity and complexities of understanding and working with families. Indeed, the term "family" has evolved into a more subjective concept. Is it enough that a group of people call themselves a family, so therefore they are a family? Certainly, the concept of family is one that has primary importance across cultures in contemporary societies.

These guiding assumptions for how we understand concepts like "family" are important because they strongly influence the operating principles and practices for working collaboratively with them. As narrative practices privilege diversity, movement of identity, and sociocultural context, it is well suited to address the complexities of working with families in contemporary society.

## Case Example

Katie, age 14, attended a family therapy session with her foster mother, Marion, and her child welfare worker, Sharon. This is her family along with a foster dad and sister who were not present. During the initial agenda setting, the two adults indicated that they wished to talk about some recent self-harming by cutting that Katie had done, and Katie indicated that she had "nothing to say." The therapist, seeing Katie's

initial position of not talking as an opportunity for her to witness the telling of subordinate storylines of her life, then asked questions of Katie's family members, while she witnessed their responses. Marion and Sharon, in response to questions, speculated that the cutting might be a reflection of distress due to an argument Katie had with a friend and the fear she was experiencing that the relationship was over. This connected up with much history of loss that Katie had experienced in her life.

As she listened to her family speculating about how frightening and distressing the fear of loss might be, I checked with Katie about the accuracy of their statements. She described that "this is right on" and that the fears of loss that she experiences after such arguments with friends are so intense that she described them as "unbearable." She agreed that the cutting was an expression of these unbearable fears and then returned to a quiet position.

Marion and Sharon commented that Katie really liked to experience close connection with others and that, in fact, she had become close to her foster parents and sister. At this point, it was possible to begin to explore Katie's value for and skills related to connection: "I'm curious about what's made it possible for Katie to become such a part of the family? What kind of qualities or things do you see in Katie that has made it possible for these 'well-connected' relationships to develop?" Stories were then shared about Katie's kind and thoughtful actions toward her foster sister and her commitment to come back to "talk out" issues with Marion after arguments in ways that were open and insightful.

The therapist then asked: As you were telling me this story, I started wondering: What is it about Katie that makes these things possible? What kind of qualities and skills of connection does she have with her that might help her get through times when "the fear of disconnection" comes?

From this point in the session, many stories were shared that reflected: giving people chances, a real desire to know people, hopefulness about relationships, and giving to others. Katie then jumped into the conversation with not only more stories that illustrated these qualities and skills but also with "advice for myself" about how she might employ these skills for the next time fear of a loss of a relationship visits her.

## Research on the Model

Narrative therapy has long been criticized for being under-researched, accused of lacking in quantitative outcome studies to support its many assertions. Nevertheless, there has been a groundswell of narrative practice research projects traversing many cultures globally and generating an ever-increasing amount of evidence that supports the effectiveness of narrative therapy with families (Duvall et al. 2012; Young and Cooper 2008). As narrative practices are philosophically distinct from traditional therapeutic practices, any attempt to conduct research with them would avoid using methods that rely on classification, pathologizing, or diagnostic categories to study their effectiveness. Moreover, there is a movement to think more about the interrelationship between practice and research. Research and narrative practices share a lot in common with the use of critically reflective practices and points of inquiry. Hence, what are the inherent possibilities that are created when both the therapeutic process and research are viewed as ethically relational practices? This relational view creates a movement from researching *on* to researching *with* the people who consult us (▶ "Research as Daily Practice" by St. George and Wuff 2017).

The present multitudes of projects that demonstrate research evidence with narrative practices cover a wide range of areas through many different countries. Some questions to consider are:

- How can research contribute to the improvement of competency-oriented, client-centered services?
- Does practice-based evidence better serve the development of ethically based therapy than evidence-based practices?
- How can research contribute to and accommodate culturally diverse forms of family?

## Cross-References

- Absent But Implicit in Narrative Couple and Family Therapy
- Externalizing in Narrative Therapy with Couples and Families
- Narrative Couple Therapy
- Research as Daily Practice
- Social Construction and Therapeutic Practices
- White, Michael
- Witnessing in Narrative Couple and Family Therapy

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# National Association of Social Workers (NASW)


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## Introduction

According to the National Association of Social Workers (2016), as of 2016, its membership totals 132,000, making it the largest membership organization of professional social workers in the world. Prior to its establishment in 1955, many social workers identified themselves professionally by areas of specialized practice or practice settings, eventually forming separate organizations to promote and advance the specialized interests of its members. For example, organizations such as the American Association of Medical Social Workers (AAMSW) became home for social workers interested in and practicing in medical settings, while the American Association of Group Workers (AAGW) became the home of social workers interested in and practicing group work.

Prompted by the need to unify the profession and for an organizational structure to better utilize the resources of the profession to improve and strengthen social welfare programs, seven organizations (American Association of Social Workers, American Association of Psychiatric Social Workers, American Association of Group Workers, American Association of Medical Social Workers, Association for the Study of Community Organization, National Association of School Social Workers, and Social Work

Research Group) consolidated to form the NASW. After a number of years of careful planning, this new organization emerged as a unified professional social work organization that, while respecting and providing for members' specialized interests, promoted the professional development and status of its members and addressed standards of professional practice for social workers as a whole.

Although NASW represents and advocates for the profession as a whole, social workers with specialized interests continue to have recognition and support through separate membership organizations such as the National Association of Perinatal Social Workers, the National Association of Black Social Workers, the National Association of School Social Workers, the Society for Clinical Social Work, and others.

## Location

With national headquarters located in Washington, D.C., NASW has 55 established chapters in all 50 states, the District of Columbia, as well as in Puerto Rico, Guam, and the US Virgin Islands.

## Prominent Associated Figures

Many of the prominent figures associated with NASW as an organization were and are leaders in advancing the association's priorities related to enhancing the professional growth and development of its members, creating and maintaining professional standards, and advocating for sound social policies.

Social work has historically been interested in and concerned about families. While Jane Addams is often associated with the founding of the profession given her focus on individuals and families in the context of their environment, advocacy for peace, human rights and social justice, and the establishment of Hull House and the Settlement Movement, her work clearly influenced the development of social work as a profession.

The list of social workers prominent in couple and family therapy is long. Many pioneered new and innovative approaches and collaborated with each other to advance the field to reach broader and more diverse populations and to address an increasing number of social and emotional issues affecting couples and families. While this entry does not attempt to be exhaustive of practitioners or models, the list of notable couple and family therapists who are social workers includes Virginia Satir, Braulio Montalvo, Harry Aponte, Insoo Kim Berg, Steve de Shazer, Monica McGoldrick, Peggy Papp, Lynn Hoffman, Olga Silverstein, Betty Carter, Marianne Walters, Douglas Breunlin, Froma Walsh, and Michael White. Social workers are found as practitioners from all models of couple and family therapy.

## Contributions

NASW promotes the professional development and status of its members and addresses standards of professional practice for social workers. The NASW Code of Ethics guides the professional conduct of social workers. The NASW publication, *Social Work Speaks*, promulgates the policy positions of the organization. Both its professional ethics and policy statements are significant contributions to the profession as a whole and to couple and family therapy. Specific standards in the Code of Ethics relate to couple and family therapy. For example, the Code of Ethics gives specific attention to conflicts of interest and confidentiality for couples in therapy. Policies related to children and families, gender issues, family violence, behavioral health, and others guide social work practice and are particularly relevant to couple and family therapy.

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# National Council on Family Relations (NCFR)

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## Introduction

The National Council on Family Relations (NCFR), founded in 1938, is the oldest multidisciplinary organization focused solely on family research, practice, and education. NCFR is a professional association comprising scholars and family professionals from sociology, psychology, family science, therapy and counseling, human development, social work, and other areas.

NCFR supports family research, education, and outreach through its scholarly journals, annual conference, information resources, member forums, career development, networking activities, and the Certified Family Life Educator credential.

## Location

Minneapolis, MN

## Prominent Associated Figures

Ernest W. Burgess
Sidney Goldstein
Adolph Meyer
Ernest Groves
Margaret Mead
Evelyn Mills Duvall
Aaron Rutledge
David Fulcomer
David and Vera Mace
Paul Vahanian
Clark Vincent
Pauline Boss
Stephanie Coontz
William J. Doherty
Philip Cowan and Carolyn Pape Cowan
Andrew Cherlin
Barry Ginsberg
Sandra Stith

## Contributions

NCFR leaders and the organization's mission are dedicated to understanding and strengthening families through its members' interdisciplinary efforts in scholarship; outreach based on research; and commitment to informing policy through evidence-based education.

NCFR was formed by Paul Sayre, law professor at the University of Iowa; sociologist Ernest W. Burgess, University of Chicago; and Rabbi Sydney E. Goldstein, a family therapist in New York. Their vision was for an association that would be

> an inter-professional forum to provide opportunities for individuals, organized groups and agencies interested in family life to plan and act together on concerns relevant to all forms of marriage and family relationships; establish professional standards; promote and coordinate educational, and counseling efforts; and encourage research. [Added in 1972: . . . and to disseminate information and to further social action].

NCFR publishes three academic journals, including the *Journal of Marriage and Family* (est. 1938), the world's leading journal on families and relationships. Additional journals include *Family Relations: The Interdisciplinary Journal of Applied Family Studies* (est. 1951) and *Journal of Family Theory & Review* (est. 2009).

Throughout NCFR's history, and especially during the first 50 years, family therapy and counseling has been a major professional emphasis within the organization. The "Marriage and Family Counseling Section" was formed in 1939 following the first annual conference. This member group was prominent in bringing practice and applied research to the forefront of NCFR activities for decades, which included:

- Participating in major national and international events, such as the First World Congress on the Family, Paris (1948) and numerous White House Conferences on families and on children
- Fostering the careers of family therapy scholars and authors teaching and writing about relationships, parenting, human development, and behavioral/emotional health
- Providing leading research through NCFR annual conference papers and in journal articles that have become professional resources for therapists and scholars in emerging practice areas such as military families, LGBTQ, stepfamilies, aging, and immigrant families

Currently, the successor member group, the "Family Therapy Section," has about 500 members and is largely composed of licensed therapists and faculty teaching in graduate programs in marriage and family therapy in universities throughout the USA and Canada.

# Negative Explanation in Family Systems Theory

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## Synonyms

Restraint

## Introduction

Family systems theory and cybernetics are theories that can be used to explain how problems form and are maintained in human systems. Negative explanation is an aspect of cybernetic theory that emphasizes restraints. According to negative explanation, events take a particular course because they are constrained* from taking other courses (Breunlin 1999; White 1986). Alternatively, positive explanation seeks to determine the causes of particular events. Rather than focusing on "Why?", negative explanation involves describing the constraints under which systems operate. Negative explanation allows therapists to better explain and understand family interactions by examining the constraints under which the family system operates (White 1986).

## Theoretical Context for Concept

Negative explanation is a concept generally associated with cybernetic theory. Cybernetics, a subset of systems theory, is the study of self-regulating systems, which aims to understand and define systemic processes by recognizing their repetitive patterns. Gregory Bateson applied cybernetics, which was originally associated with mechanical and electrical engineering, to living systems, making significant contributions to the field of marriage and family therapy when he conceptualized the family as a system (Keeney 1981). Bateson (1972) postulated that family interactions can be explained positively and negatively; however, cybernetic explanations are negative. Positive explanation seeks to explain why human systems experience problems. Negative explanation emphasizes the cybernetic descriptions of behavioral patterns in human systems, as cybernetics does not identify causes of behaviors.

## Description

*Negative explanation* in systems theory is a way of understanding the restraints within family systems that maintain problems (Breunlin 1999). Restraints are typically unconscious processes or unacknowledged patterns in family systems, as families do not recognize that they are operating under restraints, nor do they identify the particular restraints. Restraints are problematic when they limit the family system's ability to search for and implement new behaviors or solutions to family

problems (White 1986). Expectations, premises, and assumptions may all be considered examples of restraints (White 1986).

## Application of Concept in Couple and Family Therapy

Couples and families often present for therapy when they have attempted several failed solutions to their problems. Through the use of negative explanation, family members may be able to view their system from a holistic perspective, recognize the circular processes or patterns in their family, and thus free themselves from their existing patterns. Increased awareness of constraints operating within family systems can increase their ability to develop new and more functional patterns. Rather than trying to understand a problem's causes (which is consistent with positive explanation), understanding a problem's constraints (consistent with negative explanation) provides insight into the context that maintains the problem. Negative explanation in family systems theory proposes a way to recognize and define constraints, describe certain behavior or chain of behaviors within the family system and its broader context, and solicit solutions that place an emphasis on the systemic nature of relationships and patterns.

## Clinical Example

Bill and Mary present for therapy because their 35-year-old son, David, refuses to move out of their home. Bill and Mary tell the therapist that they don't know why their son chooses to remain in their home. The therapist recognizes that Bill and Mary have applied a positive explanation of the problem, attempting to understand the reason why David refuses to move out of their home. The therapist asks Bill and Mary to consider what keeps their son at home. Bill and Mary say that David does not pay rent and has no expenses, Mary cooks for David, and she does his laundry. Bill watches sports with David and takes him to games on occasion. Bill and Mary realize that there are several factors that make it appealing for David to remain at home, thus restraining him from leaving. This insight helps Bill and Mary recognize how they have contributed to making it appealing for David to remain at home. Bill and Mary are now able to alter their own behavior in effort to alter David's behavior.

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# Negative Feedback in Family Systems Theory

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## Name of Concept

Negative Feedback in Family Systems Theory.

## Introduction

Becvar and Becvar (1998, 2012) defined feedback as a central component and important criterion of cybernetic systems. It is classified as communication, or information flow, and is the energy input and output of systems. All behavior in family systems is considered communication and as such, acts as feedback to either maintain or alter

the projected course of that system (Becvar and Becvar 1998). Feedback is categorized into two groups, positive and negative. Due to the common social definition often assigned to the words positive and negative, it is important to note that the words, in reference to systemic feedback, do not connote good or bad. Instead, the terms signify the contextual response of the system to the various inputs and outputs of that particular system (Becvar and Becvar 1998). Both positive and negative feedback are typically applied at the level of first-order cybernetics. However, second-order cybernetics speaks mainly of negative feedback, with positive feedback punctuations making up a part of the negative feedback process (Becvar and Becvar 1998).

