MFT Practice Test

1. The term *schism* (referring to a family division into competing groups) was first introduced by:

a. Nathan Ackerman
b. Theodore Lidz
c. Gregory Bateson
d. Milton Erickson

2. The earliest model of *brief therapy* was established by:

a. Murray Bowen
b. Carl Whitaker
c. Gregory Bateson
d. Milton Erickson

3. The founding editor of the first journal in family therapy was:

a. John Bell
b. Virginia Satir
c. Jay Haley
d. Salvador Minuchin

4. The term *mystification* was introduced by:

a. R.D. Laing
b. Virginia Satir
c. John Bell
d. Rachel Hare-Mustin

5. The concept of a *genogram* was developed and popularized by:

a. Carolyn Attneave and Peggy Papp
b. Monica McGoldrick and Randy Gerson
c. Cloe Madanes and Froma Walsh
d. Peggy Penn and Betty Carter

6. The therapeutic modality known as *narrative therapy* was introduced by:

a. Steve de Shazer and Insoo Berg
b. Bill O'Hanlon and Carolyn Attneave
c. Cloe Madanes and Froma Walsh
d. Michael White and David Epston

7. The therapeutic approach that is inclusive of all domains of a person's life is best known as:

a. Multimodal
b. Biopsychosocial
c. Eclectic
d. Systemic

8. In the practice of modern family therapy, schools of therapy and theoretical orientations are becoming:

a. More homogenous, collaborative, and inclusive
b. More distinctive, disparate, and divided
c. More polarized, contentious and exclusive
d. More focused, narrow, and specialized

9. The term *hermeneutics* refers to:

a. A feedback loop in systems theory
b. Establishing mutual understanding
c. The interpretation of meaning
d. A positivistic theoretical orientation

10. All of the following represent *horizontal stressors* in a family EXCEPT:

a. Birth of a child
b. Family member failures
c. Children leaving home
d. Death of a parent

11. The family systems therapy approach sees the family as:

a. An emotional and psychological unit
b. A collective aggregate of individual members
c. An integrated social network
d. Secondary to the individual members

12. The term *family atmosphere* is most commonly associated with:

a. Crisis intervention
b. Bowenian family therapy
c. Freudian therapy
d. Adlerian family therapy

13. According to Adlerian family therapy, a family gets "stuck" when:

a. Role incongruence develops and families splinter and diverge
b. Parental expectations exceed children's capacity to conform
c. Parents assume roles based on their expectations of the children
d. Acting-out behaviors by family members destroy cohesion

14. Key limitations to an Adlerian family therapy approach include all of the following EXCEPT:

a. Serious psychopathology
b. Resistance to family democracy
c. Parental resistance to change
d. Medications noncompliance

15. From a Bowenian perspective, the development of family disorder is most fundamentally rooted in:

a. Stress responses of an individual that overwhelm the family system
b. Intergenerational "emotional fusion"
c. A family history of anxious attachment
d. A particular crisis for an individual that produces triangulation

16. The long-term goal of Bowenian therapy is:

a. Family member detriangulation
b. Personal accountability for one's problems
c. Behavioral change within the family
d. Reduction of anxiety within the family

17. Family systems theorist Murray Bowen has proposed eight interlocking concepts to describe how individuality and togetherness are shaped within the immediate and multi-generational networks of family relationships. These include all of the following EXCEPT:

a. Family narrative process
b. Ego strength (differentiation)
c. Family projection process
d. Societal emotional process

18. Individuals LEAST likely to become fused with predominant family emotional patterns are those who:

a. Have low levels of personal anxiety
b. Have low personal differentiation
c. Are caught up in family triangulation
d. Are cut off emotionally from their families of origin

19. From an Adlerian perspective, family *reorientation* for change is best facilitated by emphasizing family member:

a. Differences
b. Strengths
c. Goals
d. Similarities

20. According to Bowen, when *triangulation* is identified, the therapist should:

a. Align with the most dominant party
b. Align with the most vulnerable party
c. Avoid taking sides to facilitate change
d. Confront both parties to force change

21. The primary feminist critique of Bowenian therapy is that:

a. Men tend to ignore emotions driving family issues
b. The approach ignores couple power imbalances
c. Women tend to be blamed for intergenerational issues
d. Triangulation is often gender-typed

22. Common elements in a genogram include all of the following EXCEPT:

a. Birth order and gender
b. Death dates during the last three generations
c. Significant illnesses/diseases
d. Individual political views

23. The overarching focus of contextual therapy is:

a. Boundaries and respect
b. Fairness and trust
c. Caring and kindness
d. Expectations and accountability

