Test Bank for Family Therapy 12th Edition by Nichols

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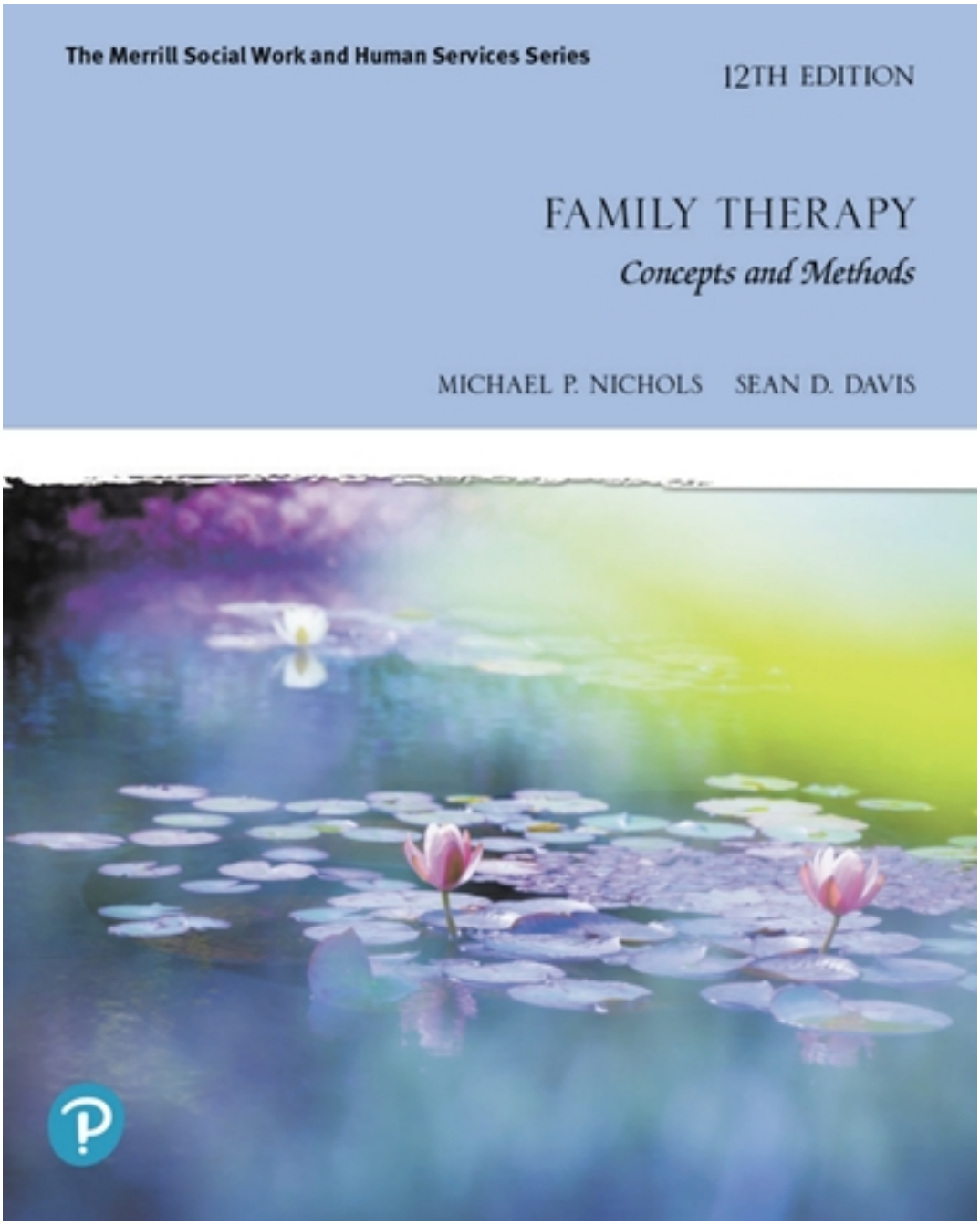

Test Bank

Instructor's Resource Manual and Test Bank

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Family Therapy: Concepts and Methods

Twelfth Edition

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Pearson

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ISBN-10: 0-13-584275-1
ISBN-13: 978-0-13-584275-1

Instructor's Resource Manual

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Preface

This new edition is produced as an ebook as well as in print. The Pearson Enhanced eText contains the following digital enhancements embedded in the chapters.

Videos: Links to video clips of therapists have been embedded for students to view throughout the chapters of the Pearson eText. Students are prompted to reflect on and analyze the videos via an accompanying question in the book margins.

Chapter Quizzes: At the end of each chapter Summary, students will find two self-assessments marked by a checkmark icon. In the Pearson eText, students click on the icon and the quiz appears. The first one prompts them to test their knowledge of chapter concepts by taking a *multiple-choice quiz*.

The second quiz icon at the end of the chapter prompts students to apply their knowledge of chapter concepts by responding to *open-ended questions* by typing their response and submitting it for immediate feedback. These self-assessments can reinforce understanding of key chapter concepts and support application of newly learned content.