## Theoretical Context for Concept

Negative feedback is a fundamental systemic component of cybernetic systems. Therefore, systems theory, or more specifically cybernetics, is the theoretical foundation upon which negative feedback is grounded. Gregory Bateson was one of the leading enthusiasts of cybernetics, being one of its formative developers after World War II (Becvar and Becvar 2012). Cybernetics is divided into two different categories, first-order cybernetics and second-order cybernetics. Positive and negative feedback may be best understood within the context of first-order cybernetics, as described below. In second-order cybernetics, however, the system is viewed as an autonomous, autopoietic entity, and as such, feedback is mainly spoken of as negative (Becvar and Becvar 1998).

## Description

*Negative Feedback*, in the classical systems terminology, refers to the notion that a system's output has reached a predetermined maximum level and as a result is attempting to cut off or reduce the inputs into the system (Becvar and Becvar 1998, 2012). Negative feedback serves the purpose of maintaining stability or homeostasis in a system. The term "negative feedback" is not evaluative, meaning wrong/bad behavior. Rather, it is descriptive. Systems theory holds that systems are self-correcting, and negative feedback is a regulatory process by which a system maintains its homeostatic state. A thermostat is an example of a system that operates through negative feedback (Bateson 1967). When the temperature in a room drops below a predetermined setting, the thermostat initiates the heater to return the room to the programed temperature (i.e., a return to homeostasis). Positive feedback indicates that a change occurred and was accepted by the system, while negative feedback attempts to maintain the status quo of that particular system (Becvar and Becvar 1998, 2012).

At the level of second-order cybernetics, a system is viewed as autopoietic and behaves by the rules of autopoiesis, which is that a system operates to maintain itself (Becvar and Becvar 2012). Thus, descriptions are typically made in terms of negative feedback, with positive feedback making up only a partial arc to a more holistic negative feedback process.

## Application of Concept in Couple and Family Therapy

Couples and families present for therapy with problems that usually center on making needed changes or a desire to undo a change that has already occurred (i.e., a return to equilibrium). Since families are systems, having an understanding of the concept of negative feedback allows the therapist insight into the interactional patterns of families and how these patterns play into the clients' difficulties. Systems are always engaged in negative feedback processes as they maintain themselves. Family systems tend to react to change (or pressures to change) in a way that keeps them functioning in their current manner. An understanding of negative feedback loops will help therapists who work with families struggling to make necessary changes or transitions from one developmental stage to the next. When couples and families seek treatment, the therapist joins

the family in a therapeutic system. Therapists who are aware of this recognize their participation in the therapeutic system and the role they can play in facilitating solutions to individual and family problems.

## Clinical Example

Family therapists are unique in their systemic views of clients, whether those seeking treatment are individuals, couples, or families. While psychology focuses on the individual, couple and family therapists approach treatment from a systemic perspective, understanding that by inducing change in one part of the system, the system as a whole changes as well. Therefore, it behooves couple and family therapists to maintain an awareness of the entire system and negative feedback loops that maintain problems or prevent important changes from occurring. For example, Justin and Rebecca came to therapy because of a long-standing pattern of not being able to resolve differences between them. They described a persistent sequence of conflict in which Justin became angry when they disagreed on something, with Rebecca eventually backing down and giving in to what he wanted. This served to stop the conflict, but it left them both unhappy. They indicated the conflict was harming their relationship, and they wanted to change it. Their therapist worked with them to alter the pattern by strengthening Rebecca's voice and assertiveness in relationship. Rebecca began to stand up for herself, rather than capitulate whenever Justin got angry. The changes she made produced a change in the couple dynamic, which Justin did not receive well. He became increasingly volatile (-negative feedback) in response to Rebecca's assertiveness, which served to return the relationship to its previous state. Justin's efforts to maintain the status quo made the process of change difficult for the wife, thus maintaining homeostasis in the relationship. Change can be difficult, and therapists need to be aware that specific changes desired by one member of the system may not be accepted by others.

## Cross-References

- ▶ Autopoiesis in Family Systems Theory
- ▶ First Order Cybernetics
- ▶ Homeostasis in Family Systems Theory
- ▶ Positive Feedback in Family Systems Theory
- ▶ Second-Order Cybernetics in Family Systems Theory

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# Negative Reinforcement in Social Learning Theory

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## Name of Strategy

Negative reinforcement in social learning theory

## Introduction

Negative reinforcement in social learning theory is defined as the removal of an aversive stimulus to aid in the promotion of a specific behavior (Bandura 1977). The removal of an irritant stimulus trains a person to learn that their completion of a particular behavior will cause the irritant to be extinguished, or forgo introduction into the situation, thus creating a favorable outcome for the person. It is important to distinguish that negative reinforcement is different from punishment, in that it is designed to increase the probability of

the behavior occurring in future scenarios that meet the situational requirements of the initial learning experience.

## Theoretical Framework

Negative reinforcement was first described in B.F. Skinner's theory of operant conditioning, as a mechanism of strengthening the behavior by stopping, removing, or avoiding a negative stimulus (Skinner 1976). In social learning theory, Bandura expands upon Skinner's concept by including observational learning as a method by which people can learn behavioral responses to their environment. This concept includes the development of behavioral skills drawn from the method of observing the effects of negative reinforcement on other subjects. Negative reinforcement is included in other theoretical approaches including cognitive behavioral marital therapy, integrative behavioral couple therapy, and parenting skills training in family therapy.

## Rationale for Strategy

The concept of negative reinforcement is used in systemic therapy to promote desired behavior in relational situations and interactions. This is commonly seen in cognitive- and behavioral-based systemic treatments where a focus on social exchange delineates the production of acceptable behaviors. Negative reinforcement in social learning theory can be experienced throughout three regulatory systems based on external, vicarious, and self-produced consequences.

- External reinforcement – This negative reinforcement is a stimulus present in the person's external environment that promotes the continuation of a desired behavior. They are usually immediate in nature and more often involve a process of social contracting. An example is if new parents have their infant's formula prepared after the child rises from a nap, they will avoid the child's crying as they scurry to prepare the meal.
- Vicarious reinforcement – This negative reinforcement is a behavioral and stimulus interaction that is learned observationally. As the person observes their environment, they are able to identify behaviors to increase, as they witness others negatively reinforced for failing to complete such behaviors. An example of this is a younger sibling adhering to their curfew time, as they witness an older sibling losing privileges as they return home after the agreed upon time.
- Self-produced reinforcement – This negative reinforcement is the self-generated use of removing an aversive stimulus when a person meets their personal standard of behavior. An example of this is a person leaving early for work each morning to avoid being late due to morning traffic. By learning the behavior of leaving early, they are avoiding the aversive stimulus of being stuck in traffic and the penalty associated with being late to work.

## Description of Strategy

Negative reinforcements in social learning theory are explained throughout literature with an emphasis on two main functions. First, a negative reinforcement is removed from a situation when the person completes the desired behavior. Second, as the person learns from experiencing the negative reinforcement, moving forward, they learn that performing the desired behavior will lead to them avoiding interactions with the aversive stimulus.

In cognitive behavioral marital therapy, negative reinforcements can be experienced when emotions of jealousy and anger lead to unhealthy behavioral interactions among couples, such as extreme attention seeking when a partner comments on the physical appearance of another eligible partner. In this scenario, the partner's behavior is being shaped to avoid the negative reinforcement of excessive attention seeking, by avoiding commenting on the physical appearance of other eligible partners (Baucom and Epstein 1990). Couples can fully explore the influence of emotion on their use of negative reinforcement for reasons such as punishment.

In parenting skills training in family therapy, psychoeducation and behavioral modification

techniques are used to uncover and target undesirable cognitions that influence behavior. Through the process of therapy, parents can learn about the frequency with which they use negative reinforcements with their children and how to more effectively tailor the technique to shape behavior effectively. In integrative behavioral couple therapy, therapists bring awareness to some of the negative reinforcements occurring in the relationship and help the couple to develop healthier patterns of interaction.

## Case Example

In a couple relationship scenario, a negative reinforcement can be experienced as a wife learns to deal with her husband's suspicions of infidelity by calling to speak with him hourly while at work. The behaviors generated by the husbands' suspicion are the aversive stimuli that the wife has behaviorally learned to avoid by calling her husband hourly during the workday. In a family system scenario, a negative reinforcement can be experienced as teenagers pick up dirty laundry from their bedroom floor, to stop parents from lecturing them about their level of cleanliness. The lecture is an aversive stimulus that the children will learn to avoid as they engage in the desired behavior of maintaining a tidy room.

## Cross-References

- ▶ Integrative Behavioral Couple Therapy
- ▶ Parenting Skills Training in Couple and Family Therapy
- ▶ Punishment in Social Learning Theory
- ▶ Social Learning Theory

## References

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# Negative Sentiment Override in Couples and Families

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## Synonyms

Negative perspective

## Introduction

Negative sentiment override is a concept that Dr. John Gottman used to describe the condition that occurs when negative thoughts and feelings about one's partner become predominant in the relationship. When an individual is in this state, their partner's statements, attitudes, and behaviors are often experienced as negative even if they are neutral or positive. Hawizins et al. (2002) For example, a partner is late coming home from work and their spouse has made several attempts to call, but there was no answer. If the partner is in *negative sentiment override* (also known as negative perspective), he or she will entertain negative thoughts like "He knows it's me calling, that's why he won't pick up the phone. He doesn't even have the decency to let me know that he's okay." Conversely, if the partner is in *positive sentiment override* (also known as a positive perspective), he or she would think "Gee, I hope he's okay. He usually answers."

## Theoretical Context for Concept

Robert Weiss (1980) theorized that couples entered into emotional states that he labeled "sentiment overrides." These sentiment overrides were highly predictive of the couples' interpretations

of their specific interactions even more than the objective response of their partners. These positive or negative sentiment overrides also predicted their affection or disaffection with their partner and their relationship in general. The research of Robinson and Price (1980) bears out Weiss' theory. They trained in-home observers to rate the behaviors of distressed and nondistressed couples. They also asked the couples to rate their own behaviors. They then compared the couples' ratings with the observers' ratings. Nondistressed couples rated their pleasurable behaviors at a much higher rate than distressed couples. However, the observers reported that both groups of couples displayed equivalent amounts of pleasurable behaviors. They found that distressed couples do not perceive their partner's pleasurable behaviors as positive.

## Description

The Gottman method builds on this concept of override systems. Most couples begin their relationships in positive sentiment override. The partner is seen as ideal with many positive attributes, and the individual feels very fortunate to have found this person and to have them as a part of their life. Couples in positive sentiment override are curious about each other. They ask questions about their partner's inner world and commit the answers to memory. They complement each other and express appreciation for each other frequently. Couples with this positive perspective are attentive to each other. They initiate bids for connection and respond positively or neutrally to those bids. If one partner happens to be grumpy or have a bad day, the other partner interprets that as uncharacteristic and gives them the benefit of the doubt. When couples are in positive perspective, there is an underlying belief that their partner is a good person even if they are negative at the moment.

Negative sentiment override represents the opposite state. Couples enter into negative sentiment override in two primary ways. The couple starts out in a positive perspective, but they gradually ask fewer questions and perhaps assume that they know all there is to know about their partner. They are less expressive about what they admire and appreciate about their partner. They start noticing what is not going well in the relationship. These couples then begin to entertain negative thoughts about their partner. They might keep those negative thoughts to themselves or bring them up as complaints that are critical or blaming of the partner. These negative statements are taken very personally, and the individuals experience emotional pain. This creates a cycle of negativity that is hard to change. Gottman refers to this as the negative absorbing state. Once the couple has entered into this negative absorbing state, it is difficult to return to the positive perspective (Gottman 1994).

The second path to negative sentiment override is through poorly managed conflict. A couple might be positive toward each other when they are not in conflict, but when they do disagree they argue and engage in the four horsemen: criticism, defensiveness, contempt, and stonewalling. The attempts to repair their conflicts become ineffective, and the relationship begins to feel emotionally unsafe. The harsh, unrepaired conflicts have a lasting negative emotional impact which leads to negative sentiment override.

While some couples slowly drift into negative sentiment override, others arrive there much more quickly. Traumatic incidents such as betrayals are likely to fracture the relationship and leave the couple in a state of negative sentiment override. Betrayals come in many forms: sexual, emotional, and financial, to name a few. Betrayals call into question how well one really knows their partner, and if they can trust their partner ever again.

## Application of Concept in Couple and Family Therapy

Negative sentiment override is difficult to treat in therapy. Therapists cannot effectively tell the couple to be more positive toward each other, or say nice things to each other. Rather, it needs to be addressed indirectly. That is, to shift the couple's perspective from negative toward positive, the therapist must address the factors that led to the negativity. This is where a thorough assessment is helpful to determine if the negative perspective is a result of

the couple's conflict management or if it stems from a lack of connection and friendship, or both.

Gottman method couples therapists lead couples in exercises designed to improve all aspects of their friendship. They encourage couples to find ways to be curious about each other, express fondness, appreciation, admiration, and respect for each other and turn toward each other's bids for connection in small moments in time. In Gottman method couples therapy, there are several interventions that address the friendship system. They include: love maps card deck, open-ended questions card deck, the opportunity card deck, the adjective checklist, the 7 week relationship enhancing thoughts exercise, and the salsa card deck.

If the negative sentiment override stems from the couple's dysfunctional conflict interactions, these must be addressed. Gottman method therapists help couples develop specific skills to improve their conflict management. The therapist helps the couples develop specific skills such as gentle start-up, accepting influence, and building compromises. They also stress repairing negative interactions using interventions such as the aftermath of a regrettable incident and repair checklist.