24. The fundamental goals of contextual therapy include all of the following EXCEPT:

a. Promoting consideration among family members
b. Helping family members to more freely give among each other
c. Holding others accountable when injustice occurs
d. Making personal wishes known through open dialogue

25. Limitations to contextual therapy include all of the following EXCEPT:

a. Family member initial unawareness of low trust and lack of fairness
b. Family member opposition to establishing and enforcing boundaries
c. An unwillingness to accept accountability due to past injustices
d. A need for the therapist to be a leader instead of a co-collaborator

26. Although both Carl Whitaker and Virginia Satir founded experiential family therapy, there were distinct theoretical differences in their approaches. These differences are best described by which of the following statements:

a. Whitaker emphasized the use of power and control between family members, while Satir focused more on the need for self-actualization and differentiation.
b. Whitaker emphasized the influence of non-verbal messages on relationships, while Satir focused more on family structural dynamics and roles.
c. Whitaker emphasized the need for emotional family cohesion while Satir focused more on improving family communication.
d. Whitaker emphasized the influence of prior family history on the dynamics of subsequent family behaviors, while Satir focused more on cultural and societal expectations that shape family behaviors.

27. Ivan Boszormenyi-Nagy's contextual therapy was a belief that therapy should encompass all aspects of a client's life. According to this model, therapy too focused on a particular theoretical orientation (such as a model focused on genetics or physical health) is likely to:

a. Help isolate particular issues stemming from one aspect of life
b. Make the therapy easier to implement
c. Hinder the therapist's ability to see particular issues
d. Overburden the client with one aspect of therapy

28. Whitaker felt that a family's interpersonal problems most typically arise from:

a. Restricted emotional closeness and sharing
b. Societal pressures that constrain family life
c. Enduring untreated psychiatric disorders
d. Deficits in patterns of family formation

29. Whitaker's "psychotherapy as absurd" is designed to:

a. Identify distortions in the family
b. Alienate problematic family members
c. Heighten family discord and turmoil
d. Enrich existing family coping skills

30. Whitaker's atheoretical approach has been called:

a. Confrontational, rude, and disruptive
b. Provocative, forceful, and threatening
c. Spontaneous, directive, and biased
d. All of the above

31. The major foci of Virginia Satir's conjoint family therapy are:

a. Self-esteem, open communication, and congruence
b. Role ascription, power asymmetries, and ego
c. Hierarchy, triads, and family dysfunction styles
d. Nurturance, emotional bonding, and communication

32. Virginia Satir proposed eight core areas in which balance was required for a healthy *self* to exist. These include all of the following descriptive sets EXCEPT:

a. Intellectual, emotional, interactional
b. Physical, nutritional
c. Contextual, spiritual, sensual
d. Financial, educational

33. Virginia Satir identified five styles of communication. Which of the following is NOT one of the five styles?

a. Blamer
b. Engager
c. Distractor
d. Placater

34. In conjoint family therapy, the primary purpose of co-therapy is to:

a. Offer another perspective to family participants
b. Provide secondary observation during sessions
c. Prevent family induction and balance transference
d. Keep therapeutic work more engaging and interesting

Answer Key and Explanations

1. B: Theodore Lidz, in 1940. He also introduced the term "skew" in reference to the distortions that a serious personality disorder can introduce into a family. This American psychiatrist's studies of schizophrenia and family interaction patterns and dynamics made significant early contributions to the ultimate emergence of the field of family therapy in the 1960s. Other key contributors include: A) Nathan Ackerman, author of *The Psychodynamics of Family Life* (1958), who used family process dynamics in the treatment of mental disorders; and B), Gregory Bateson, who produced the theory of dysfunctional communication known as the "double bind." His controversial theory posited that veiled contradictory messages from differing levels could produce confusion and even schizophrenic behaviors when devolving upon individuals within a family construct.

2. D: Milton Erickson. Using hypnosis, Erickson began a short-term intervention model he referred to as "strategic therapy." This model was further developed, with Erickson's help, from the Bateson Project (1953) into the establishment of the Mental Research Institute's "Brief Therapy Project" in 1965. Other significant contributors to family therapy in the 1950s include: A) Carl Whitaker, who published work in dual ("conjoint") couples therapy; and B), Murray Bowen, who initiated family therapy sessions in work with schizophrenia – identifying concepts such as "emotional reactivity," intergenerational influences of mental health, and the "undifferentiated ego mass" of troubled families brought together, when projection, triangulation, and poor boundaries strip away the individual's self-concept.

3. C: Jay Haley. In the 1960s, Haley began developing strategic family therapy, during which time he founded the journal *Family Process*. Other key family therapy contributors in the 1960s included: A) Salvador Minuchin, who practiced family therapy with urban slum families, during which he identified cultural barriers to therapy between Caucasian therapists and Hispanic and African-American clients; B) Virginia Satir (the only woman family therapy pioneer), who focused on issues of self-esteem, compassion, and the need for congruency in the expression of feelings; and C) John Bell, who applied the tools of group therapy in working with families.