To reinforce use of these assessments above, incorporate them in your syllabus. Videos can be used in a variety of ways: assigned to watch particular videos associated with chapter reading, assigned as part of a journaling exercise or another written or discussion exercise.

Note: Students use their Access Code Card to register for access online to the Pearson eText.

This Access Code Card most likely accompanied the new edition (if you adopted the package of book + eText access code card). OR you might have adopted the eText alone, without a print component OR the student might have purchased the eText online. If you have questions about this, contact your Pearson sales representative.

The book Preface notes new content additions to this new edition.

Introduction: The Foundations of Family Therapy

INTRODUCTION

Family therapy isn't just a novel set of techniques; it's a whole new approach to understanding human behavior -- as fundamentally shaped by its social context. There are a relatively small number of systems dynamics that, once understood, illuminate the challenges of family life and enable therapists to help families move through predictable dilemmas of life more successfully.

SUMMARY OF KEY POINTS AND ISSUES

The Story of Holly's Therapy

Holly's story illustrates how meeting with a patient's family can suddenly make that person's symptoms understandable. Holly's depression began to make sense when the therapist met with her parents and discovered that Holly was afraid that if she grew up and left home her mother would be left behind in a bad marriage. Even a therapist untrained in family dynamics may gain enormous insight by inviting a patient's family for a consultation.

The Myth of the Hero

While our culture celebrates the uniqueness of the individual, we cannot deny our inescapable connection to our families. We do many things alone, but we are defined and sustained by a network of human relationships. Yet when we do think about families, it is often in negative terms. Talk of "dysfunctional families" frequently amounts to little more than parent bashing. People feel controlled and helpless not because they are victims of parental failings, but because they don't see past individual personalities to the structural patterns that govern families. Plagued by anxiety or depression, some people turn to individual therapy for help and, in the process, turn away from the relationships that propelled them into therapy in the first place. When they seek the safety and privacy of therapy, the last thing they want to do is take their families with them.

Psychotherapeutic Sanctuary

The two most influential approaches to psychotherapy, Freud's psychoanalysis and Carl Rogers's client-centered therapy, were both predicated on the assumption that therapy should be conducted in private, isolated from interfering influences. Problems were thought to arise from upsetting interactions with others and were best alleviated in a confidential relationship between patient and therapist. In many ways, psychotherapy displaced the family's function of dealing with the problems of everyday life.

Family Versus Individual Therapy

Individual and family therapy each offer an approach to treatment and a way of understanding human behavior. Individual therapy provides a concentrated focus to help people face their fears and learn to become more fully themselves. Treatment is directed at the person and his or her individual make-up. In contrast, family therapists believe that the dominant forces in our lives are located externally -- in the family. Therapy based on this framework is directed at changing the organization of the family. Family therapy exerts influence on the entire family because each and every family member is changed, and continues to exert synchronous changes on each other.

A family approach is often preferable for treating problems with children, complaints about marriage or other intimate relationships, family feuds, or symptoms that develop around the time of a life-cycle transition. Individual therapy may be especially useful in cases where people identify something about themselves that they've tried in vain to change while their social environment seems stable.

Although psychotherapy can succeed by focusing on either the psychology of the individual or the organization of the family, both perspectives -- psychology and social context -- are necessary for a complete understanding of individuals and their problems. In the early days, therapists were encouraged to learn modes of treatment that

focused on either the individual *or* the family, because they were considered different enterprises. Today, family therapists often treat individuals, recognize the impact of psychopathology, and see family therapy as an orientation more than a technique. Individual therapists also recognize the importance of family dynamics and direct their efforts to understanding and changing patterns of relationships. In short, a good therapist looks at the whole picture -- barriers that exist in the environment as well as those in a patient's mind. Working with the whole system requires a focus on the family unit *and* each individual's personal experience.

Thinking in Lines; Thinking in Circles

Mental illness has traditionally been explained in *linear* terms, medical or psychoanalytic. Emotional distress is treated as a symptom of internal dysfunction with historical causes. Such linear explanations take the form of A → B. Recursive, or circular, explanations take into account interaction and mutual influence, A ←→ B. The illusion of unilateral influence, or linear thinking, tempts therapists to see problems rooted in individuals, especially when they only hear one side of a story. But once they understand that *reciprocity* is the governing principle of relationship, therapists can help people get past thinking in terms of villains and victims. Learning to think in circles rather than lines empowers clients to look at the half of the equation they can control. The power of family therapy derives from bringing parents and children together to transform their interactions. Instead of isolating individuals from the emotional origins of their conflict, problems are addressed at their source.

The Power of Family Therapy

The power of family therapy derives from including people with a significant impact on the identified patient and addressing their interactions. Instead of relying of a client's account of relationship problems, those relationships are brought into the consulting room. Moreover, when positive changes are initiated in family therapy, the fact that the whole family is included means that changes in each of them can continue to reinforce progress. The downside of this is that the inclusion of other family members may allow individuals to blame each other for problems and quarrel about who is responsible for what. Getting past blaming in order to help family members recognize their own role in family problems is part of the art of family therapy.