Conflict management in Gottman method therapy goes beyond skill development. The most persistent conflicts in relationships are believed to have deeper symbolic and emotional meaning. The Gottman method therapist guides couples through intense emotional conversations to explore and uncover those symbolic meanings and the needs associated with them. The Gottman-Rapoport conversation, the Dan Wile intervention, and the dreams within conflict intervention are examples of those intense emotional conversations. Once these conflict management skills are built and the partners can discuss their problems gently with each other, the negativity begins to subside.

## Conclusion

Negative sentiment override, along with its opposite, positive sentiment override, are central concepts in Gottman method couple therapy. Most couples begin their relationships in a state of positive sentiment override, but distressed couples find their relationships entering negative sentiment override due to failures to maintain emotional connection or failure to practice successful conflict management, or both. When a state of negative sentiment override exists in the couple seeking therapy, the therapist identifies the source of the negativity and designs a therapy plan to address it using appropriate interventions.

## Clinical Example

Sally and Bob came in to therapy on the brink of divorce. Sally stated that she could not stand the negativity anymore. During the couple's first conflict discussion, Sally slipped into criticizing Bob. When she did so, Bob began to laugh. Her heart rate then soared over 100 bpm and she stated "That's it! I'm done! He thinks it's funny for me to be in pain!" After getting Sally to calm down through the use of a relaxation exercise, the couple were encouraged to go back to the original conversation. The therapist assisted Sally in expressing her pain using an intervention called the "Dan Wile" where the therapist spoke as if she were Sally, using emotional language and metaphor to describe what it felt like to believe that she was alone in the relationship and how she longed for that connection they once had. Sally was the oldest of four children and was expected to be the caretaker for her younger siblings at a very young age and anything that the younger siblings had done wrong was ultimately blamed on her. As a result, she felt emotionally abandoned by her parents, and constantly criticized. She felt emotionally abandoned by Bob when she asked for what she needed and he ignored those needs. Bob put his friends before his family and expected Sally to do all the child care. Bob had a history with criticism too. His father was a harsh, punitive man, and Bob could do no right in his eyes. Bob discovered that the only way to protect himself from his father's onslaught of negativity was to laugh. After speaking for Sally, the therapist spoke for Bob using the same intervention. The therapist again used the language of emotion and metaphor. She spoke of the daggers of pain that

pierced Bob's heart when he heard Sally's critical words. Those old familiar messages of worthlessness from his childhood continue to ring in his ears on a daily basis. The therapist intuited that Bob laughed to keep the tears at bay, lest he crack because he feared he would shatter into a million pieces. As the therapist spoke Bob nodded in agreement and began to sob. Sally looked stunned. She had never realized that the critical comments she hurled at him in fits of frustration had been hurtful to him. She assumed his laughter meant he was indifferent and un-phased. Sally was able to soften toward Bob and in fact teared up as well. Bob was able to apologize to Sally for emotionally abandoning her in her time of need. There were many conversations in the therapy office around this perpetual issue but through these discussions the couple was able to let down their guard and risk exposing their vulnerabilities with each other. Through this process they found the path to rebuild their friendship and enhance their positive thoughts. At the time of this writing, Bob and Sally are doing well.

## Cross-References

- Doubling in Couple and Family Therapy
- Emotion in Couple and Family Therapy
- Four Horsemen in Couple and Family Therapy
- Gottman Method Couples Therapy
- Gottman, John
- Gottman, Julie
- Psychoeducation in Couple and Family Therapy
- Research in Relational Science
- Weiss, Robert
- Wile, Daniel

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# Negentropy in Family Systems Theory

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## Introduction

Negentropy can be defined as the degree of order, organization, and adaptiveness in a family (Beavers and Hampson 2000). On the other hand, entropy can be defined as the degree of chaos, randomness, disorganization, and disorder in a family (Beavers and Hampson 2000). Negentropy exists opposite from entropy on an infinite continuum. In general, a distressed family may come to therapy in a state of entropy while the therapist works with the family in making changes that allow movement towards negentropy (Hecker et al. 2003). Negentropy describes family functioning as working towards optimal organization (Beavers and Voeller 1983). Families are theorized to be drifting towards entropy unless effort is made to maintain the structure, boundaries, and order of a more negentropic family system.

## Theoretical Context for Concept

Negative entropy (i.e., negentropy) and entropy are terms from the field of thermodynamics. Originally coined by Erwin Schrödinger (1944), they are frequently used in physics, biology, and other fields, and generally refer to the distribution of

energy in a system and resultant changes in that system. More specifically, the second law of thermodynamics states, in part, that entropy is expected to increase across time in closed systems, meaning that these systems move towards a distribution of energy that is more spread out and chaotic. Conversely, naturally occurring systems are often open, as they are constantly interacting with their environment and other systems (von Bertalanffy 1968). These interactions allow open systems to stop the increase of entropy and even reverse this process to move towards negentropy (higher levels of organization and order; von Bertalanffy 1968). Beavers and Vollers (1983) applied these concepts to family interaction by viewing entropy and negentropy as occurring on a continuum based on the degree of openness of the family system. As in thermodynamics, entropy is expected to increase in closed systems, whereas negentropy is expected to increase in open systems. The Beavers Systems Model was developed as an alternative to the existing Circumplex Model of Marital and Family Systems (Olson et al. 1979). The Circumplex Model, which proposed cohesion and adaptability as optimal and anything on the extreme as pathological, identified 16 possible classifications for family functioning. The Beavers Systems Model instead advocated for an infinite continuum in which families' behaviors can be described somewhere between entropy (e.g., chaotic, poor or diffused boundaries, disorganized) and negentropy (e.g., organized, clear boundaries, adaptable).

## Description

The Beavers Systems Model (Beavers and Voeller 1983) included a diagram description marking the progression from entropy to negentropy. Families that are highly entropic are severely dysfunctional in regards to structure and flexibility. As families move towards negentropy, their health and competence increase, resulting in the capability to effectively handle stressful situations. Negentropic families are adept at balancing change and maintaining stability, in part through having boundaries that allow new information to come into the family and keeping structure within their families.

## Application of Concept in Couple and Family Therapy

The classification of families in relation to structure and adaptability has been a staple of the field from the time when Salvador Minuchin (1974) first introduced his work on boundaries in families. The theoretical constructs of open- and closed-boundaries are bolstered by the theoretical propositions that having extremely open or closed boundaries within families may be problematic – resulting in entropy – and that in general, more closed boundaries are also more prone to entropy. Theoretically, this is because more closed-boundaries in families do not import new ideas and strategies to handle challenging situations. Therapists can help families improve their overall level of negentropy by attending to opening boundaries that allow more information, resources, and desired changes to occur. Indeed, some theorists have conceptualized negentropy as an energy-producing force in the family system (Ward 1995), allowing families to make desired changes.

## Clinical Example

The Jones family presented for therapy due to stressful interactions at home and frequent difficulty in managing their two children. The family described how this was especially frustrating because they used to be much closer to one another and the children were better behaved in the past. Mrs. Jones informed the clinician prior to the session that she recently had a miscarriage. Since the miscarriage, Mrs. Jones has been spending a lot of time alone in her room and leaving the majority of parenting responsibilities to Mr. Jones, along with the breadwinning. The children were not informed about the miscarriage and subsequently could not understand Mrs. Jones' sudden withdrawal and apathy. The children's grades began to drop and their behavior at home ranged from anger to anxiety. Mr. Jones also

displayed a significant temper and appeared confused about how to care for his wife and children. Without Mrs. Jones' involvement, the family was no longer adapting to current needs, boundaries were blurred, and the lack of communication was resulting in confusion and hurt. This family originally functioned higher on the negentropic continuum; however, recent events, a lack of reorganization, and operating in a more closed system pulled the family towards entropy, characterized by the chaotic and problem-laden environment.

## Cross-References

- ▶ Beavers Systems Measures, The
- ▶ Beavers, W. Robert
- ▶ Circumplex Model of Marital and Family Systems, The
- ▶ Morphogenesis in Family Systems Theory
- ▶ Morphostasis in Family Systems Theory

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# Nelson, Thorana

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## Introduction

Dr. Thorana Nelson has made significant and sustained contributions in the areas of family therapy education and supervision on local, national, and international levels. She has been a prolific scholar and trainer and is known for her contributions to solution-focused brief therapy and education and training in couple and family therapy and gender and LGBT issues and her organizational contributions to the American Association for Marriage and Family Therapy, the American Family Therapy Academy, and the Solution-Focused Brief Therapy Association.

## Career

Dr. Nelson received her M.S. and Ph.D. in counseling and human development from the University of Iowa, with an emphasis in marriage and family therapy. She is an emerita professor in marriage and family therapy from Utah State University, where she taught until her retirement in 2011. Prior to that, Dr. Nelson taught from 1986 to 1992 at Purdue University.

## Contributions to Profession

Dr. Nelson's contributions to marriage and family therapy education and supervision are many and varied. For example, she has shown leadership in the following:

- **The Basic Family Therapy Skills Project**. Dr. Nelson's work, with Dr. Charles Figley, to identify and operationalize basic family therapy skills has helped family therapy educators identify and train clinicians in the

basic skills necessary for competent clinical practice. This work is reflected in a number of key journal articles, the *Basic Skills Evaluation Device*, and many presentations and master's theses.

- **Leadership in Core Competencies.** Perhaps, more than anyone else, Dr. Nelson has brought both the vision and realization of core competencies to the field of couple and family therapy through the AAMFT core competencies.
- **Journal Articles and Books on Other Aspects of Family Therapy Education.** Dr. Nelson also has contributed to the literature on family therapy education through numerous articles on such diverse training topics such as outcome-based education, supervision of solution-focused brief therapy, theory of change projects, training in circular questioning, gender in family therapy supervision, and supervision by way of long-distance telephone. Moreover, she was coauthor (with Robert E. Lee) of *The Contemporary Relational Supervisor* (Lee and Nelson 2013), as well as author or editor of additional 12 books. Dr. Nelson also has written 41 refereed journal articles and 26 book chapters, many on topics related to family therapy education and supervision.
- **Clinical Training Through Other Publications.** Dr. Nelson has been the editor of the Intervention Interchange Section of the *Journal of Family Psychotherapy*, providing the field an outlet for clinicians to share their interventions with others. Similarly, her co-editorship (with Dr. Terry Trepper) of *101 Interventions in Family Therapy* (the most popular book in the history of Haworth Press) and various spin-offs (e.g., *101 More Interventions*. . .) has served the clinical training needs of a generation of family therapists.
- **Leadership in Two COAMFTE-Accredited Family Therapy Programs.** Dr. Nelson taught in Purdue University's COAMFTE-accredited doctoral program for 6 years, during which time she was the clinical director of their on-campus marriage and family therapy center. From there she was hired to develop and be the first director of Utah State University's COAMFTE-accredited master's program in marriage and family therapy. Dr. Nelson served as the director of that program from 1992 to 2005.
- **Supervision Courses at the State and National Level.** Dr. Nelson has taught fundamentals of supervision and supervision refresher courses numerous times for the American Association for Marriage and Family Therapy, including developing the AAMFT online supervision courses. She has also been a frequent teacher of a "crash course" in marriage and family therapy for AAMFT's winter and summer institutes. She has provided many other national and international training events, as well.

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# Network in Family Systems Theory

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## Name of Concept

Network in family systems theory

## Synonyms

Deep ecology; Network theory

## Introduction

Many ancient cultures emphasized that people, animals, plants, etc. were all part of one giant integrated system, "Mother Nature," "Mother Earth," or "Gaia." These ancient beliefs of an integrated world where humans are a part of the larger system have been receiving greater philosophical and research support. One such theory, network theory*, or deep ecology* (Capra 1996), represents a synthesis of systemic ideas from general systems theory, cybernetics, human communication processing model, autopoiesis, physics, and nonlinear mathematics. Capra's articulation of network theory* holds profound implications for the study of family systems in general, as well as the practice of couple and family therapy.

## Theoretical Context for Concept

The evolution of systemic ideas familiar to the CFT field also informed Capra's ideas. Specifically, Bertalanffy's general systems theory, Wiener's cybernetics, and Bateson's human communication processes model were key influences. However, the work of Chilean neurologists Maturana and Varela whose study of biological cells and processes led to their concept of autopoiesis and the role of language in meaning making became foundational to network theory*.

Many systems-based ideas lacked mathematical models that provide methods to support or, more importantly, disprove components of the theories. Furthermore, most mathematical, and statistical, models used in the CFT field and social sciences are based on linear, cause-effect, assumptions which are inappropriate to use when modeling complex systems. Only the emergence of a branch of mathematics referred to as nonlinear dynamics, or dynamical systems theory, has the door opened to unifying mathematics and systemic ideas.

One final contribution to network theory* came from physics experiments where stable, emergent patterns occurred when energy was introduced into a previously instable environment. Self-emerging patterns out of energy-filled, chaotic environments are called dissipative structures. Dissipative structures may appear to have the characteristics of homeostasis but are in fact the result of irregular processes in the context of irregularity and energy.

## Description

Capra's synthesis contains three interdependent main components along with nonlinear mathematics: (1) the pattern of organization (informed by autopoiesis), (2) the structure (informed by dissipative structures), and (3) the life process (informed by Bateson, Maturana, and Varela's ideas related to cognition, communication, and the role of language).

First, a living system has a closed boundary that contains components that interact with each other that result in replication of the system while also transforming the components themselves (i.e., the pattern of organization or autopoiesis). Second, the structure of the system is a result of dynamic processes within the boundaries of the system that utilize the inflow and outflow of matter/energy. Homeostasis in the traditional sense of the term is an illusion in network theory. Structure is actually a result of inherent instability of processes (dissipative structure) and would be expected to change as matter and energy moving through the structure change. Third, cognition operates as the process. Cognition in network theory occurs through a complex system that consists of *interactions* within one's own physiology, interactions between individuals, and interactions between structures and their environments. Simply put, cognition, or the "mind," is brought forth and maintained through interactions between individuals and their environment as well as within individuals.