4. A: Ronald David (R.D.) Laing. As a key family therapy researcher in the 1970s, Liang drew upon Marx, who conceived of mystification as a misrepresentation of events (process) or actions (praxis) to serve the interests of one class over or against another. Laing theorized a similar set of events between individuals and particularly family members. Mystification was used to "mask" family issues through conflicting and contradictory narratives. Recognizing this pattern would be crucial to progress in the practice of family therapy. Another important contributor to family therapy in the 1970s was Rachel Hare-Mustin, who wrote an article entitled "Feminist Approach to Family Therapy" in 1978. Her goal was to enhance the strength of women both within the family construct and in society.

5. B: Monica McGoldrick and Randy Gerson, who developed and published the concept of a genogram in 1985. The genogram provides a graphic way of displaying people in a family lineage, as well as how all relatives relate to each other. Genograms help identify patterns in world views, strengths, and dysfunction. Therefore, the use of genograms quickly became particularly important in the practice of family therapy. Other key contributors to family therapy in the 1980s included Carolyn Attneave, Betty Carter, Cloe Madanes, Peggy Papp, Peggy Penn, and Froma Walsh.

6. D: Michael White and David Epston. During the 1980s, White and Epston began to develop narrative therapy, which became widely used in the 1990s and beyond. This collaborative approach

views individuals as separate from their problems, and as possessing many of the skills needed to solve their problems. Using thematically linked narratives, "problem-saturated" stories often emerge, which are likely to become "identity stories" or self-defining narratives. These stories can exert a powerfully negative influence. The focus then moves to conversations that help people to co-discover their previously unrecognized possibilities and unseen positive story lines. The result is an empowering "re-authoring" of their lives. Steve de Shazer and Insoo Berg followed by developing solution-focused brief therapy, while Bill O'Hanlon produced solution-oriented or possibility therapy.

7. D: Systemic. The concept of "multimodal therapy" refers to the use of a variety of theoretical orientations (modes) in engaging the treatment process. The "biopsychosocial" approach endeavors to assess an individual or couple from multiple perspectives, including biological (health, physiological/cognitive capacity), intrapsychic issues, and social context. However, it lacks the full range of systemic conception. An "eclectic" approach refers to the absence of any single or clear collective therapeutic orientation(s) in favor of a composite approach drawn from many different orientations. The family systems approach not only encompasses all the domains of the biopsychosocial perspective, but utilizes a "systems" view of all the interactive components of an individual, couple, and/or family in the various interactive domains in which they exist and interact. It recognizes that a variety of systems (family, culture, community, society, etc.) often synergistically interact to shape individuals in ways far beyond the obvious direct influences that can be perceived by evaluation of each domain individually.

8. A: More homogenous, collaborative, and inclusive. Boundaries between theoretical orientations and schools of thought are increasingly blurred, with techniques borrowed and shared with increasing frequency. In part this is because practice has become increasingly client-specific, with the need to tailor techniques and approaches to specific needs and circumstances. Practice also more frequently accommodates a post-positivistic view – that science and knowledge is increasingly less certain. Indeed, the majority of accepted practices have been deconstructed and revealed to contain social conventions and biases rooted in the personal agendas of the developers. Nowhere has this been more evident than in feminist critique and multiculturalism, where a great many perspectives (including general systems theory) have been confronted and called into question. The result has been social constructionism and the narrative revolution. Constructionists emphasize relativism and the subjective nature of reality, recognizing that matters of perception and preconception may distort an understanding of what is actually occurring. Narrativists help families to discover their stories and understandings that drive their family experience. This results in a more collaborative endeavor, with therapists conducting therapy "with" their clients as opposed to giving it "to" their clients.

9. C: The interpretation of meaning. A Greek term for "interpretation" (derived from the name of Hermes, the messenger of the gods), it was originally used to refer to the interpretation of meaning in scriptural texts (more properly, "exegesis"). However, Aristotle introduced the term into the domain of philosophy. It has since been broadened to refer to the interpretation of levels of meaning found in all human experiences. The study of feedback loops in systems theory (whether positive or negative in action) is known as "cybernetics." Cybernetic feedback loops allow systems to be self-correcting and self-sustaining. While hermeneutics can promote greater shared understandings, it is not primarily a communication tool. Psychoanalysis is clearly a positivistic theoretical orientation (i.e., rooted in scientific observation, deduction, and theoretical certitude), while hermeneutics is decidedly not positivistic in nature.