SUGGESTED LEARNING ACTIVITIES

Films

Salvador Minuchin: Unfolding the Laundry Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") Minuchin demonstrates his structural approach with a large blended, recently married, dual-career family with five stepchildren. The IP is the youngest son (age 11) who is acting out. Minuchin defocuses attention on the IP, relabels the sibling behavior, and focuses his attention on the couple. VIDEO, 147 minutes.

Paul Watzlawick: Mad or Bad? Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") In his consultation with a family whose 25-year-old son presents with chronic somatic symptoms, Watzlawick employs the strategic use of Ericksonian-style questions. The systemic function of symptoms in protecting the family from other problems is highlighted. VIDEO, approximately 136 min.

Luigi Boscolo and Gianfranco Cecchin: What to Call It? Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") This Milan team consults with a couple and their 27-year-old daughter who has a history of hospitalizations for delusions and manic depressive symptoms. Pre-, inter-, and post-session hypothesizing includes beliefs about genetic origins, double binds, incest, and hopes of priesthood. Therapists

demonstrate therapeutic neutrality through a range of historical and circular questions. VIDEO, approximately 138 min.

Virginia Satir: Of Rocks and Flowers Distributor: Golden Triad Films
To order: www.goldentriadfilms.com/films/satir.htm Satir works with a blended family in which the couple has been married for a year. The husband, a recovering alcoholic, is the father of two boys, ages 4 and 2, who were repeatedly abused by their biological mother. The children are highly active and violent on occasion. The wife, abused by her previous husband who was also an alcoholic, is pregnant and afraid the boys will abuse her own child. In a moving segment, Satir interacts only with the two young children--she has them touch her face gently, reciprocates, and then asks if they would like to do the same with their parents. Then she gently coaches the parents how to touch and respond to the children. Following the session, Virginia comments on her use of touching, both in this session and generally.

Carl Whitaker: Usefulness of Non-Presented Symptoms Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") Whitaker consults with a grandmother, mother, and two pre-adolescent sons. The women are recent widows and the boys were abused by their deceased, alcoholic father. The intergenerational rules that hypnotize people to act in destructive ways are searched out, as the family is challenged to deal with issues in a healthier fashion. VIDEO, approximately 93 min.

Internet Resources

Have students look up two or three of the web sites listed below that feature the field of family therapy. Instruct students to write a one-page reaction paper outlining the purpose, nature, and activities of the national organizations in family therapy, major family therapy training institutions, and publishers in the field of family therapy. Several suggested sites include:

American Association for Marital and Family Therapy (www.aamft.org): provides resources for family therapy practitioners, training video for purchase, instructions on how to become a student member, licensing requirements, announcements for AAMFT sponsored conferences, and information on how to make local referrals to AAMFT-licensed practitioners, etc.

American Family Therapy Academy (www.afta.org): provides resources to practitioners, seeks to promote research and teaching in family therapy, lists information on how to become a member, etc.

Ackerman Institute for the Family
49 East 78th St
New York, NY 10021-0405
(www.ackerman.org): lists training conferences, continuing education opportunities, training materials for rent or for sale, etc.

Allyn and Bacon (www.abacon.com/ftvideos) and Guilford Press (www.guilford.com) have special sections devoted to family therapy.

You may also have students search the internet and compile a list of the most useful web sites devoted to family therapy, and distribute the list to each class member for their resource files.

Discussion Questions

1. What do you believe to be the necessary and sufficient conditions for real therapeutic change to occur: a brief but decisive intervention in the family system or long-term exploration of one's personality? Some argue that changes initiated via family therapy are lasting because change is exerted throughout the entire system--and each family member changes and continues to exert synchronous change on each other. Others assert that long-term, insight-oriented therapy is necessary to prevent a patient's personal pathology from reasserting itself.

2. The choice of individual versus family therapy can be based on technical considerations (e.g., which approach works best for a given problem--marital conflict, school phobia, alcoholism) or philosophical issues (e.g., what is one's understanding of human nature and behavior, and the therapist's role in treatment). Discuss how your own views of therapy are shaped by each of these considerations.

3. As a client, which form of therapy would you be more comfortable with, individual or couples or family? What's the relationship between being comfortable and being in the most effective form of treatment?

4. Have students interview 3-4 people and ask them about what strategies, successful and unsuccessful, they have used to try to improve their relationships with important others. As a class, have students discuss responses to their inquiries and attempt to extract themes characteristic of successful vs. unsuccessful relationship strategies.

5. In a family like Holly's, when conflict develops between a child and stepparent, what is gained by seeing the problem as triangular (rather than as a result of personalities)? What is gained be seeing the problem as transitional?