## Application of Concept in Couple and Family Therapy

In application, network theory changes the relationship between clinicians and clients as compared to traditional CFT conceptualizations of systems theory. Clinicians are not trying to break homeostatic mechanisms that are keeping the family "stuck." A network (i.e., family) is responsive to its environment through processes between the components (individuals) within its structure. As the therapist joins with the family, a new component (the therapist) is invited into the structure. The pattern of organization has changed due to the additional component, thereby requiring each component (family member) of the system to alter interactions with each other and the therapist – no battles, paradoxes, or sneakiness required. Through language, the new system (therapist and family together) "bring forth" a new, different, or altered world. As the family reproduces the altered world, the components (family members) are also transformed which constitutes the process of autopoiesis (autopoiesis = "self-making"). The transformed components in turn help reproduce the new/different world brought forth through language.

## Clinical Example

It is important to note that Capra's network theory* has not been formally articulated as a treatment model (Kozlowska and Hanney 2002 did use network theory* as a frame to integrate with attachment theory). Thus, the following vignette represents a possible approach using this theory.

Dan, 40, and Maria, 43, are a newlywed couple who both have children from previous marriages and are seeking therapy for issues related to conflict in their blended family. Before their marriage, all the children enjoyed being together. Over the last few months, Dan's girls (ages 3 and 5) have grown increasingly adamant about not wanting to be around Maria's children (ages 4 and 5), while Maria's boy, who recently started kindergarten, has been exhibiting increased outbursts of anger at home. Conflict between Dan and Maria has also begun to escalate as they each defend their own children while blaming their partner's children.

As the therapist asks each family member about their own perception of the interaction patterns, roles, and hopes in the family, the therapist is attending to the world brought forth and recreated through their interactions. As they interact with each other and the therapist, the family notices that the family was self-replicating a world where children are afraid to lose their parents (Dan's girls were told by their grandfather that they will have to share their father with Maria's children and advised them to enjoy their time with their father while they still had the chance) and that change was "scary" (Maria's boy revealed that he has been frightened by some of the other students who had been acting aggressively toward him). This frightening world in turn influenced change in each family member to continue to act more fearful and angry.

However, through the altered interactions with each other with the therapist, a different world is brought forth where children are reassured and protected by parents and stepparents who in turn reassure and protect each other. The natural network processes continue so that the new world is being reproduced within the network which then transforms individuals in the family.

## Cross-References


- ▶ Autopoiesis in Family Systems Theory
- ▶ Maturana, Humberto
- ▶ von Bertalanffy, Ludwig


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# Neurobiology in Couples and Families

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## Name of Concept

Interpersonal Neurobiology

## Introduction

Family therapy originated as a reaction against biological reductionism. However, recent decades have witnessed a rapprochement between neurobiology and family therapy both in understanding mental health problems and in designing more effective interventions for relational problems. The impact of neurobiology in couple and family therapy can be seen in several domains described in the Application section.

## Theoretical Context for Concept

Diverse contributions have created the theoretical context for interpersonal neurobiology including works on self-regulation, emotional regulation, attachment theory, behavioral biology, genetics, and basic neuroscience. These theoretical concepts are interrelated. For example, attachment behaviors of a mother rat (licking and grooming her young) facilitate brain development (myelination) that in turn facilitates self-regulation skills. These core concepts have led to applicable clinical models such as the ecobiodevelopmental model which describes the interplay between parenting, stress, attachment, and brain development. In couples work, the critical role of safety can be viewed as both a physiological process and an interpersonal construct.

## Description

The brain has dual social cognition systems – one for person-to-person relatedness, enabling empathy and mindsight, and one for categorical social cognition, enabling sociobiological systems that provide family organization with its attachment relationships, hierarchy, boundaries, reciprocal altruism, and family identity. While these two social cognition systems normally operate in a highly integrative, complementary manner in daily life, couple and family therapists may focus on one or the other depending upon their theoretical orientations. For example, psychodynamic and narrative therapists tend to prioritize therapeutic strategies reliant upon person-to-person social cognition, while structural family therapists emphasize interventions involving categorical social cognition and change in family organization.

## Application of Concept in Couple and Family Therapy

1. Neurobiological explanations for relational problems can have rhetorical value in reducing blame and shame. John Gottman's demonstration that males tend to have gender-related vulnerabilities for dysphoric emotional flooding during marital conflict has provided a biological (and face saving) rationale for interventions to improve emotion regulation in couples.
2. A neurobiological model for emotion generation and regulation provides an overarching model for how loss of top-down regulation by prefrontal cortex over subcortical systems, such as the amygdala, results in emotional flooding that then disables empathy, reflection, and problem-solving. This model shifts the focus of therapeutic intervention away from problem-solving and towards emotion regulation strategies. It supports therapeutic strategies for couples, parents, and children aimed at keeping emotional arousal within each person's zone of tolerance.

3. Neurobiological research has demonstrated that brain systems for monitoring threat are anatomically distinct from systems that produce a sense of safety. For example, the autonomic nervous system that produces fight-or-flight responses helps explain family members' responses, especially in conflict situations. Attachment relationships have potent effects for activating safety systems, and hyperarousal can be viewed as a result of insecure attachment relationships that do not facilitate emotion regulation when a family member is distressed. This broader model provides theoretical support for trauma-informed therapies, such as emotion-focused couple therapy.
4. An understanding of the neurobiological processes that underpin relational life enable interventions that specifically target vulnerabilities associated with major psychiatric illnesses, such as expressed emotion and cognitive loading (psychotic disorders), disruption of biological rhythms (bipolar disorder), avoidant coping style (anxiety disorders), and rumination (depression). Neurobiological models provide a rational framework for integrating psychopharmacological and family relational therapies.

## Clinical Example

A relationship pattern frequently seen by therapists is a pursuer-distancer pattern. With couples, the pattern follows a familiar sequence: During conflict, Terrance and Chris experience physiological arousal. To cope with the discomfort, Terrance withdraws to calm down, which increases the anxiety of Chris, who pursues Terrance for continued emotional and physical connection. If the pattern is not effectively interrupted, each partner can eventually withdraw, resulting in increased social isolation and emotional dysregulation. Also, the pursuer-distancer roles can be linked to the family of origin: Terrance experienced intrusiveness and poor boundaries in his relationship with his parents; Chris experienced rejection and rigid boundaries in her relationship with her parents.

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# Neutrality of Therapist in Couple and Family Therapy

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Neutrality in couple and family therapy was first defined by the Milan group (Selvini et al. 1980). Since then, neutrality has primarily been defined as (1) the clients believing that the therapist is not aligned against any one person and (2) the therapist not internally aligning with or against any person.

Neutrality has also sometimes been referred to as a therapist not bring personal values into therapy or not taking a stance regarding client behavior. These ideas of neutrality have been consistently rejected as being both impossible and destructive (Fife & Whiting 2007; Doherty 1995).

## Neutrality from the Perspective of Clients

Selvini et al. (1980) said that if a therapist maintained a neutral stance and after a session

the family was asked whom the therapist supported or sided with or what judgments the therapist made regarding each individual or the family as a whole, the family would be "puzzled and uncertain." (p. 11). Cecchin is quoted as saying if each family member was asked at the end of a session whose side the therapist was on they would all say "My side" (Campbell 2003, p. 17). Whether they are puzzled or they all think the therapist is on their side, what is key is that each member of the family does not believe the therapist is aligned with someone else.

Maintaining a neutral position from a client's perspective can be difficult because regardless of how the therapist is thinking, feeling, or behaving in session, family members may perceive the therapist as taking sides. Several techniques can be important in helping to maintain a neutral position:

- **Joining with and developing a strong therapeutic alliance with each client**. When clients feel validated, valued, and respected, it creates a sense of safety, and they become less concerned about the therapist seeing them as the bad or sick one or the therapist taking the side of someone else.
- **Focusing on systemic interaction**. When the therapist asks circular questions – questions that focus on process, not content – it helps the clients feel the therapist is not singling out any one member as being the problem.
- **Tend to diversity issues**. It is important to be aware of clients' possible past experiences with the age, culture, gender, and other diversity-related characteristics of the therapist which might lead clients to consciously or unconsciously not feel safe with the therapist. Awareness of possible blocks to safety can help the therapist know where to work harder to develop a safe alliance. For example, a male therapist may need to be particularly sensitive with a female client who has been abused by a male. An older therapist may have to make a special effort to show interest in a teenage client.

## Therapist Internal Neutrality

Internal neutrality involves the way the therapist thinks and feels about various participants in the therapy as well as how the therapist conceptualizes the case. When a therapist blames, pathologizes, takes sides, or decides who is right or wrong or who is bad or good, the therapist has moved out of neutrality. Again this does not mean that a therapist cannot decide what *behaviors* are destructive and take actions to stop them. Therapists have a duty to both report and prevent child abuse, stop domestic violence, etc. Identifying and stopping bad behavior are very different than deciding who is bad.

For the therapist to internally maintain a completely neutral position is impossible since all therapists have values, wounds, and life experiences. However, striving to maintain an internally neutral position is a helpful goal. There are ways a therapist may work toward internal neutrality:

- **Thinking systemically**. When a therapist thinks systemically, the therapist is focused on how to improve functioning through understanding and changing relationships. The therapist is not focused on who is to blame or who is sick. This does not mean the therapist ignores mental health issues such as depression or psychotic disorders. Rather it means that symptoms only make sense in their context, which usually includes multiple systemic levels such as biological systems; intrapsychic systems; couple and family systems; social, economic, and cultural system; and environmental systems.
- **Doing self-of-the-therapist reflection and growth**. As therapists work on becoming aware of their own biases, wounds, values, privileges, and perspectives, they can approach clients in a more grounded, secure, and neutral manner (Aponte 1992).
- **Seeking out supervision**. Talking through cases with a supervisor can help the therapist avoid moving away from neutrality. Telling the

supervisor that the therapist wants to maintain a neutral position can help focus the supervision on a systemic understanding of the case.

## Case Example

A middle-aged couple, Tim and Abby, came to Shanika for couple therapy. Tim was tall and overweight, and Abby was small and petite. Early on, the couple reported that Abby was often very angry with Tim and that Tim typically shut down. By the end of the first session, Shanika found herself thinking it made sense that Abby was upset since Tim was so overweight, even though Abby focused on how emotionally closed he was and did not mention his weight. Recognizing she was blaming Tim, Shanika sought out supervision. In supervision she realized she had an uncle who was also mean to her when she was young and overweight. Simply recognizing this helped her separate Tim from her uncle.

In the next session, Shanika was able to keep her focus on the pattern of interaction and soon no longer saw Tim's weight. Instead she saw him as a person in pain that was caught in a negative cycle with his partner. The couple likely never saw Shanika's struggles with neutrality, but with the help of Shanika's supervisor, she was able to regain a neutral, systemic view of the couple.

## Cross-References

- ▶ Joining in Couple and Family Therapy
- ▶ Split Alliance in Couple and Family Therapy
- ▶ Values in Couple and Family Therapy

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# Nichols, Michael

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## Name

Nichols, Michael

## Introduction

Michael P. Nichols is a family therapist, teacher, and author. His writing includes a classic systematization of the field of family therapy, as well as his own contributions to theory and practice.

## Career

Nichols obtained his Ph.D. in clinical psychology from the University of Rochester (1973) and undertook postdoctoral training with Salvador Minuchin at the Philadelphia Child Guidance Clinic, with Murray Bowen in Washington DC, and at the Lenox Hill Psychoanalytic Institute in New York.

In 1973 Nichols began teaching at Emory University, as assistant professor of clinical psychology, and later served as acting director of clinical training. In 1977 he moved to Albany Medical College where he worked for 17 years, as

professor of psychiatry, director of family therapy training, and director of outpatient psychiatry. Since 1994 he has been professor of psychology at the College of William and Mary. He has taught on a wide range of subjects, including family therapy, psychoanalytic psychotherapy, self-psychology, abnormal psychology, personality theory, group therapy, and research methods in psychotherapy.

In addition to the teaching and service awards garnered during his career, Nichols has also excelled in an extracurricular activity. In his 50s, he took up powerlifting and has been a member of the US national team in four masters worlds championships, earning a gold medal in one and silver medals in two others.

## Contributions

Nichols considers his work with patients and with students to be his primary contributions. His influence on the field of family therapy, however, extends far beyond those endeavors. Students and practitioners of family therapy have enjoyed and benefited from the solid conceptualization and engaging style of his many writings, which cover the whole range from case studies to broad systematizations. At one end, *Inside Family Therapy: A Case Study in Family Healing (1998)* offers a closeup look at one therapist and one family and seamlessly intertwines the developmental history of the family, the process of therapy, and the therapist's thoughts as he interacts with the family. At the other end, *Family Therapy: Concepts and Methods* presents a wide-angle perspective of the whole field of family therapy. Currently in its 11th edition (2016), this book has long been recognized by teachers, students, and practitioners around the world as the best guide to the understanding and practice of family therapy. Thorough and substantial in content, and clear and fluent in style, it covers the origins and development of family therapy, draws comparisons between the various schools, and makes ample use of real cases as illustration. Nichols' vast knowledge and appreciation of the diverse strains of family therapy also led to his collaboration, as the editor of the Guilford Family Therapy Series, with the authors of many other influential books.

Nichols' early training in psychoanalysis is manifest in his insistence on the need to reintegrate the individual into the family therapy endeavor. The explicitly titled *The Self in the System: Expanding the limits of family therapy* (1988) prods family therapists to explore the inner world of family members, rather than seeing them as dimensionless points in a diagram. Twenty years after *The Self in the System*, Nichols coauthored *Assessing Families and Couples: From Symptom to System* (2006) with Salvador Minuchin and Wai-Yung Lee. This book introduced a four-step assessment model, which includes an exploration of the worldviews that each family member learned from their families of origin.

In his teaching and writings, Nichols is careful to differentiate the integration of a psychodynamic *perspective* into family therapy, which he supports, from any attempt to mix psychodynamic and family *techniques*, which he does not recommend, lest the impact of the original models is watered down.