10. B: Family member failures. Two categories of experiences, **horizontal and vertical stressors**, encompass and/or identify the more common challenges that may arise within families.

Horizontal stressors are expected or common life events that families encounter as they move through the stages of the family life cycle. Examples include infertility or child bearing, demise of a parent, career changes, menopause, health problems, etc. Vertical stressors are patterns of a relational nature that may be transmitted intergenerationally. Examples include family expectations, hopes, failures, secrets, emotional challenges, taboos, etc. The **family cycle of life** consists of eight "stages": Stage 1: couples living without children; Stage 2: couples bearing children; Stage 3: families with children of pre-school age; Stage 4: families that include school-aged children; Stage 5: families that have teenagers; Stage 6: families with young adults being launched; Stage 7: families with parents in middle age (from empty nesters to retirement); and Stage 8: family members who are aging (retirement to demise of both partners).

11. A: An emotional and psychological unit. As an emotional unit, it is noted that any individual change will affect the entire family. As a psychological unit, treatment is often not aimed solely at a family member with a problem (the "symptomatic" individual), but at everyone who has a role in the issue(s) being generated, maintained, and/or resolved. Even so, individual, couples, and family counsel approaches may all be used to identify and exercise solutions to problems. Successful therapy involves assisting families to think of issues (e.g., communications, conflict, disruptions, etc.) from a systems and/or multigenerational perspective. This approach to problem-solving reduces the tendency to blame, and fosters both individual and collective responsibility for change. Key figures in the development and refinement of family systems therapy include Nathan Ackerman, Gregory Bateson, Murray Bowen, Milton Erickson, Jay Haley, Virginia Satir, Ludwig von Bertalanffy, and Carl Whitaker.

12. D: Adlerian family therapy. The term "family atmosphere" refers to the nature of the relationships existing among family members. The focus is on the influence of the family of origin on one's current personality, as revealed by a review of the past to determine its present impact. Interpretation and insight development are fundamental elements of Adlerian group counseling. As a system, each member of a family exerts influence on all other members.

As role models, parents help shape all family relationships. The term "family constellation" includes each family system (i.e., parents, children, and extended family), by which alignments and relationships within the family are established and maintained. Key motivations for these alignments and relationships include: 1) birth order (which shapes subsequent behaviors); 2) family goals; and 3) growth of increasing skills that are ultimately needed for independence and achieving success.

13. C: Parents assume roles based on their expectations of the children. Typically birth-order oriented, the parents' roles and expectations constrain the children into assuming compensating /collaborative roles. The entire family soon sees the roles as fixed and unchangeable. In dysfunctional response, children may act out in four key ways: 1) attention seeking (intermittent interactions incorporating annoyance or irritation); 2) power struggles (increasingly intensive opposition, resulting in challenges to authority, anger, and defeat or further challenges); 3) revenge (escalating interactions increasingly producing hurt); or 4) demonstrations of inadequacy (role refusal and/or isolation, coupled with despair). Parents may then react badly, attempting to assert adequacy, exerting overt control, acting to elicit revenge, or (if unsuccessful) responding with their own displays of inadequacy. Interventions include: 1) tracing motivational patterns; 2) family reorientation to unlock mistaken goals and poor patterns of interaction; 3) emphasizing the equal right of all family members to be valued and respected; 4) helping children to discover options to resolve current problems; 5) generating alternatives to mistaken interactions; and, 6) illustrating ways to live more harmoniously and effectively within the family system.

14. D: Medications noncompliance. Adlerian family therapy does not typically involve the use of psychotropic medications; thus, medication noncompliance would not normally be a therapeutic limitation. However, parental willingness to make changes is crucial and thus resistance would meaningfully undermine the therapeutic process. Some parents are also averse to the democratic nature of Adlerian interventions, while others lack adequate mutual respect or have a fundamental reluctance to relinquish control in ways that can prevent family reorientation. Further, Adlerian family therapy assumes general mental wellness among family members. Thus, the presence of true mental illness (e.g., schizophrenia, bipolar disorder, personality disorders, etc.) could prove to be a confounding variable. It should also be noted that lessons acquired in the process of therapy must be implemented in the home, and where adequate transfer does not occur, the value of the interventions and education offered may then be significantly limited. Finally, this approach requires considerable therapist skill to accurately assess family interactions and to form correct hypotheses regarding mistaken goals among the children. Where these skills are lacking, the therapeutic process will of necessity be limited.