6. Does the myth of the hero have a greater influence on young men than on young women? To what extent is this changing? What are some cultural narratives (novels, television shows, movies) that support the myth of the hero? Are certain story lines that feature women as action heroes opening up space for women or simply putting them into masculine myths?

7. Have the class generate a list of problems for which students believe families typically enter family therapy. Categorize each problem on the list with respect to locus of the problem using a scale ranging from 1(linear causality) to 7 (circular or reciprocal causality). Divide the class into smaller groups and have each group take a portion of the presenting problems and brainstorm creative ways to translate linear explanations into circular or systemic explanations. (See Assessment section in Chapter 6.) Reconvene the class and review students' ideas about how to shift family members' constructions of presenting problems from linear/intrapsychic to systemic/interpersonal.

8. How could a family systems perspective be incorporated into the treatment offered at a college counseling center? (See Chapter 4.)

9. Ask students what is a family? Hopefully what will emerge is something about a group of people organized is such a way that the properties of the whole go beyond a collection of individuals. Then ask what is psychotherapy? What should emerge is some notion that psychotherapy (as opposed to counseling) involves some sort of transformation. Family therapy, therefore, considers the family as a group with superordinate properties and attempts to produce change in its organization.

10. Compare and contrast individual and family therapy. What types of clients and problems may be best suited for each and why? Provide examples to illustrate your answer. Is it possible to integrate individual and family treatment? Take a position and argue for or against.

11. What do you believe to be the necessary and sufficient conditions for real therapeutic change to occur: a brief but decisive intervention in the family system or the long-term exploration of individual personalities? Some argue that changes initiated via family therapy are lasting because change is exerted throughout the entire system--that each family member changes and continues to exert synchronous change on each other. Others believe that long-term insight-oriented therapy is necessary to prevent the patient's personal pathology from reasserting itself. Take a position for or against and cite evidence to support your view.

12. Define linear and circular thinking, and give an example of a treatment model based on each.

13. What advantage does family therapy offer over individual therapy in maintaining positive therapeutic change? What *disadvantage* does family therapy create in initiating positive therapeutic change?

14. What is gained by seeing family problems, such as those seen in Holly's family, as transactional? As triangular?

15. Identify:
    (a) linear
    (b) recursive

Supplemental Readings

Anderson, C., and Stewart, S. 1983. *Mastering resistance: A practical guide to family therapy*. New York: Guilford Press.

Guerin, P.J., Fay, L., Burden, S., and Kautto, J. 1987. *The evaluation and treatment of marital conflict: A four-stage approach*. New York: Basic Books.

Hoffman, L. 1981. *The foundations of family therapy*. New York: Basic Books.

Imber-Black, E., ed. 1993. *Secrets in families and family therapy*. New York: Norton.

Isaacs, M.B., Montalvo, B., and Abelsohn, D. 1986. *The difficult divorce: Therapy for children and families*. New York: Basic Books.

Kerr, M.E., and Bowen, M. 1988. *Family evaluation*. New York: Norton.

Minuchin, S., Nichols, M.P., and Lee, W-Y. *A four-step model for assessing families and couples: From symptom to system.* Boston, MA: Allyn & Bacon.

Nichols, M.P. 2009. *Inside family therapy*, 2nd ed. Boston: Allyn & Bacon.

Minuchin, S., and Nichols, M.P. 1998. *Family healing: Tales of hope and renewal from family therapy*. New York: Touchstone/Simon & Schuster.

White, M., and Epston, D. 1990. *Narrative means to therapeutic ends*. New York: Norton.

Chapter 1: The Evolution of Family Therapy

INTRODUCTION

In the 1950s, family therapy emerged independently in four different places: John E. Bell began family group therapy at Clark University; Murray Bowen treated families of schizophrenics at the Menninger Clinic and later at NIMH; Nathan Ackerman began his psychoanalytic family therapy in New York; and Don Jackson and Jay Haley started communications family therapy in Palo Alto.

The family is the context of most human problems. Like all human groups, the family has emergent properties -- the whole is greater than the sum of its parts. The systemic properties of a family fall into two categories: structure and process. The structure, or organization, of families includes triangles, subsystems, and boundaries. Among the processes that describe family interactions -- emotional reactivity, dysfunctional communication, pursuer-distancer-- the most basic is circularity. Rather than worrying about who started what, family therapists treat human problems as a series of moves and countermoves in repeating cycles. In this chapter, the author examines the antecedents and early years of family therapy.

Leading Figures

Early Family Researchers. Gregory Bateson, Don Jackson, Jay Haley; Theodore Lidz; Murray Bowen; Lyman Wynne.
Pioneers in Family Treatment. Milton Erickson, Nathan Ackerman, John E. Bell, Murray Bowen, Don Jackson, Jay Haley, Salvador Minuchin, Ivan Boszormeny-Nagy, Virginia Satir, Carl Whitaker.