Nichols' collaboration with Salvador Minuchin includes another co-authored book, *Family Healing: Tales of Hope and Renewal from Family Therapy* (1993), as well as his prime contribution to the systematization of structural family therapy, namely, his research and writings on the technique of enactment. Here Nichols' clinical and expository talents combine to gift practitioners and students of family therapy with a solid understanding of the rationale underlying this most essential tool of structural family therapy, as well as step-by-step instructions for using it (Nichols and Fellenberg 2000).

A summary of Michael Nichols' contributions would not be complete without mentioning his books intended for the general public, which have been lauded for their accessible wisdom: *No Place to Hide: Facing Shame So We Can Find Self-Respect* (1991), *Stop Arguing with Your Kids* (2004), and, the best-selling, *The Lost Art of Listening* (1995).

## Cross-References

- ▶ Bowen, Murray
- ▶ Colapinto, Jorge
- ▶ Davis, Sean
- ▶ Enactment in Structural Family Therapy
- ▶ Lee, Wai Yung
- ▶ Minuchin, Salvador
- ▶ Philadelphia Child Guidance Clinic
- ▶ Structural Family Therapy

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# Nielsen III, Arthur C.

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## Name

Nielsen III, Arthur C.

## Introduction

Arthur C. Nielsen, III, MD, is a board-certified psychiatrist, psychoanalyst, and couple therapist, practicing in Chicago, Illinois. He is a clinical associate professor of psychiatry and behavioral sciences at Northwestern University's Feinberg School of Medicine and serves on the faculties of the Chicago Institute for Psychoanalysis and The Family Institute at Northwestern University. He is best known for his work in marriage education and integrative couple therapy.

## Career

Arthur C. Nielsen, III, MD, was born and raised in Winnetka, Illinois, where he was captain of the New Trier High School state championship tennis team. Dr. Nielsen earned his undergraduate degree magna cum laude from Harvard College, the Department of Social Studies. His summa cum laude honors thesis is entitled "The Ku Klux Klan in the 1920s." He received his MD from Johns Hopkins University School of Medicine in 1972 and completed his internship at the Los Angeles County-University of Southern California Medical Center.

In the mid-1970s, during the heyday of the community mental health movement, Dr. Nielsen did his psychiatry residency at Yale University, followed by a fellowship at the Yale Student Mental Health Clinic. After graduation, he spent 3 years in the Division of Manpower and Training of the National Institute of Mental Health and received family therapy training at the Philadelphia Child Guidance Clinic with Salvador Minuchin (see ▶ "Philadelphia Child Guidance Clinic," and ▶ "Minuchin, Salvador," this volume).

In 1980, he moved to Chicago and became assistant psychiatric residency training director at Northwestern University. He graduated from the Chicago Psychoanalytic Institute in 1992. Soon after coming to Chicago, he established a close relationship with The Family Institute at Northwestern University (see ▶ "Family Institute at Northwestern University," this volume), where he has taught couple and family therapy and later served on its board of directors. With William M. Pinsof, PhD (see ▶ "Pinsof, William M.," this volume), Dr. Nielsen developed the nationally renowned undergraduate course, *Marriage 101: Building Loving and Lasting Relationships*. He taught and coordinated that course from its inception in 2001 until 2015.

Since graduating from his residency, Dr. Nielsen has taught an integrative approach to emotional disorders to college undergraduates, medical students, psychiatric residents, marriage and family therapy students and fellows, psychoanalytic candidates, and practicing professionals at the Northwestern University School of Medicine, The Family Institute at Northwestern University, and the Chicago Institute for Psychoanalysis. In addition, he has presented his premarital education work in many venues, especially at annual Smart Marriages Conferences. Dr. Nielsen has presented the integrative model for couple therapy at conferences in the United States, Ireland, Spain, France, and China. In 2016, his integrative work in couple therapy culminated in the publication of *A Roadmap for Couple Therapy: Integrating Systemic, Psychodynamic, and Behavioral Approaches.*

## Contributions to Profession

Throughout his career, Dr. Nielsen has integrated thought from different disciplines – economics, history, sociology, psychology, and biology – and from different theoretical approaches to psychotherapy. He has actively bridged gaps between mental health professions, linking academics and clinicians across disciplinary lines, schools of thought, and university departments. Most importantly, he has been a liaison between organized psychiatry, psychoanalysis, and family therapy. As part of a study group, led by psychoanalyst and couple therapist, Jack Graller, MD, he studied and wrote about their experiences of collaboration between individual therapists and couple therapists, emphasizing the value of such collaboration in coordinating treatment.

Dr. Nielsen's interest in couples and couple therapy led him to develop an academically rigorous undergraduate course in marriage to teach what is known about successful marriage. Additionally, he wanted the course to be experiential by providing students with opportunities to develop practical skills to help them succeed in their current and future relationships. Lastly, he wanted to expand premarital education to college-age students, hoping that it would have more impact on emerging adults before they had selected their marital partner. Following a two-pronged research study that simultaneously asked college students what they wanted to know about marriage, and experienced couple therapists what they thought should be included in such a course, Dr. Nielsen and Dr. Pinsof emphasized increasing student self-awareness. The course is known for exercises that ask students to reflect on their personal tendencies during conflict, structured interviews students conduct with mentor couples in the community, and structured interviews students conduct with their own parents.

Building on his work in premarital education, psychoanalysis, structural family therapy (see ▶ "Structural Family Therapy," this volume) and Tavistock Group Relations Conferences (see ▶ "Tavistock Clinic," this volume), Dr. Nielsen developed his comprehensive, integrative model of couple therapy. This model begins with what he terms Couple Therapy 1.0, in which partners talk to each other with the assistance of the therapist. Then, to increase the power of the intervention, "upgrades" (techniques from the major schools of therapy) are added.

Dr. Nielsen has reviewed books and journal submissions for many mental health journals and served on the editorial boards of *Family Process* and *The Journal of Marital and Family Therapy.* He has served on numerous committees and advisory boards, including Planned Parenthood, Family Focus, the Chicago Bar Association, the American Psychiatric Association, the American Psychoanalytic Association, and the American Board of Psychiatry and Neurology. Dr. Nielsen is a Distinguished Fellow of the American Psychiatric Association and the author of over 40 papers in psychiatry, psychoanalysis, and couple therapy.

## Cross-References

- ▶ Family Institute at Northwestern University
- ▶ Integration in Couple and Family Therapy
- ▶ Marriage

- ▶ Minuchin, Salvador
- ▶ Philadelphia Child Guidance Clinic
- ▶ Pinsof, William M.
- ▶ Structural Family Therapy
- ▶ Tavistock Clinic

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# No Harm Contract in Couple and Family Therapy

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A No Harm Contract is an agreement between client and therapist that the client will not take steps to hurt themselves or others over a specified length of time, often leading up to the next scheduled session or the next opportunity for the client to be reassessed. At that point, the therapist can determine whether further steps are needed to protect the client's safety. The agreement is typically made in writing and signed by the client to demonstrate their commitment to its terms.

In couple and family therapy, No Harm Contracts have been applied more broadly, not just to physical harm but also to actions that could be detrimental to the couple or family system. For example, if a couple has been struggling with the revelation of an affair, a No Harm Contract applied to this context might be an agreement where the person who had the affair contracts that he or she will not have any contact with their affair partner while the couple attempts to repair their relationship in therapy.

In recent years, No Harm Contracts have fallen out of favor in all forms of psychotherapy. They are not contracts in the traditional legal sense; other than terminating treatment, there is little penalty a therapist could invoke if the client failed to hold up their end of the agreement. Further, there has been concern that such a contract demonstrates an inadequate response to what the therapist has clearly recognized as a potential safety issue. To document that a therapist simply took a dangerous client at their word that they would not harm themselves or others over a specified length of time may open the therapist to liability.

For these reasons, it is now preferred to develop a Safety Plan with clients who display significant risk factors for dangerous behavior but do not express intent or other indicators of immediate danger.

In a Safety Plan, not only does the client commit to not engaging in harmful acts during the time period specified, but the client and therapist also agree on specific actions the client will take should the client begin having thoughts of harming themselves or others. Such actions typically are listed in a stepwise progression. For example, it may begin with calling a friend or family member for support. At each step, if that effort is ineffective, there is a next step for the client to take. Contacting the therapist is typically included, with provisions for those times when the therapist may be unavailable. Many such plans include, as a final step, calling a Crisis Line or 911.

No Harm Contracts, like the more modern Safety Plans, are generally considered appropriate interventions only for those clients who present risk factors for harm but no immediate plan or intent. These documents represent a very low level of intervention and are thus appropriate to clients who demonstrate low levels of risk. For

clients assessed as being at greater short-term risk for doing harm, more intensive interventions may be appropriate, such as increasing the frequency of sessions, ensuring that the client always has a member of their support system present at home, or moving toward hospitalization.

# Nodal Thirds

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## Name of Concept

Nodal third

## Synonyms

Nodal third; Significant member; "Tiers pesant"; Weighty third

## Introduction

The term ***nodal third*** refers to someone whose presence (physical or evoked) is almost essential to "good" balancing of relationships within a system (Goldbeter-Merinfeld 2016, 2017). While everyone can be a third for two others, in a manner unwitting rather than consciously or even voluntarily, the *nodal third* unlike what could be called a *light third* is assigned or takes a specific and permanent feature as the third in relationships in the family. It allows families to stabilize (and rigidify) their functioning around one of their members, who acquires therefore an essential role in the conservation of the balance of the system being a regulator of affective distances and emotional balance among its members.

The departure (in any form) of a *light third* is easy to live with: the system quickly finds another partner to fulfill this function. In contrast, given the "need for his function," it is difficult for the *nodal third* to leave, as it is for the rest of his family to bear his absence, whatever its form: death, brutal rupture, or gradual distancing. The other members of the system are faced with an impossible grief because they are not ready to change their inter-relational organization. The emergence of a *nodal third* system is related to a difficulty to cope with the necessity of a profound transformation of the system, that is to say a second order change to evolve.

Therefore, when doing family therapy, we can use the working hypothesis that behind the official presented problem the family may be confronted to a crisis linked to the recent disappearance of such a *nodal third*.

## Theoretical Context

The concepts underlying the model of the *nodal third* emphasize the *triangular relationship* and include the assumption that all relationships are triangular. This reading differs from that of Bowen (1976) in the sense that it does not consider the existence of a purely dyadic relationship.

The model refers to the work of Norman Paul (1986) about the *experience of absence*, mourning management, and the concept of replacement. It therefore deals with the evolution of human systems over time, with elements favoring continuity and those creating discontinuity in their history.

The *nodal third* model refers also to a *transgenerational perspective*; the nodal third can belong to previous generations and the unfinished mourning of his departure can be passed down through generations.

It implies a *second-order cybernetic* view, considering that the therapist is included in the system where he operates. Therapeutic intervention can therefore be based on the analysis of the function that the therapist is supposed to fulfill in the therapeutic system in order to efface absences that are too difficult to confront. It therefore employs the unique *resonances* (Elkaïm 1990) emerging in the meeting between the therapist and the family which consults highlighting the possible intersections between the construction of the world of the family and that of the therapist around absence and the *nodal third*.

## Application in Couple and Family Therapy

When a family asks for therapy, the first meeting is prepared by setting more chairs than the expected number of participants (therapist included) in the session. As the family sits first in the room, it always arouses in the therapist's mind the question of what place he will himself choose. One or more of the empty chair(s) – when all the family members sit – may belong to absent third(s). It is important to let this absent keep his seat rather than taking it for us as if it does not matter.

Supernumerary seats offer therefore many advantages: they involve the recall of the choice of the place we are facing as therapists. This emphasizes that such a choice is not random and pushes us to consider its possible meanings in the system. Empty seats dramatize absences by making them "tangible" and pointedly remind the family as well as the therapist that *the system is (always) incomplete*, there are those absent who are present, and they have the right to be there.

The moment we feel a ghost is appearing, it is easier to avoid embodying it. We can strengthen this movement by interviewing partners about the place that would be occupied by the absent if he would still be present. It may be that they mean precisely the chair on which we sit; standing up to change places is a dramatization of the absence of the third – his "irreplaceability" – and allows displacement of the definition of our own function in the system. *Instead of masking the absence by taking over its function, we will confront the therapeutic system with the mourning not performed and initiate work to resolve this grief*.

Acknowledging the presence of an absent at the meeting mobilizes each one differently: the members of the family are faced with their unique relationship with the absent; at the same time, different possibilities of grief open up to them, individual time resumes its importance with respect to systemic time. In this context, the therapist must be ready to assist members of the family to develop both a collective family mourning and individual grief. He must provide a container for the intense emotions.

## The Therapist as a Professional *Nodal Third*

Along 35 years as a trainer, I have observed repetitively the same pattern in the presentation of own family histories and genograms of trainees (already clinical professionals): they all started very young to help other members of their own family, e.g., refereed conflicts, deviated tension onto themselves, sometimes being Identified Patients, etc. They also had the feeling of not having achieved the desired result and somehow lacked finesse or skill. It was as if they had then selected studies that permitted them to improve their skills. They abandon with difficulty this role of *nodal third* in their family of origin and continue to feel they have a mission that they should bring to an end.

During the establishment of the therapeutic system, the meeting will be organized between a "professional *nodal third"* in search of a (his?) family to repair and a family in search of a (its?) *nodal third*. Everything happens as if, before the first meeting or the first call, the therapist has a form of identity or a predetermined role for the family.

The dance around the establishment of a systemic time will occur silently. The issues will be the restoration of a previous state, where the family had no lack and where the therapist will be able to help his family of origin, or on the contrary the emergence of a present and a future.

Far from claiming neutrality, the therapist must be aware of the sensitive points his patients touch in him and then verify that there is a *resonance* (see entry in this encyclopedia) and not an outright invasion by his own concerns that have emerged independently of the relationship with the other. The model referring to the *nodal third* leads therefore to consider the meaning of a therapeutic session from other elements than those derived from the direct analysis of the demand.