15. C: A family history of anxious attachment. Anxious attachment has been described as a pathological form of closeness that leads to a condition called "emotional fusion," which is manifest in either dysfunctional dependency or untoward isolation. Emotional fusion is passed intergenerationally, and thus can disrupt family wellness over multiple generations. Wholesome family development occurs when family members (particularly parents) are adequately differentiated (i.e., possessing a functionally secure sense of self), anxiety is low (emotional stability and security are in evidence), and functional emotional contact exists between parents and their own families of origin. While processes of behavioral disorder development include stress (usually centered in one person) that exceeds the family system's coping capacity, crisis responses (that feed the growing behavioral disorder), and emotional fusion, the most fundamental cause is the seed of anxious attachment.

16. D: Reduction of anxiety within the family. All other activities are designed to achieve this end, which then allows for normal family processes and development. Specifically, the need for detriangulation is to assist family members to deal directly with their own problems instead of using vulnerable family members to achieve a standoff on the problems; owning one's personal problems is a part of the process of detriangulation; and behavioral change is a natural outgrowth of anxiety reduction in the immediate family and between the current family and the family of origin. In particular, children do much better as parents gain control over their anxieties, which also serves to break the cycle of intergenerational transmission of anxiety and problem-perpetuating emotional fusion.

17. A: Family narrative process. Narrative therapy aids families in developing narratives regarding issues missing in the plot of family problems. The focus is on collaborative "meaning making" via historical and informational questioning. Bowen's eight interlocking concepts describe how family relationship networks shape individuality and togetherness – and family system wellness. The eight concepts are: 1) ego strength (differentiation); 2) triangulation (use of a third-party, e.g., a child) to deflect interpersonal (e.g., marital) tension, but also preventing problem resolution); 3) nuclear family emotional system (an undifferentiated family ego mass, with emotional fusion, often including overt conflict, emotional/physical dysfunction in one spouse, and projection of problems onto one or more of the children); 4) family projection process (transmission of family problems to the children – frequently by impeding a child's differentiation and then treating the child critically); 5) emotional cutoff (coping with emotional fusion by total contact withdrawal, yet also preventing problem resolution); 6) multigenerational transmission process (transmitting chronic anxiety intergenerationally); 7) sibling position (often with

predictable characteristics and susceptibility to family projection); and 8) societal emotional process (pressures on the family from class, ethnicity/race, gender, etc.).

18. A: Have low levels of personal anxiety. Optimal protection from emotional fusion occurs when individuals: 1) are well differentiated; 2) keep anxiety levels low; 3) maintain good emotional contact with a balanced family of origin; and 4) have well-defined roles in their respective family subsystems. Well-differentiated individuals desire meaningful relationships, but do not: 1) depend on approval and acceptance of others; or 2) lose rational or critical assessment skills, even if rejected, criticized, or in conflict. Bowen saw family problems as arising from multigenerational transmission processes that produce increasingly lower family member differentiation with each new generation. Transmission occurs when undifferentiated individuals marry. Issues are exacerbated when "vertically" transmitted problems (intergenerationally relayed poor role modeling, negative family attitudes, etc.) intersect with "horizontal" problems (environmental stresses and/or family developmental transitions – births, career changes, health issues, etc.). Acute disorders arise from emotional fusion (increased levels of family emotion and anxiety) coupled with low differentiation (over-conformity or pressuring others to conform to themselves). Key indicators are: 1) cutting off family of origin, yet repeating the same problem patterns; and 2) relationship triangulation, preventing problem resolution.

19. B: Strengths. In this process, the therapist should also "normalize" family relations by pointing out observed interactions that are common to families with the similar values and makeup. Other useful techniques include: 1) engaging parents in a "parent interview" to better discern concerns, problem descriptions, and underlying patterns of interactions that are problematic; 2) producing a family "genogram" to help expand family insights and to initiate family communication; 3) conducting "child interviews" to assess the degree to which the children are aware of key problematic behaviors (goal disclosure), as well as to explore alternative goals; 4) utilizing "system description" to reframe interactive misconceptions in a way to reveal related difficulties (an out-loud narration can also help unlock dialogue around problematic behaviors); 5) the use of "goal disclosure" can help to identify underlying motivations and is most effective when addressing specific misbehaviors rather than general concerns; and 6) between sessions, the family is assigned tasks to aid in redirecting mistaken motivations.

20. C: Avoid taking sides to facilitate change. While the therapist must attend to process (emotional relationship processes) and structure (interlocking triangles), neutrality must be maintained to draw the involved parties into working on issues rather than deferring to the therapist. This is best facilitated when the therapist avoids taking sides and uses "I" statements of opinion (rather than judgments) to encourage self-reflection, growth in relationships, and de-triangulation. Encouraging new behaviors can help facilitate change, as well as identify relationships and processes needing further attention. Education regarding listening and speaking skills (avoiding interruption and focusing on "I-positioning" instead of confrontation and blaming, etc.) can help family members address needs without overreacting and escalating conflicts. Emphasis should be more on "I feel" than critiques of other family members. Three-generation genograms can identify the roots of emotional fusion (i.e., over anxiety and low differentiation) in longstanding family characteristics and processes. Emotional fusion is best revealed by asking questions of individuals (not groups) that encourage self-reflection, diminish anxiety, and slow down emotional processes. The focus should be to turn from how others are upsetting the individual, to their role in the interpersonal problems.