Important Terms

circular causality: the idea that events are related through a series of interacting loops or repeating cycles.
complementary: relationships based on differences that fit together, where qualities of one make up for lacks in the other.
cybernetics: the science of communication and control mechanisms that focuses on the way systems maintain stability and control through levels of feedback.
double-bind: Bateson and colleagues' concept for the conflict created when a person receives contradictory messages on different levels of abstraction in an important relationship and cannot leave or comment.
marital schism: Lidz's term for overt marital conflict.
marital skew: Lidz's term for a marriage in which one spouse dominates the other.
metacommunication: given that every message has two levels, report and command, metacommunication is the implied command or qualifying message.
morphogenesis: the process by which a system modifies its structure to adapt to new contexts (and a swell word to impress people at cocktail parties).
pseudohostility: Wynne's term for superficial bickering that masks pathological alignments in schizophrenic families.
pseudomutuality: Wynne's term for the facade of family harmony that characterizes many schizophrenic families.
quid pro quo: literally "something for something"; an equal exchange.
rubber fence: Wynne's term for the rigid boundary surrounding many schizophrenic families, which allows only minimal contact with the surrounding community.
undifferentiated family ego mass: Bowen's early term for emotional "stuck-togetherness" or fusion in the family, especially prominent in schizophrenic families.

SUMMARY OF KEY POINTS AND ISSUES

The Undeclared War

Traditionally clinicians believed that in order to treat hospitalized patients it was necessary to exclude family contact. Now we know better. In the 1950s hospital therapists began to notice that when a patient improved, someone else in the family often got worse. These same therapists observed that patients frequently improved in the

hospital, only to get worse when they went home. Case studies dramatized how parents sometimes used their children's problems -- to give them a sense of purpose, or as a buffer to protect them from intimacy they found difficult to handle -- *and* how some children accepted that role. And while the official story of family therapy was one of respect for the institution of the family, therapists often took on a sense of mission in rescuing scapegoated victims from the clutches of their families. While it was eventually reasoned that changing the family might be the most effective way to change the individual, the shortsightedness of isolating patients from their families in psychiatric hospitals continues (c.f., Elizur & Minuchin's *Institutionalizing Madness*). Some 45 years after the development of family therapy, psychiatric hospitals still often segregate patients from their families.

Small Group Dynamics

Group therapy influenced the beginning of family therapy through the literature on group dynamics and through some of the pioneers of family therapy (e.g., John Bell, Rudolph Dreikurs), who were trained as group therapists. One of the reasons that studies of group dynamics were relevant to family therapy is that group life is a complex blend of individual personalities and superordinate properties of the group. The obvious parallels between small groups and families led some therapists to treat families as though they were just another form of group. The first to apply group concepts to family treatment were John Elderkin Bell and Rudolph Dreikurs.

Several group concepts were borrowed for use in family therapy. Kurt Lewin's notion that groups are psychologically coherent wholes, rather than collections of individuals, is one such concept. His ideas about the need for "unfreezing"--a shakeup that prepares a group to accept change--foreshadowed early family therapists' attempts to disrupt family homeostasis. Wilfred Bion's study of group dynamics (fight-flight, pairing, dependency) guided systemic thinkers' understanding of group properties, with their own dynamics and hidden structure. Warren Bennis described group development as consisting of two main phases, each with several subphases. The notion that groups go through predictable phases was used by family therapists who conducted therapy in stages, and who later consolidated these ideas to form the concept of the "family life cycle." Role theory has been useful in understanding families, because roles tend to be reciprocal and complementary. What makes complementarity resistant to change is that complementary roles reinforce each other-- and each person waits for the other to change.

Group theories tend to be ahistorical, maintaining a focus on the "here-and-now." A focus on *process* (how people talk), rather than *content* (what they talk about), is key to understanding the way a group functions. This process/content distinction, formalized in the study of group dynamics, had a major impact on family treatment. Family therapists learned to attend more to how families talk than to the content of their discussions. However, as family therapists gained more experience, they discovered that the group therapy model was insufficient for families. Therapy groups are composed of strangers with no past or future outside the group, whereas families consist of intimates who share a history and a future together, the same myths and defenses, etc. Families also contain generational differences -- their members are not peers who should relate as equals.

The Child Guidance Movement

At the turn of the twentieth century, major social reforms led to the creation of child welfare laws and greater respect for children's rights. The child guidance movement was born out of these concerns, and founded on the widening belief (e.g., Alfred Adler) that treating problems of children was the best way to prevent the development of problems in adulthood.

Gradually, child guidance workers concluded that tensions in the family were often the real source of children's difficulties. The typical treatment in child guidance centers consisted of a psychiatrist seeing the child while a social worker met with the mother. The mother was seen primarily to improve her parenting skills. Throughout the 1940s and 1950s researchers in child guidance clinics believed that parental psychopathology caused child pathology. It was during this time that Frieda Fromm-Reichmann introduced her concept of the *schizophrenogenic mother*--aggressive, domineering mothers thought to foster schizophrenia in children.