Using chairs as metaphors of an absent member of the family gives to these chairs a special quality: they become a representation of the reality, being at the same time not the accurate reflection of this reality. Therefore, they encourage imagination, free association, and movement at a new level. This creates a shock,

surprise, and a tipping of some rooted certainties, all essential conditions for a therapeutic step. One enters a creative process.

## Clinical Example

I met some time ago a family constituted by the parents in their 70s and their two married daughters (40 and 42) and single son (38). The father, a still active businessman, complained of the difficult relation he had with his son who was a "failure professionally." I proposed that all the family should come to the first session. They were sitting in my office in a circle: the son, the father, then the two daughters aside, an empty chair, then the mother. To close the circle, it remained a large sofa of three possible places where I chose to sit in the middle. It was obviously a high standing-bourgeois' family, the three women wearing elegant and expensive clothing. Father and son were fighting, the young man accusing his father not to support him and the father saying that he was not able to manage by himself. When I interviewed sisters and mother about the family situation, I was unexpectedly a witness to a very hard attack of the two young women saying that "Mother was stinking" and that they "approved and understood that father had mistresses"! When visiting their parents, they usually avoid remaining in the same room where she stays. They could barely stay with her in my office because my presence gave them a feeling of security and calmness (!).

I discovered that this tense atmosphere amplified 6 months ago. I asked if somebody helped them before to avoid such fights and they told me that father's sister, a single nurse, was the person with whom everyone could speak quietly when she was visiting, and they all enjoyed a family dinner together with her. She was a calm, secure person, helping everyone to feel safe. She died 6 months ago, and everything fell apart. I noted also that they used the same words to qualify this woman and me. . .

When I asked where this aunt would sit if she would participate to our meeting, unsurprisingly, they all showed to my place. I stood up saying that then, it was her place and not mine, a stream of intense emotion crossed the family. . . I helped them afterwards to enter in the mourning process.

The model presented here does not pretend to be an objective explanation of reality and does not offer the only possible construction of the "therapeutic reality." It may make sense when particularly intense vibrations occur around the theme of absence, amplifying one another in the encounter between patient and therapist. It offers the therapeutic system a common metaphor that refers each member to the experience of absence that is universal but nevertheless so unique every time.

## Cross-References


- ▶ Resonance in Couple and Family Therapy
- ▶ Triangles and Triangulation in Family Systems Theory


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# Norms in Couples and Families


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## Name of Concept

Norms in couples and families

## Introduction

Norms in couples and families include both social expectations and behavior. Family norms, broadly speaking, are social guidelines, expectations, and commonly held rules for the behavior of members of the family (Rodgers and White 2004). Norms also encompass family relationship rules, such that the way in which family members interact with one another is influenced by social expectations and one's social position. Family norms prescribe preferable and objectionable behavior based on one's culture and position in the family; norms can be healthy and functional or destructive. Understanding family norms has important clinical implications within case conceptualization and clinical intervention.

## Theoretical Context for Concept

Systemic and developmental perspectives provide the theoretical context for norms within couples and families. Through homeostatic mechanisms, ecological influences, and multigenerational processes, commonly held patterns of expectations and behavior (i.e., norms) are created and maintained in families. In further delineating the concept of family norms, at least two types are present in social institutions, including families: (1) static norms which regulate behavior and expectations within an age group or stage (e.g., launching into adulthood) and (2) process norms which regulate the timing and sequencing of expectations and behavior (e.g., empty nests and retirement) (Rodgers and White 2004). The dynamic interplay among family members and between family and biopsychosocial variables creates a unique context by which families adopt expectations for behavior. Norms, therefore, are not universal or fixed.

## Description

Family norms can vary widely among families and may change from one generation to the next. Because of the ecological and societal influence on family norms, however, some norms have been relatively stable across time and context (e.g., the expectation that children should respect their parents). Norms may dictate such behavior as who typically takes care of organizing family get-togethers or who will care for aging parents. Accepted patterns of communication (i.e., frequency, type, and depth of content) are examples of norms passed through generations, yet may change from one generation to the next. Emergent technology and other social forces allow for adaptation within the family. Family roles, in contrast to norms, are all the norms attached to a given social position (Rodgers and White 2004). Because norms change over time and vary by social circumstance (e.g., working mothers) and developmental stage (e.g., adolescence vs. adulthood), roles also change.

Norms must be considered in light of social forces. Norms cannot be separated from forces such as role, position, and status because of the intense interaction between norms and social structure (Bates 1956). Within the family, the head of household, for instance, carries certain expectations, power, and privilege to make decisions for the family. In the same way, social structure may affect individuals within the couple or family based on issues of privilege and oppression. One common example is the assertion of power within relationships involving intimate partner violence. Norms within couples and families are inherently connected to issues of power and control as a result of race, gender, religion, age, sexual orientation, ability, and more. Furthermore, the broader societal context in which individuals, families, and groups exist affects norms within couples and families. As a result, norms can be both functional (healthy) and dysfunctional (associated with distress). In conjunction with social structures, an individual family's goals, context, resources, and culture dictate family patterns (Walsh 2011).

Norms develop through homeostatic mechanisms within the family system and societal context. Over time, expectations are circumscribed into a narrow range of acceptable behaviors, bringing about norms (Jackson 1965). The development of norms within couples and families results from familial processes expressed through explicit and unspoken rules, as well as expectations about actions and consequences within the family (Jackson 1965; Walsh 2011). This may

occur through story-telling or role modeling, for instance. Within the family group, members create internal family norms that may complement or deviate from other institutional norms (e.g., education, employment; Rodgers and White 2004). For example, a common family pattern may be career first, then marriage, followed by children.

In order for norms to change, there is typically a deviation in behavior among multiple members (or across multiple generations) which creates a new expectation (Rodgers and White 2004). A good example of this is the increasing age by which individuals are entering committed relationships. While the norm in most families had been much younger a few generations ago, the norm is older today. Another example is changing gender norms that occurred as a result of changing behavior (e.g., women working outside the home during World War II), which preceded the expectation and acceptability of working mothers. However, there are circumstances in which norms are altered in response to unexpected adversity (e.g., loss of a child; Walsh 2011). Alternative norms may develop to adapt to the new life circumstance. Finally, norms may change as a result of intervention, such as through therapy.

## Application of Concept in Couple and Family Therapy

Couple and family therapists who assess family norms are better equipped to draw on the resources of the family system, while working to alter or eliminate dysfunctional or maladaptive patterns. Understanding norms within couples and families guides conceptualization of the presenting problem within the system at any given time. For instance, a strong family norm regarding the behavior of fathers as breadwinners may perpetuate feelings of inadequacy or shame in a family whose father has been laid off from work. Because gender is a strong organizing norm, examining gender roles, expectations of males and females within the family, and the problem of gender binaries is necessary (Knudson-Martin 2011).

Because therapist bias can be detrimental to treatment progress, it is critical to examine the therapist's own expectations about behavior within couples and families and how they may influence his or her work with clients, particularly when the therapist's and client's family norms are in conflict with one another. Assumptions about normality and healthy functioning should be separated, such that healthy functioning can appear in a variety of forms (Walsh 2011), even if different than therapist expectations.

## Clinical Example

Sydney (age 29) and her mother, Elena (age 67) entered therapy after a series of explosive arguments regarding Sydney's life decisions and Elena's disapproval. The most recent argument centered on Sydney's lack of commitment to education and career. Sydney currently works as a bartender and lives with her fiancé. Elena is recently retired after a 45-year career as a registered nurse. Sydney's father passed away when she was young, and Elena did not remarry. Sydney has four older siblings.

Conflict in the mother-daughter dyad has been growing since Sydney shared that she is pregnant and planning to stay at home with her child. Elena expressed concern that if Sydney doesn't finish school and start a career, then she won't ever be able to support herself or her children. Sydney is frustrated with her mother's imposition on her life. Both desire for a more enjoyable relationship.

To start, the therapist completes a genogram with Sydney and Elena as a tool to assess family norms from each perspective and compares and contrasts their opinions. The therapist asks Sydney and Elena to reflect on generational patterns regarding education and career paths. For instance, Elena's grandmother did not complete high school, but suffered greatly as a result when her husband passed away. As a result, Elena's mother and she both achieved college degrees and were successful in their careers outside the home. Gaining insight into the explicit and implicit expectations allowed Sydney to see her mother's perspective about the role of education in gaining financial security.

The therapist then engages Elena and Sydney in a discussion regarding other norms within the

family to illustrate how some norms have changed across time and to list the pros and cons of each change. Through this exercise, Elena realizes how pressuring Sydney will only alienate her (similar to what occurred with her siblings). After highlighting the role of family norms and allowing opportunity for perspective-taking, the therapist and clients begin to unpack the root of each other's concerns and fears regarding the future.

## Cross-References

- ▶ Biopsychosocial Model in Couple and Family Therapy
- ▶ Family Rules

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# Nuclear Family

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## Name of Family Form

Nuclear families

## Synonyms

Traditional family; Two-parent household; Two-parent family

## Introduction

Nuclear families are typically "traditional" family* units, meaning there is a mother figure, whose primary role is caretaker of the family; a father figure, whose primary role is to provide financial stability; and the children (Canetto 1996). Usually, marital couple and their children are considered to be part of the nuclear family but generally do not include extended family members, such as grandparents, aunts, uncles, and cousins. Recently, there has been a shift in this definition of nuclear families. The modern definition of a nuclear family invites other persons, such as grandparents, aunts, uncles, cousins, same-sex partner, and other members to be included within the nuclear family structure (Canetto 1996). Because of the change in the definition of the nuclear family, the application of some therapy models and the decision of who to include from the family system in treatment may also be changing.

## Description

The definition of nuclear family is greatly impacted by the time and geographical location in which individuals have lived (McGoldrick & Shibusawa 2012). As little as a couple decades ago, the nuclear family was primarily portrayed as a two-parent household*, where the male partner was seen as the primary financial provider and the female partner as the household manager and caregiver of their biological children (Canetto 1996). This definition of a nuclear family was seen as "normal and traditional" and any others as a deviation. Any deviations from the nuclear family norm were potentially seen as unhealthy in the eyes of society and were discouraged. This lack of acknowledgment of differences hindered the examination of potential benefits inherent in a variety of family structures.

The definition of a nuclear family has expanded to include and accept a variety of structures, which creates space for greater understanding of families. Aside from two-parent families*, single-parent families and two-income households are now more common. Reasons for such change in structure are higher divorce rates, decline in marriage rates, greater opportunities of employment for both genders, longer life expectancy, increase in single-parent adoptions, kinship care, stepfamilies, cohabitation, educational achievement, and cultural differences. Additionally, a greater acceptance of same-sex couples led to more opportunities for adoption and greater implementation of same-sex reproductive approaches (e.g., surrogacy or artificial insemination) (McGoldrick et al. 2011). A large number of couples who divorce may remarry or cohabitate, making stepfamilies where two sets of parents are involved in the upbringing of children more common.

Aside from undergoing changes throughout time, culture is also an element that ought to be considered when exploring the definition of the nuclear family. The United States is comprised of individuals and families from diverse cultural backgrounds, allowing other definitions of nuclear family to be established. For example, from a collectivistic perspective, it is common for extended family members to be considered as part of the nuclear family. Many Latino, Asian, and African-American families' households consist of both nuclear and extended family members (Canetto 1996). Within these cultures it is also common to see grandparents as members of the nuclear family. The vision of the nuclear family within these groups is believed to result from economic, demographic, and/or cultural influences.

However, at the same time, the United States has been described as an individualistic culture, in which independence is greatly valued. Throughout history, the number of people living in a single household has decreased. In 1850, the average household consisted of ten individuals (McGoldrick et al. 2011). Whereas in the past, identifying more than one caregiver in a household was common (e.g., a grandmother and a mother), it is now more common to see American households comprised of three individuals or less (McGoldrick et al. 2011). More recently, the nuclear family is limited to a couple and a child, a couple alone, grandparents and a child, or a parent and a child.

## Relevant Research on Nuclear Family

As the nuclear family came to be increasingly diverse in structure in the past decades, the function of the nuclear family has also changed from social institutional to emotional supportive (Bengtson 2001). Urbanization and industrialization increased individualism and secularism. The shift in women's role transformed the family from a social institution based on law to one based on companionship. These changes are becoming increasingly important to individuals and families in American society.

The growing diversity of the nuclear family has led to an interest in how each family structure affects the well-being of the children that are raised within it. The literature is mixed on the effects of different family structures on nuclear family with some literature focusing on deficits created by nontraditional nuclear families. Researchers argue that children who grow up with both biological parents have more positive outcomes in adolescence and young adulthood than those who do not live with both biological parents (Cookston 1999; Hannan & Halpin 2014). Meanwhile, other studies argue that negative outcomes (e.g., isolation, juvenile delinquency, etc.) associated with other family structures are not the result of the family structure itself. For example, financial resources or experience of discrimination and oppression within society can negatively impact the family unit (Pensieroso & Sommacal 2014).

Other literature has examined the advantages of different nuclear families. For example, a nuclear family inclusive of multiple generations tends to be associated with increased multigenerational bonds (Bengtson 2001) and allows

for more availability of family support. Nuclear families with same-sex parents have at least as high of relationship quality, social investment, and parenting skills, compared with opposite-sex parent families (Patterson 2000). Same-sex couples also have high levels of shared employment, shared decision-making, and relationship satisfaction (Biblarz & Savci 2010).

## Special Considerations for Couple and Family Therapy

Given the shifts in family structures and expanded definition of the nuclear family, the therapist's approach to family therapy should also undergo changes to continue meeting the needs of families. The therapist's own understanding of the definition of a nuclear family may impact the process of therapy (Sporakowski 1988). Conceptualizing a nuclear family is easiest with family structures that most closely resemble our own, meaning that therapists in their work might view their own experience of the nuclear family as the norm. Being able to (1) be aware of one's own biases over the definition of nuclear family and the meaning ascribed to it, (2) acknowledge the changing nature of the family structure, and (3) expand beyond the initial definition of the nuclear family are essential components of the therapy process (Bengtson 2001; Sporakowski 1988). Self-of-the-therapist work allows therapists to differentiate their own biases and personal struggles from those of the clients, which in turn helps the therapist be more present and work within the client's point of view (Aponte and Kissel 2014) Not adopting above-described components that are necessary for effective therapy work could lead to difficulty establishing rapport with clients, ineffective time spent in session, inability to connect with clients, and not being able to reach mutual understanding of treatment goals.