21. B: The approach ignores couple power imbalances. Feminists believe that power within a couple tends to be unequal and favors men. The problem can be made only worse where Bowenian guidelines insist on therapist neutrality. A defense is that the therapist is charged to explore

emotional cutoff and isolation within the family system as vigorously as any other interrelational elements. One might fairly reject the stereotypic view that only men ignore emotional issues or that women are more prone to triangulation. Finally, Bowenian theory scrupulously avoids assigning blame (intergenerational transmission or otherwise). Key limitations of the approach include: 1) high therapist differentiation is essential to remain free of triangulation and tolerate marked anxiety, etc., yet differentiation is never perfectly complete in anyone; 2) the therapist must equally develop a relationship with all in the family, yet this may not be possible; 3) family members may perceive the therapist as taking sides, even if it is not accurate; 4) open conflict must be addressed and controlled (as it generates anxiety and sustains triangulation and emotional fusion), though individual tolerances, personality disorders, and other imbalances may not always permit such control.

22. D: Individual political views. The genogram is not typically used to follow individual or family political views over time. Although the early concept of the genogram was particularly used and emphasized within Murray Bowen's family systems orientation toward intergenerational therapeutic practice, the model was first developed by Monica McGoldrick and Randy Gerson. Other common elements in a genogram include numbers of families, marriages and divorces, substance use disorders, mental health issues (depression, major mental disorders, etc.), family member alliances, living situations (where, with whom, etc.), and other important (positive or negative) relationships among family members. It is important to emphasize that, beyond the simple "family tree" information, genograms may vary substantially depending on the informant and his or her unique perspective in the family. Therapists do not "take sides" in these matters, but rather look for repetitive behaviors and patterns that shed light upon family function, attitudes, taboos, hopes, fears, expectations, struggles, triangulation, emotional fusion, and other features that may persistently appear within existing family relationships and intergenerationally over time.

23. B: Fairness and trust. Contextual therapy, as developed by Ivan Boszormenyi-Nagy, emphasizes "therapeutic leverages in mobilizing trust" to bring about greater family wholeness and stability. Based on the psychodynamic model, emphasis is placed on mutual support, trust, fairness, and loyalty. These and other ethical principles are necessary to generate and maintain positive family relationships. Fairness (justice) must always be achieved only through standards of accountability and boundary setting, rather than by blaming, retaliation, or revenge. Not unlike Bowenian Therapy, contextual therapy recognizes that destructive family patterns can often be traced back multiple generations. The goal of relational ethics is balanced through giving and receiving. Family dysfunction arises when a loss of accountability and caring leads to a deterioration of trust. Expressions of disturbance arise when an imbalance in giving and receiving and/or loyalties and ethical conduct emerge among family members. When families are unable to balance entitlement and fulfillment needs (especially as related to caring), negative symptoms are experienced. Perpetuation of these imbalances can extend to future generations, leading to further failure and/or exploitation of others.

24. C: Holding others accountable when injustice occurs. While boundary setting and accountability are important in building trust and balance in the family system, they are primarily tools used to achieve the fundamental goals of: a) caring consideration, b) giving more readily of themselves, and c) more confidently and comfortably expressing their wishes and needs to other family members. Contextual therapy goals include: 1) assisting the family through previously avoided emotional conflicts; 2) promoting shared understanding to foster a greater sense of fairness and mutual trust; 3) guiding the family to find balance beyond an accounting of "merits and demerits" toward mutual responsibility and sharing; and 4) treating the family as an integrated unit to motivate structural and collaborative change. Interventions focus on: 1) fostering dialogue; 2)

exploring family patterns of transaction and behavior to induce change and bolster the integrity of relationships; 3) facilitating questions, focused on whether or not choices are mutual and fair; 4) helping find positives by giving credit and helping members acknowledge current and past wrongs; and 5) teaching collaboration and mutual empathy in suffering without assigning blame or taking sides.

25. A: Family member initial unawareness of low trust and lack of fairness. Awareness of damaged trust and injustice at the outset of therapy is not a prerequisite for successful participation in contextual therapy. Indeed, building this awareness is one of the primary therapeutic goals of this approach. However, as awareness of trust and fairness evolves, it is important for the therapist to allow family member goals to evolve and change as well. Contextual therapy requires a meaningful level of personal consciousness and systemic awareness that may be beyond some family members. Similarly, the persistent misuse of power by family members who are intellectually immature and lack insight will blunt the effectiveness of this approach for some families. Other families may resist a collaborative approach and will require more aggressive direction and guidance. In such circumstances, other treatment modalities may be required. Of additional note, some have criticized the emphasis of contextual therapy on fairness and trust, as this narrow focus may obscure many of the other values and positive benefits that are readily produced within families.