Eventually the emphasis in child guidance shifted to viewing pathology as inherent in family relationships -- a shift with profound consequences. Psychopathology was no longer located solely within the individual. Parents were no longer seen as villains and children as victims. Once the nature of family interactions was seen as the problem, this changed the very nature of treatment and resulted in a more optimistic prognosis. Instead of trying to separate

children from their families, child guidance workers began to help families support their children. While John Bowlby experimented with family therapy, Nathan Ackerman first successfully carried it out.

Marriage Counseling

Marriage counseling began as a relatively informal procedure and is still widely practiced outside of traditional mental health settings--e.g., by ministers, family doctors, and lawyers. Psychoanalytic and behavioral therapists experimented with both concurrent and conjoint couples sessions, and then, with Jay Haley and Don Jackson, couples therapy was absorbed into the new discipline of family therapy. But although Nichols follows the convention of considering couples therapy a subtype of family therapy, the practice of couples therapy (especially in psychoanalytic, cognitive-behavioral, emotionally-focused, and integrative models) tends to permit more in-depth focus on both dyadic exchanges and on the psychology of the partners.

Research on Family Dynamics and the Etiology of Schizophrenia

The initial breakthroughs in family therapy were achieved by clinical researchers. In Palo Alto, Bateson, Haley, Jackson, and Weakland discovered that schizophrenia made sense in the context of pathological family communication. The two great discoveries of this talented team were: (1) multiple levels of communication, and (2) destructive patterns of relationship that are maintained by self-regulating interactions of the family group. At Yale, Theodore Lidz found patterns of instability and conflict in the parents of schizophrenics, patterns that appeared to profoundly affect the pathological development of children. Lyman Wynne at NIMH (and later Rochester), demonstrated how communication deviance in a family may contribute to schizophrenia. Role theorists, like John Spiegel, described how individuals were cast into social roles within families, and the polemical R.D. Laing pointed out that when parents "mystify" (distort) their children's experience, the children may learn to project a "false self" and keep their real selves buried.

These researchers observed that the behavior of schizophrenics fit with their families. Unfortunately, they assumed that, because schizophrenia made sense in the context of the family, the family must therefore be the cause of schizophrenia. Moreover, they concluded that family dynamics (i.e., double binds, pseudomutuality, etc.) were products of the "system," rather than features of individuals who shared certain qualities because they lived together.

From Research to Treatment: The Pioneers of Family Therapy

In the 1950s research on family dynamics and schizophrenia led to the pioneering work of the first family therapists. These pioneers had distinctly different backgrounds and clinical orientations -- not surprisingly, the approaches they developed to family therapy were also quite different. This diversity still characterizes the field today.

John Bell started seeing families in the 1950s. Although he was a significant pioneer in family therapy, his influence on the field was not great. Bell's approach was based on the group therapy model. In his "family group therapy," he relied primarily on stimulating an open discussion in order to help families solve their problems.

Three specialized applications of group methods to family treatment were *multiple family group therapy, impact therapy,* and *network therapy.* Multiple family group therapy, developed by Peter Laqueur, involved seeing four to six families together and treating them like traditional therapy groups as well as using encounter group techniques. Multiple impact therapy was used at the University of Texas in Galveston by Robert MacGregor and his colleagues as a way to have maximum impact on families over the course of several days. Network therapy, developed by Ross Speck and Carolyn Attneave, was the most influential of these specialized group models. In network therapy, a patient's entire social network is convened by teams of therapists who help them mobilize support for families in crisis.

Of the Palo Alto group, **Don Jackson** and **Jay Haley** were the most influential in developing family treatment. Jackson turned his back on his psychoanalytic training and focused on the dynamics of interchange between people. His concept of *family homeostasis* became the defining metaphor of family therapy's early years. (*Note*: Today we can see how an emphasis on homeostasis and the cybernetic metaphor led therapists to become more mechanics than healers. In their zeal to rescue family scapegoats, therapists provoked some of the resistance they complained of.)

Many of Jackson's concepts, such as the *marital quid pro quo*, *complementarity*, and *symmetry* are still used by family therapists today.

Like Jackson, Jay Haley concentrated on the marital dyad. He believed that everyday relationships were shaped by struggles for control. Symptomatic behavior was seen as an insidious way to control people while denying that one is doing so. Within the therapeutic relationship, patients attempt to control the therapist. According to Haley, the therapist's job is to outwit patients in such a way as to defeat their resistance. For a more complete description of Jackson's and Haley's work, see Chapter 5.

Virginia Satir was another member of the Palo Alto group who played a major role in the development of family therapy. In her work with families, she concentrated on clarifying communication, expressing feelings, and fostering a climate of mutual understanding. Her 1964 book, *Conjoint Family Therapy*, did much to popularize the family therapy movement.

Murray Bowen believed that pathological dynamics found in schizophrenic families were present to a lesser extent in all families. Bowen experimented with different methods of working with individuals, couples, and families until about 1964, when he developed the method that stands today (see Chapter 4). Bowen believed that the best way to become a family therapist was to resolve emotional problems within one's own family of origin.