Numerous theoretical frameworks exist that guide therapists in their work with diverse family units. While working from a particular theoretical framework, it is beneficial to integrate the client's definition of the family unit. Doing so allows therapists to accept the position of curious learner, show acceptance, and work collaboratively with the client. Collaborative approaches tend to emphasize the co-constructive nature of the social interactions, which allows the therapist and client to have more space to explore their own meanings of family and other concepts, while the therapist values the idea of multiple truths and different ways of making meanings (D'Aniello 2013). Collaboration with clients, no matter what theoretical framework therapists accept, serves as a necessary component that helps to develop the therapeutic alliance as well as allows client to have freedom to express his/her views, beliefs, and values.

Therapists need to make conscious steps toward shifting from the traditional definition that was offered in the mid-1950s to a much more fluid definition of nuclear family. Another option is to abandon the initial idea of the nuclear family and let clients define what it means for them. Integrating client's language and definition of the nuclear family may assist the therapist in the decision of who needs to be included in the therapy process, could give some information about the client's immediate social circle, and could help understand additional contextual factors that are present in the client's life. It is important to have clarity on who each client calls "family," but it is even more important to view the client and the family in the context of the multidimensional social network and context they are in.

## Case Study

Nadine (34 years old) and her son, Tom (7 years old), scheduled an appointment with the family therapist due to Tom's misbehavior at school. Nadine defines her relationship with her son as distant, disconnected, and awkward. About a year ago, she got a job promotion, which requires her to work longer hours and be available on the weekends as well. Her work schedule does not allow her to bring her son to school or to attend any school events or spend much time with him. She spends most of her time at work, on business trips, and in meetings with

her colleagues. While she is working, her sister, Linda, and her mother, Maria, take care of Tom. Linda and Maria live with Nadine and Tom, and they are consistently involved in Tom's life.

After gathering all this information, the therapist makes the decision to invite Linda and Maria to therapy as well, since they might be able to provide more information about Tom's behavior. Maria and Linda were more informed by the school teacher on Tom's recent difficulties at school as well as were able to provide an additional view on his relationship with his mother. They were able to tell the therapist about the times when Tom has expressed sadness over not being able to spend as much time with his mother recently, something that Tom was not able to verbalize in therapy on his own. The therapist then emphasized that it would be beneficial for Nadine to continue attending therapy, because it would allow her to spend some time with her family and learn about the aspects of her son's life she is not able to be part of due to her demanding work schedule. This would also allow her to connect with her family and her son more. The therapist continued working with the whole family, which appeared to be helpful for the family, Nadine's relationship with her son, and Tom's behavior at school. After a couple months of therapy, Nadine and Tom were able to become closer and started enjoying time with each other. Tom's behavior changed, and teachers started expressing their satisfaction with his behavior as well as his performance in school. Nadine was also able to find balance between her work and family. Because the therapy sessions included all persons who were part of Nadine and Tom's nuclear family, the necessary information was available to the therapist to help in treatment planning. Treatment then allowed the family to develop closer relationships and learn how to express their needs and difficulties, which equipped family members with tools that allowed them to deal with any difficulties in other social environments.

## Cross-References

- ▶ Autonomy in Families
- ▶ Boundary Making in Couple and Family Therapy
- ▶ Cultural Competency in Couple and Family Therapy
- ▶ Culture in Couple and Family Therapy
- ▶ Curiosity in Couple and Family Therapy
- ▶ Development in Couples and Families
- ▶ Family Structure
- ▶ Genogram in Couple and Family Therapy
- ▶ Norms in Couples and Families
- ▶ Roles in Couples and Families

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# Nurtured Heart Approach to Parenting Enrichment Program

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## Name of Model

The Nurtured Heart Approach

## Introduction

The Nurtured Heart Approach (NHA) was originally developed to help parents understand how to manage the behavior of children with oppositional defiant disorder, attention deficit hyperactivity disorder (ADHD), and conduct disorder (Glasser and Easley 2016). NHA is increasingly promoted as a valuable strategy for parents of any children. Glasser has designed a training protocol through which facilitators are certified to deliver NHA training through individual coaching or workshops for groups of parents or educators. This training and other training resources are offered online (Children's Success Foundation 2017), as well as through in-person training sessions conducted by Glasser.

Parents can learn how to use NHA through several modes. They can take a class from a trained facilitator or an online class offered by the Children's Success Foundation; participate in therapy, coaching, or consultation with a trained facilitator; or simply read and work independently through the workbook by Glasser et al. (2007). Classes typically run for 6 weeks.

## Prominent Associated Figures

Howard Glasser is the originator of NHA (Glasser and Easley 1999). Lisa Bravo has co-authored NHA books and co-facilitated training workshops with Glasser.

## Theoretical Framework

Glasser and Easley (2016) did not base the design of NHA on any explicit theory or on published empirical research, but rather on Glasser's own experiences as a difficult child and his observations in clinical practice (Glasser et al. 2007). Nevertheless, NHA does have an implicit theoretical framework, as described and evaluated by Hektner et al. (2013). One of the core concepts of the model is negativity. Much as family coercion theory describes (Patterson 2002), NHA assumes that parents and children often find themselves in a cycle of escalating negativity, with each responding more aversively to the other. Children are thought to initiate misbehavior in order to garner attention and energy from their parents; therefore, parents in NHA are trained to respond to misbehavior with minimal energy, by responding very briefly and with flat affect. At the same time, parents are taught to notice and respond with positive energy to positive behaviors in order to build "inner wealth" in their children (Glasser and Block 2007). The goal of building inner wealth is a key element of the model that aligns it closely with positive psychology (e.g., Fredrickson 1998).

Change occurs in NHA through a change in both what the parent attends to (noticing more neutral and positive child behaviors) and how the parent responds (with much more energy to positive and much less to negative). NHA relies in this way on principles of behaviorism, but it also strives to build stronger, more positive parent-child relationships.

## Populations in Focus

NHA was initially intended for clinical populations, but Glasser later adapted it for educational settings (Grove et al. 2007) and clearly intends his books to appeal to a broad range of

parents. Still, the primary focus of the approach continues to be on children identified as "intense" or "high energy" or diagnosed with behavior disorders. Although NHA is being used in Australia, Europe, and Latin America, to date there has been no research on its effectiveness cross-culturally.

## Strategies and Techniques Used in the Model

Parents are given an orientation to NHA using illustrative stories and metaphors to explain key concepts. For example, the "Toys Are Us" metaphor suggests parents are the most interesting "toys" in a child's life, and children will "push buttons" (i.e., engage in certain behaviors) to garner animated responses and attention (Glasser et al. 2007). A number of metaphors and stories are employed to explain the need for parents to shift their focus, create incentives and rewards for good behavior, and avoid unintentionally rewarding undesirable behavior.

Parents are instructed in the use of specific strategies and techniques intended to facilitate each of the three foundational stands of the approach. Strategies associated with the first stand, *refusing to energize negativity*, are intended to be implemented immediately. In order to establish an environment in which misbehavior is not rewarded, parents are instructed to refrain from animated responses to misbehavior, including verbal responses (e.g., lectures) and nonverbal communication of negative emotions (e.g., scowling). Parents are instructed to halt use of harsh punishments and to refrain from engaging in power struggles. Glasser et al. (2007) suggest the first stand of the approach be implemented in tandem with the second stand of the approach, *energizing success*.

The shifting of parents' focus and use of reward contingencies are achieved through four specific recognition techniques hypothesized to develop children's inner wealth. The goal of these techniques is for parents to be attuned to children's existing strengths, to reward already occurring successes in the moment during day-to-day interactions, and to create opportunities for children to directly experience success. The simplest recognition strategy is referred to as *active recognition* and entails parents describing children's positive actions in the moment, without evaluation. Glasser et al. (2007) instruct parents to "watch, describe and document what you see out loud – as if for a blind companion" (p. 59). Because active recognition does not contain any evaluation, but only observation, Glasser et al. propose that active recognition is particularly useful with children who might be initially distrustful of praise.

The second recognition technique, *experiential recognition*, is similar to active recognition in the use of detailed descriptions of observed positive behavior. However, unlike active recognition, experiential recognition includes an evaluative statement intended to help children understand the value of their behavior and connect behaviors with aspects of inner wealth. Some of the words parents are encouraged to use with this recognition technique are "integrity," "responsibility," "cooperation," and "self-control" (Glasser et al. 2007, p. 72).

The remaining two recognition techniques, *proactive recognition* and *creative recognition*, are essentially scaffolding and shaping of desirable behavior. Proactive recognition entails describing misbehavior that is *not* occurring. This recognition technique is intended to honor the self-control and effort required to refrain from engaging in misbehavior, particularly among children for whom negative behavior has been a frequent and chronic problem (Glasser et al. 2007). Creative recognition requires parents to strategically give commands for a child to complete an action that the child is likely to perform. After the child complies with the command, the child is recognized with enthusiastic praise. As children become increasingly cooperative and compliant, parents give more complex commands requiring greater effort. With both of these techniques, parents must have sufficient experience and knowledge of their children's existing strengths and behavioral patterns to make statements and give commands that are appropriate and effective.

The third and final foundational stand of the approach, *clarity of rules and consequences*,

should be implemented only after the first two stands are in motion (Glasser et al. 2007). The following strategies and techniques are included as part of stand three: phrasing of rules as negatives (e.g., "no hitting"), avoiding the use of warnings, using the "reset" to halt negative behavior, refraining from corporal punishment, and delivering consequences with flat affect. The "reset," a technique similar to time-out, is the typical consequence used in NHA. Parents are instructed to make use of this technique in the moment during which negative behavior is occurring and to do so "unceremoniously and without emotional expression" (Glasser et al. 2007, p. 108). Resets are intended to be brief, and the restoration of rewarding "time-in" is emphasized.

In addition to the specific strategies and techniques associated with each of the three stands, parents may also be provided with information on optional strategies to support and enhance the main features of the approach. The use of a credit system is encouraged, particularly to promote school success. Specific ways to maintain communication between parents and teachers are also described in the workbook (Glasser et al. 2007).

## Research About the Model

Hektner et al. (2013) published a review of the theoretical basis and empirical evidence underlying NHA and concluded that its strategies were largely consistent with empirically supported approaches. NHA includes the strategies found to be effective in a meta-analysis of 77 controlled studies on parent training programs (Kaminski et al. 2008). However, to date there have been no published randomized controlled trial studies of NHA. There have been at least one dissertation and two master's theses written about NHA, and one non-randomized comparison study was recently published (Brennan et al. 2016). In that study, parents trained in NHA were found to decrease their yelling and scolding and increase their positive attention to their children; by the end of their training, they reported increased parenting confidence and decreased frustration.

## Case Example

Darin and Tammy had been concerned about their daughter Lexi's negative self-image ever since she had been a young child. Lexi had always been quiet, shy, and defiant. By the time she entered grade school, she began to display moods which were difficult to manage. Her moods were highly unpredictable. Her thoughts were extremely rigid and negative. She was easily overwhelmed and discouraged. At these times she would say things such as, "*I hate myself*," "*I am so stupid*," and "*I wish I weren't alive*." She was cruel to her brother and constantly put him down. Her parents were worried about Lexi but also began to worry about the effect she may have on their younger son. Lexi was becoming increasingly emotionally withdrawn from her family and began to display signs of depression.

By the time she was in second grade, Darin and Tammy brought Lexi to see a therapist. Over the next 3 years, they would see three different therapists, each one trying a different approach before giving up and referring the family elsewhere. Darin and Tammy felt frustrated and hopeless. Rather than try yet another therapist, they attended a 5-week (7.5 h) class on the Nurtured Heart Approach, after which Tammy recalled feeling a sense of hope she had not felt in a long time. Tammy later described the first thing they tried after they had learned about recognitions in class. They came home and Lexi had been babysitting her brothers. She was angry and in tears because her brothers had not been listening to her. On a previous babysitting occasion when Lexi had had a similar experience, she had pushed her brother and he almost fell down the stairs. On this night after class, Tammy recognized Lexi for not pushing her brother even though she was as mad as the last time. Tammy told Lexi that she showed a lot of self-control and that she was very proud of her. Lexi stopped crying and listened.

Over the next few months, Tammy and Darin worked hard to implement the Nurtured Heart Approach. It was working very well with their younger sons, ages 5 and 8, but Lexi did not seem to be responding. Tammy attended additional trainings, one with Howard Glasser and

one with Lisa Bravo, who suggested that they "notch it up" with Lexi and find different ways to recognize her when she didn't appear to be digesting what they would tell her. One tactic Tammy then tried was to say, "*I know you don't like it when I tell you good things about yourself, so I am not going to tell you that I noticed how kind you were by helping your brother with his homework or that I noticed you were responsible when you cleaned up the mess you made in the kitchen*." Tammy noticed that Lexi did not respond with a negative comeback when this approach was used and sometimes even smiled. Another approach was to say, "*Lexi, I noticed some really good things I would like to recognize you for. Would that be ok*?" Most of the time, Lexi would respond by rolling her eyes and saying "*fine*," and then Tammy would proceed to tell her about the positive things she had witnessed. This gave Lexi more power and control. There were rare occasions when Lexi would say "no" to the request. At this point Tammy had already gotten to tell her daughter that she had noticed some really great things even if Lexi didn't hear the specifics.