26. C: Whitaker emphasized the need for emotional family cohesion while Satir focused more on improving family communication. More specifically, Whitaker felt that optimal self-fulfillment was dependent on the quality of family cohesiveness, whereas Satir felt that quality personal and family experiences depended on good communication skills and practices among family members. Experiential family therapy utilizes techniques to promote communication and interaction, and encourages clients to reduce defensive fears to allow for genuine emotional expression. The result is enhanced communication and greater compassion and nurturing among family members. This approach draws on humanistism (a focus on the here and now), gestalt (role playing and emotional confrontation), and psychodrama (sculpting, family drawing). Whitaker theorized that "emotional suppression" was the culprit in most family dysfunction. He saw a tendency in families to repress the expressive and instrumental functions of emotion by: 1) attempting to regulate children's behavior by controlling their feelings; and 2) constraining emotions that promote individuality (resulting in children emotionally estranged from themselves). Thus, his goal was to aid families to recover emotional authenticity, by which to produce more meaningful and honest family attachments.

27. C: Therapy too focused on a particular theoretical orientation can be a hindrance to a therapist. The contextual therapy model posits that therapy should look at all aspects of a client's life. If the therapist focuses too much on one particular aspect, other areas of life that are contributing to the client's problems could easily be ignored. Another aspect of a strong theoretical focus is that therapists may be blinded by their focus, trying to fit elements into the theory, rather than looking at the client's life as a whole.

28. A: Restricted emotional closeness and sharing. Other sources of family dysfunction include: 1) the keeping of negative family secrets; 2) undue suppression of family member individuality (sufficient to prevent self-actualization and self-determination); 3) problematic sociocultural pressures; 4) family controls to ensure peace and quiet; 5) the perpetuation of "family myths" (i.e., shared distortions in history and experience that ensure preferred forms of family compliance to rules and expectations); and 6) "mystification" (relabeling, distorting, or even denying children's experiences outright in order to create a façade or circumstance that limits personal choice, authenticity, growth, and freedom. Necessary therapeutic interventions include: 1) facilitating the

free expression of thoughts and feelings by family members; 2) promoting family member flexibility among themselves; 3) focusing on the authentic "here and now" rather than on past hurts or future fears; and 4) unmasking pretense and family secrets to promote authenticity. Change is best achieved when the therapist is personally active and forceful in guiding the family through three specific phases: 1) engagement (with the therapist powerfully involved), 2) involvement (with the therapist as a dominant parent figure, adviser), and 3) disentanglement (more personal, but less directly involved).

29. C: Heighten family discord and turmoil. This approach utilizes techniques and interventions (at times perhaps even rude and confrontational, then playful and cajoling) that intensify longstanding turmoil to the point where issues of the "here and now" are more evident. Then the family is coached to resolution of the turmoil. At times, rather than attempting to eradicate family pathology, it is augmented until it "self-destructs." In this way, family self-actualization is achieved, and the reasonable responses to absurdities (e.g., sarcasm and manipulation) then come out on top. In this process, the therapist retains a "facilitator" role, and the processes of family interaction are revealed through the "reflection" of a genuine and non-defensive observer. In this way, family members also obtain more objective distance as they model the objectivity and distance of the therapist. Whitaker was also known for: 1) doing therapy with a "crowd" (i.e., even including extended family at times); 2) the pioneering use of co-therapists in a manner that retained objectivity; and 3) the "psychotherapy of the absurd" approach.

30. D: All of the above. Many substantive critiques have been rendered in evaluation of Whitaker's approach to experiential family therapy, referred to at times as "outrageous" and even "disrespectful." Concern has been expressed about the one-size-fits-all style that Whitaker used. Further, the de-emphasis on theory offers few boundaries by which to shape and guide the therapeutic process. Teaching the process is difficult, as it is more a feature of Whitaker's personality and intrinsic wisdom than a therapeutic technique. The process is inescapably subjective at times, leaving ample room for skewed and biased perspectives. The confrontational approach may be poorly suited to more fragile families and those in crisis, with lower-functioning families potentially unable to engage the underlying processes. The focus remains primarily on alleviating symptoms and improving the quality of emotional life, as opposed to changing the family system, although changes can occur as issues are engaged.