The goal of Bowen therapy is to help patients achieve *differentiation of self* in the context of family relationships, to teach them enough about family systems to handle future crises, and to develop the motivation to continue working toward further differentiation after therapy is terminated. Differentiation is best accomplished by developing individual relationships with each parent and with as many family members as possible. In addition to his work with couples, Bowen often worked with individual family members. Bowen saw family therapy both as a method and an orientation. As an orientation, it means understanding people in the context of emotional systems. Some argue that Bowen's work with individual family members is more focused on family issues, systems concepts, and emotional processes, than almost any other family therapy approach.

Nathan Ackerman never lost sight of the fact that people are individuals as well as members of families. Like Jackson and Bowen, he came to family therapy from psychoanalysis. While he maintained an emphasis on psychodynamic conflict, he also demonstrated a keen sense of the overall organization of families. The creative flexibility of Ackerman's approach makes it difficult to describe, yet there were clear themes in his work. He thought it necessary to be deeply committed and involved with families. He believed in the existence of an interpersonal unconscious within each family. His techniques suggest that he was somewhat more concerned with the content of family conflicts than with the process by which family members dealt with them, and more interested in secrets and hidden conflicts than in distance, proximity, and patterns of communication.

While his clinical writings present few systematic strategies for working with families, he was a brilliant artist of family therapy technique, interacting with families in an active, open, highly emotional and effective manner. His contributions as a teacher may be his most important legacy.

Carl Whitaker's view of psychologically troubled people was that they are alienated from their emotions, thus incapable of autonomy or real intimacy. Whitaker eschewed theory in favor of creative spontaneity. He pioneered the use of cotherapy in family treatment, believing that a cotherapist allowed family therapists to react spontaneously in sessions without fear of unchecked countertransference. His "Psychotherapy of the Absurd" was designed to open individuals up to their own feelings and help them share those feelings within the family. For a description of Whitaker's experiential approach, see Chapter 7.

Another seminal thinker, **Ivan Boszormenyi-Nagy,** came to family therapy from psychoanalysis. In 1957, he founded the Eastern Pennsylvania Psychiatric Institute (EPPI) in Philadelphia, a center for research and training in treatment for families and schizophrenia. He attracted a number of highly talented colleagues, including James Framo, David Rubenstein, Geraldine Spark, and Gerald Zuk. Nagy's most important contribution was introducing ethical accountability into family therapy. He believed that family members should base their relationships on trust and loyalty. Depending on the integrity and complementarity of their needs, marital partners develop trustworthy give-and-take relationships. His term "invisible loyalties" describes the unconscious commitments and guilt that children take on to help their families, often to the detriment of their own well-being.

Though not one of the first family therapists, **Salvador Minuchin** entered the field early and his accomplishments rank among the most influential. Minuchin and his colleagues (Haley, Montalvo, and Rosman) developed structural family therapy, among the most widely used systems of family therapy. Minuchin's (1974) *Families and Family Therapy* is the most popular book ever written on family therapy.

Structural family therapy begins with the observation that family transactions, when they are repeated, develop a patterned regularity, or structure. The nature of *family structure* is determined by emotional *boundaries*, which keep family members close or distant. Problems arise when families fail to modify their structure to fit changing circumstances. The techniques of structural family therapy fall into two general strategies. First, a therapist must accommodate to a family in order to join with them. Once the initial joining is accomplished, a structural therapist uses restructuring techniques -- active, directive maneuvers designed to disrupt dysfunctional structures by strengthening diffuse boundaries and softening rigid ones. For more on structural family therapy, see Chapter 6.

LESSONS FROM THE EARLY MODELS

The first family therapists turned to models from group therapy and communications theory to guide treatment of families. Group family therapy was developed by clinicians who had a background in group therapy and others who applied group dynamics concepts to families. It was an approach widely used in the 1960s, but no longer. Today we realize that families have unique properties that cannot effectively be treated with a group therapy model.

The communications theory that emerged from Palo Alto in the 1950s had an enormous impact on the entire field of family therapy. Its adherents focused on the *process* of communication, rather than its *content*. The paradigms of the communications model, derived from general systems theory, cybernetics, and information theory, were so well received that they have been absorbed by the whole field. Eventually, its proponents branched off to form new schools, especially the strategic, experiential, and structural approaches to family therapy.

The great advance of systemic thinking is that behavior in families is the product of mutual influence. The danger in forgetting that systems metaphors are only metaphors leads to overestimating the system's power over individuals. Systems *influence* but do not *determine* our behavior. Family therapists taught us that our behavior is governed in unseen but powerful ways by the actions of others. Family rules and roles operate as invisible constraints influencing all that we do. These ideas are liberating; if one is playing a role (i.e., based on rigid gender stereotypes), then it's possible to play a new one (e.g., based on a broader, more authentic definition of self).