Darin and Tammy were relentless in their efforts over the next few years. Tammy eventually became a NHA trainer herself. They continued to utilize the approach with all of their children. They tried new ways of phrasing things. They became better at not engaging in negative interactions with Lexi and giving less energy to her negative moods. While doing this they became resolute about recognizing her during times when she was kind to her brother, when she was in a positive mood, and when she tried something new, especially when it did not go as Lexi had hoped it would. Over time the negative moods became less frequent and the positive moods increased. She engaged in a shared activity with her brother that was her idea. She began to be kinder to him. Her negative self-appraisals such as, "*I hate myself*," "*I am so stupid*," and "*I wish I weren't alive*" stopped completely. She would let people hug her and she began to re-engage emotionally with her family. Darin and Tammy also found a therapist who knew NHA and was be able to understand and support what they were doing at home.

Today Lexi is 17. Now her parents describe her as mature, loving, and positive, with a good head on her shoulders. She makes wise choices because she is confident in the person that she is. She is a teacher for younger children at her church and she uses the Nurtured Heart Approach in her class.

## Cross-References

- Authoritative Parenting
- Behavioral Parent Training in Couple and Family Therapy
- Parent Management Training
- Parenting Skills Training in Couple and Family Therapy
- Patterson, Gerald
- Positive Reinforcement in Couples and Families

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# Nurturing Parenting Enrichment Program

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## Name of Model

Nurturing Parenting Programs

## Introduction

The Nurturing Parenting Programs (NPP) provide evidence-based interventions that focus on building the competency of parents as nurturers. These programs are designed to be family-centered and prevent the development and continuation of abusive or neglectful child-rearing practices. The National Institute of Mental Health (NIMH) provided the necessary support for the 2-year-long research and program development effort for NPP to help diminish the growing problem of child abuse and neglect, its associated childhood deaths, and the high delinquency and incarceration rates connected with youth having been abused and/or neglected (Bavolek 2000). Bavolek, Kline, and McLaughlin conducted this research in 1979, which compared the parenting beliefs of teens from abusive backgrounds with teens from nonabusive backgrounds (Bavolek and Hodnett 2011). Findings from this research yielded significant differences in parenting beliefs between these two groups. As a result, four parenting constructs were identified as being significantly influential in childrearing. These constructs include expectations of children that are developmentally inappropriate, a lack of empathy toward a child's needs, belief in and use of corporal punishment for disciplining children, and parentification of the child to meet parental needs (Bavolek and Hodnett 2011).

This study was replicated with two groups of parents, abusive and nonabusive, and identical findings emerged (Bavolek and Hodnett 2011). The four constructs were then utilized to develop the *Adult-Adolescent Parenting Inventory* (AAPI), which was later reformulated to include another construct, oppressing children's power and independence. The reformulated inventory, known as the *Adult-Adolescent Parenting Inventory-2* (AAPI-2), is comprised of items that query about all five of the identified constructs and provide a risk index for each construct (Bavolek and Keene 2001). The Nurturing Parenting Programs were birthed from the research conducted to develop these inventories (Bavolek and Hodnett 2011).

## Prominent Associated Figures

Stephen J. Bavolek, Christine M. Cornstock, and John A. McLaughlin developed NPP through funding from NIMH in 1983.

## Theoretical Framework

NPP is a prevention model, which asserts parenting beliefs and practices that lead to harmful parenting behaviors during childhood can be changed through education and practicing nurturing behaviors. This theory assumes parenting practices are learned during childhood and replicated later in life when a child becomes a parent (Maher et al. 2012). It is believed abusive and neglectful parenting patterns can be replaced by nurturing and supporting parenting strategies. Two philosophical principles underlie

this premise: (1) parents can adopt nurturing beliefs, knowledge, skills, and practices and (2) through learning to nurture themselves, parents will become nurturing parents (Bavolek and Hodnett 2011).

The concept of nurturing is essential in this model. It espouses that both positive and negative nurturing practices exist in parenting, with positive nurturing bringing about aspects parents want in their own lives and the lives of their children and negative nurturing being those unwanted aspects, which also manifest (Bavolek and Hodnett 2011). Positive experiences are believed to build positive self-worth, strong character, and model a nurturing parenting style for children (Bavolek 2000). In contrast, negative experiences model abuse, neglect, exploitation, and victimization of children. Since both positive and negative nurturing experiences tend to be present in a child's life, the focus of the model is to reduce or replace as much of the negative as possible with positive parenting styles. This effort is paramount to NPP and is based on the research suggesting that children will grow up to parent their children with the parenting attitudes and practices they most experienced and internalized in their own childhoods (Bavolek 2000).

The foundation for responsive parenting is empathy; thus, NPP aims to cultivate parental empathy. Within this philosophy, empathy is understood as the process of identifying with another through fully understanding the other person's feelings and motivations (Bavolek and Hodnett 2011). Nonviolent parenting is the bedrock of NPP and the goal is to educate parents to adopt these practices through the development of parent–child attachments built on positive parental responsiveness, care, and empathy (Bavolek and Hodnett 2011). Therefore, NPP aims to help parents resolve identified patterns that lead to child maltreatment by targeting the five parenting attitudes known to underlie child maltreatment: developmentally inappropriate expectations of children, a lack of empathy toward children's needs, the use of corporal punishment for disciplining children, parentification of children to meet parental needs, and oppressing children's power and independence (Bavolek and Hodnett 2011).

## Populations in Focus

NPP has been developed for use in a variety of setting (e.g., schools, Head Starts, mental health, residential treatment, parent education programs) and target families at risk of child maltreatment as well as families in which child maltreatment has occurred.

## Strategies and Techniques Used in Model

NPP addresses a wide array of familial issues at different stages of need. Four program levels have been developed: primary, secondary, tertiary, and comprehensive, each targeting a different level of dysfunction. Primary Prevention-Education Programs are designed to empower individuals with new knowledge, beliefs, strategies, and skills to make "healthy lifestyle choices" (Family Development Resources Inc. 2015). Prevention-Education Programs are approximately 5–18 sessions and are short-term interventions. Secondary Prevention-Intervention Programs target at-risk youth, teen parents, and parents and families experiencing mild to moderate levels of individual and family dysfunction. Ending familial dysfunction and engaging participants in building positive nurturing beliefs, knowledge, and skills are the goals of these programs. Program length generally ranges from 12 to 20 sessions. Tertiary Prevention-Treatment Programs were designed for families involved in mental health or social services because of child abuse, neglect, or family dysfunction. Tertiary programs aim to increase parental understanding of how personal histories of abuse and neglect have affected parenting beliefs and practices. These programs differ in length and may vary from 15 to 25 or more sessions. Comprehensive Programs were developed to provide agencies with empirically supported curriculums to provide long-term parenting education. The length of these programs varies from 26 to 55 sessions. All four intervention models have been adapted for different family circumstances, such as military families and other cultural adaptations or families with substance abuse

issues (Family Development Resources Inc. 2015).

NPP can be implemented in both group and home-based settings. Group-based classes are held once a week for 2.5–3 h with parents and children attending separate but concurrent classes. In the group-based model, two facilitators work with a group of 12–15 parents and three or more facilitators work with the children's group. Children are grouped by age and participate in developmentally appropriate activities and lessons (Family Development Resources Inc. 2015). Children's groups generally include both structured and unstructured play activities. Teen groups are organized a bit differently with teens and parents engaging in role-plays, discussions, and structured expressive activities to encourage open communication and explore emotional issues within the family. Like the children's and teen's groups, parent classes are experiential, using interventions such as art, music, psychodrama, role-plays, visualization, and meditation to increase self-awareness and parenting skills (Bavolek and Hodnett 2011). In each session, there is also a family play-time, during which parents and children engage in playful activities and facilitators model and teach new parenting skills (Bavolek 2000).

Home-based programs allow facilitators to work individually with families while meeting with the parent(s) and children within the context of their home. In this model, facilitators, referred to as "home-visitors," meet with families weekly in their home for 90 min. Home-visitors can address many caregiver dynamics in this setting as they meet with any member of the family who has taken on caregiver roles (e.g., parents, life partners, grandparents, teens) within the family. Home visits are highly structured and begin with a "check-in" to allow parents to update the home visitor about any changes in the family since the last visit. Following the check-in, "home practice assignments" are reviewed to assess whether the caregivers have practiced the skills taught in previous sessions. If more practice is needed, the home visitor will engage the parents in a role-play or monitor the parents practicing the skills with their child and provide feedback to them. Once parents have mastered skills from previous sessions, new concepts and skills are introduced during the main lesson time. A dyadic intervention follows the lesson providing the family an opportunity to learn and practice new skills and engage in fun, nurturing activities (Bavolek 2000). Like the group-based model, expressive interventions, DVDs, or role-plays are used to increase parents' self-awareness, knowledge, and skill development (Bavolek and Hodnett 2011).

A combined group and home-based model may be used when parents need more intensive intervention. This model may be most appropriate for families who have experienced chronic maltreatment. In such cases, families can share in a group learning environment but also have the individualized attention attained through home visits (Bavolek and Hodnett 2011).

Pre- and post-tests are used to collect outcomes data while process data is collected throughout the program to help facilitators and parents track how well parents are building competencies. The AAPI-2 (Bavolek and Keene 2001) and *Nurturing Skills Competency Scale* (NSCS-3; Bavolek and Keene 2016) are used to collect outcomes data. A Family Nurturing Plan, Family Nurturing Journal, and Session Evaluation Form are used to help facilitators and parents monitor parent learning and acquisition of skills throughout the program (Bavolek and Hodnett 2011).

## Supporting Research

The National Institute of Mental Health-sponsored model was first tested utilizing a sample of abusive parents and their children in a program that met once a week over a 15-week period (Bavolek 2000; Bavolek et al. 1983). The program was aimed at improving family relationships, increasing knowledge about appropriate parent–child dynamics and attitudes, decreasing maladaptive parenting behavior and attitudes, and substituting positive parenting techniques in lieu of negative physical punishments. Data collected using the AAPI and various other methods and measures indicated the program was successful in influencing the cognitions and affect of parents

and children in four identified constructs: developmental expectations, empathy, behavior management, and self-awareness/role reversal. Most families participating in the program were satisfied with the changes in their family dynamic and some positive changes in parent and progeny were evident even up to a year after their last meeting.

The NPP model, and its variants, has been implemented in areas across the nation, including Hawaii (Bavolek 2009), Louisiana (Hodnett et al. 2009), and North Dakota (Brotherson et al. 2012), and with a wide range of populations. Thomas and Looney (2004) found improvement in parenting attitudes and beliefs using a modified version of the NPP with adolescents who were pregnant or parenting. Modified versions of the NPP have also been associated with positive parental behavior and attitudes in incarcerated parents, those receiving services for substance use issues, and other parents identified as at high-risk for maladaptive parenting behavior (Palusci et al. 2008). In a comparison of three family intervention programs' strengths in influencing various facets of family relationships, the NPP model was found to be the most successful in improving family attachment and cohesion (Matthew et al. 2005). Additionally, Cowen (2001) determined that families who were located in geographically rural areas and had participated in NPP programs experienced changes in their parenting philosophies and attitudes, placed more emphasis and importance on the emotions and experiences of the children, and were more sensitive to age-appropriate parent–child dynamics.

Completion of the NPP appears to have an impact on immediate and future family conflicts. Maher et al. (2012) conducted a cost analysis study on a NPP program in Louisiana and found that the cost of implementing and running the program was counterbalanced by the potential savings from the reduction of costs related to child mistreatment offenses and subsequent investigations. They also found a direct correlation between the number of sessions attended and decreased maltreatment reports within 6 months and substantiated reports within 2 years of completing the program. Further analyses completed on the program in Louisiana revealed that the odds of future reported offenses decreased with each weekly meeting that was attended (Maher et al. 2011).

In conclusion, research on the NPP model has shown it to be a viable and effective treatment for the prevention of child maltreatment. The NPP can help train parents to reconfigure their negative, learned patterns, and instead work on becoming nurturing figures who are attentive to the needs of their children in appropriate, supportive ways.

## Case Example

Sarah is a 21-year-old single mother who works long hours as a waitress to support her 2-year-old son Kyle. Sarah loves Kyle very much but sometimes feels overwhelmed with the responsibilities of parenting. She lacks confidence in her parenting skills and is often stressed. Sarah spent many years of her childhood in foster care and youth homes due to her parents' drug addictions and still today does not feel like she has good social supports.

During a medical checkup, Kyle's pediatrician picks up on Sarah's high level of stress and notices a lack of warmth in the way she interacts with him. The pediatrician asks Sarah how things are at home and what her biggest challenges are as a mother. Sarah shares that she often feels "stressed out" when Kyle throws temper tantrums and does not know how to "get him to listen." She admits to spanking him when he does something wrong but stated she did not think it helps because "he doesn't change." The pediatrician told Sarah the clinic offered parenting support classes and referred her to the program coordinator. After speaking with the program coordinator, Sarah decided to attend the classes in the Secondary Prevention Education Program.

During the first session, Sarah met a couple of mothers who shared some of her parenting struggles. She liked participating in the activities with other parents and valued the program's the emphasis on nurturing herself. She especially enjoyed the play activity with Kyle and appreciated how the facilitator modeled skills for her to

practice. Sarah continued to attend the classes and learned many parenting skills, such as setting limits and enforcing effective discipline with toddlers; creating nurturing routines for Kyle; using praise to reinforce positive behavior; and recognizing Kyle's feeling and empathically responding to them. Sarah also learned that nurturing herself was important and noticed that practicing self-nurturing made her aware of how much she wanted Kyle to feel nurtured by her. The longer she attended the classes, the more competent she felt as a parent. She also realized how her childhood experiences affected her parenting of Kyle, as well as her self-esteem. At the end of the 12 weeks, Sarah felt more emotionally connected to herself and Kyle, and much more capable of meeting his emotional needs. She no longer used spanking as a form of discipline, but rather used redirection, limit setting, and timeouts when needed. She also found that she did not need to discipline Kyle as often because he listened to her much better than in the past. Sarah continued to be more in tune with her own emotional needs and made it a priority to engage in self-nurturing activities regularly. Attending the classes had also strengthened her support system, as she had built lasting friendships with some of the other mothers.

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