31. A: Self-esteem, open communication, and congruence. At the heart of conjoint family therapy are issues of self-esteem. Family is seen as key (particularly via the parents-child nurturance triad) to the development of self-identity and wholesome self-esteem. Poor communication that is closed, rule-bound, and emotionally incongruent is at the heart of much family dysfunction. Dysfunctional families utilize distorted rules (spoken and unspoken) that are rigidly fixed, arbitrary, and inconsistent. Through these, symptomatic behavior seems to make sense and is usually covertly rewarded. Dysfunction is rooted in negative communication patterns and in the behavioral roles played by family members, such as: 1) disciplinarian, 2) hard-working caregiver, 3) peacekeeper, and 4) victim. Lack of respect for members' needs lowers self-esteem, as will impossibly rigid rules (always look happy, never be upset with your parents, etc.). When family members fail to conform, guilt, fear, dominance, and punishment result. Attempts to conform lead to stress, coped with through dysfunctional roles such as: 1) entertainer, 2) rescuer, 3) people pleaser, 4) placater/enabler, and 5) acting-out disruptor. Poor self-esteem (particularly of the parents) leads to closed communication, enmeshment, and a loss of intimacy and individuality.

32. D: Financial, educational. The core of a healthy self does not directly include these two areas. According to Satir, growth in these areas is enhanced as families do the following: 1) strive for honesty and openness in their communications; 2) allow each other the opportunity to

individualize (i.e., having a life separate from the family, with freedom and flexibility in communication with others in the family); and 3) use similarities to unite and use differences to help family members expand and grow. Growth is enhanced when communication and interactive patterns support congruence, emotional honesty, and a systemic understanding of existing. Satir believed that every interpersonal communication must recognize and reflect three key elements to be fully functional: the interests of the individual speaking, the interests of the receiver, and the overarching context. Where any of these three parts is absent, dysfunctional communication tends to be the result.

33. B: Engager. The five communication styles are: 1) Blamer: using guilt and accusation to cover their own inadequacies and emptiness, they attempt to control by bullying and attacking faults; 2) Irrelevant or Distractor (often the youngest child): wish the problem away and pretend it doesn't exist, hoping others will do the same; 3) Placater: fearing rejection, they strive to please and ultimately becoming enmeshed and dependent; 4) Super-Reasonable (also called "Computers"): afraid of feelings, they use emotional detachment and intellectual rationalization to keep emotions and others at a "safe" distance, to protect their feelings and emotional vulnerabilities. The above four styles are dysfunctional: avoidant, dishonest, manipulative, and/or resistant to change. The fifth style is functional: 5) Leveler (or Congruent): they are open, direct, honest, and genuine. Body posture, facial expression, and vocal tone are all consistent and congruent to the message. Levelers share feelings instead of concealing them. They respond with integrity and unified beliefs, thoughts, and emotions – framing problems realistically, accurately, and openly, with desires and intentions portrayed honestly.

34. C: Prevent family induction and balance transference. While some systemic family therapy approaches seek to incorporate the therapist into the family to induce change, conjoint family therapy seeks to prevent "induction" into the family to maintain professional distance and objectivity. The presence of a co-therapist helps in this regard, while also assisting in balancing potential transference issues. When interacting with the family, the primary goals of the therapist are to: 1) support growth through the acknowledgement of meaningful differences; 2) identify individual needs and family decisions that can validate and bolster the self-esteem of family members; 3) transform some rules into guidelines, and create more functional and useful rules from those that are overly extreme; 4) identify, teach, and enhance important coping skills; and 5) evaluate family roles and develop them into relationships

35. B: Five freedoms. Satir proposed five key "freedoms" that allow families to remain open, positive, and mutually functional. The five freedoms are (quoted here): 1) to see and hear what is here instead of what should be, was, or will be; 2) to say what one feels and thinks, instead of what one should; 3) to feel what one feels, instead of what one ought; 4) to ask for what one wants, instead of always waiting for permission; and 5) to take risks in one's own behalf, instead of choosing to be "secure" by not rocking the boat. To explore ways to achieve these five freedoms, therapists may: 1) help families in relationship mapping and producing key chronologies; 2) liberate family members by creating new meanings and understandings; 3) foster communication that fully permits the open expression of feelings, perceptions, and opinions; and 4) assist each family member in constructing a "mind, soul, body triad" (thoughts, feelings, and attitudes about the body) by which to better secure a well-integrated sense of self-identity.

36. C: Family reconstruction model. This model uses a three-generational view of one's psychosocial-emotional roots and the role of each generation as it emerges in the current family system. It may potentially be explored through psychodrama to identify the source and nature of any identified dysfunctional patterns. Other conjoint therapy tools include: 1) the use of family sculpting to reveal relationships, roles, and key family interactions (Satir sometimes included