Yet systems thinking in the extreme rejects selfhood as an illusion. Systems thinkers implied that the family role plays the person, rather than the other way around. Whether acting in unison or separately, it must be the individuals in the system who act to bring about change in the family. In sum, while systems thinking reminds us of our connection with others, the systems metaphor is not a complete model for human systems. Although individuals respond to forces outside themselves, they are also people with names who experience themselves as centers of initiative, with imagination, reasoning, creativity, memories, and desires.

THE GOLDEN AGE OF FAMILY THERAPY

The 1970s and 1980s saw the flowering of the classic schools of family therapy -- Bowenian, psychoanalytic, behavioral, experiential, and, especially, structural and strategic. Those two decades may have been the high-water mark of family therapy's enthusiasm and vitality. Subsequently, however, a reaction set in both to the aggressiveness of the interventions and to the competitiveness of the different schools. Today, family therapists favor a more collaborative approach to families and are likely to integrate theories and techniques from various models.

SUGGESTED LEARNING ACTIVITIES

Films

The Case of the Dumb Delinquent Philadelphia Child Guidance Center, Mike Schmidt Video Department, 34th St. and Civic Center Blvd., Philadelphia, PA 19104. Minuchin interviews a 13-year-old pre-delinquent boy and his single mother. Minuchin highlights the complementary patterns that link mother to son, through skillful use of

relabeling and reframing, and challenges the mother's plans for institutional placement. VIDEO, 3/4 inch Cassette, S-VIDEO, approximately 38 minutes.

Virginia Satir: Of Rocks and Flowers Distributor: Golden Triad Films.
To order: www.goldentriadfilms.com/films/satir.htm Satir works with a blended family in which the couple has been married for a year. The husband, a recovering alcoholic, is the father of two boys, ages 4 and 2, who were repeatedly abused by their biological mother. The children are highly active and violent on occasion. The wife, abused by her previous husband who was also an alcoholic, is pregnant and afraid the boys will abuse her own child. In a moving segment, Satir interacts only with the two young children--she has them touch her face gently, reciprocates, and then asks them if they would like to do the same with their parents. Then with the parents, she gently coaches them how to touch and respond to the children. During the post- session interview, Virginia comments explicitly on her use of touching, both in this session and generally.

Carl Whitaker: Usefulness of Non-Presented Symptoms Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") Whitaker consults with a grandmother, mother, and two pre-adolescent sons. The women are recent widows and the boys were abused by their deceased, alcoholic father. The intergenerational rules that hypnotize people to act in destructive ways are searched out, as the family is challenged to deal with issues in a healthier fashion. VIDEO, approximately 93 min.

Carl Whitaker and Gary Connell: Creating a Symbolic Experience Through Family Therapy Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") Note: Whitaker is spelled "Whitake" in the catalogue. Whitaker demonstrates his Symbolic Experiential Therapy in his interviews with two extended families. VIDEO.

Paul Watzlawick: Mad or Bad? Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") In his consultation with a family whose 25-year old son presents with chronic somatic symptoms, Watzlawick employs strategic use of Ericksonian-style questions. The systemic function of symptoms in protecting the family from other problems is highlighted. VIDEO, approximately 136 min.

Jay Haley & Judge Clinton Deveaux, In the Maze: Families and the Legal System Distributor: AAMFT To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") This video offers guidelines for compulsory therapy as an alternative to incarceration. VIDEO.

Virginia Satir: The Use of Self in Therapy #7953 Discovery Education: 800-213-8395. *The Use of Self*, draws on Satir's legacy of clinical recordings to demonstrate the tenets of her theory and practice. Therapy footage is interspersed with expert commentary. Explored are methods to empower family members, bolster self-esteem, reframe problems, and communicate with congruence. VIDEO, 30 minutes.

Virginia Satir: The Lost Boy Distributor: AAMFT
To order: www.aamft.org/family therapyresources/search.asp (Note: this link can also be reached from the AAMFT website by going to www.aamft.org clicking on the pink line on the left marked "FamilyTherapyResources.net, and then clicking on "Search This Web Site.") Satir conducts an experiential session with a large intact family with ten children whose presenting problem is grief following the loss of one of the children who is still missing a year after his abduction. This session provides a good demonstration of Satir's open, directive, spatial style. VIDEO, approximately 80 min.

Discussion Questions

1. Have students choose a supplemental sources on the pioneer of their choice (e.g., Gregory Bateson, Murray Bowen, Jay Haley, Virginia Satir, Lyman Wynne, etc.) to read and present to the class. Presentation of theoretical papers should address the following issues: the author's theoretical formulations, ideas about normal family development, how behavior disorders develop in the family, goals of treatment, techniques used in treatment, and ideas about how and why change occurs in therapy. Presentation of researchers should include: research questions posed, types of research design used (i.e., qualitative vs. quantitative, and specify type), interpretation of findings, and implications of the research findings for the field.

2. What are the pros and cons of segregating hospitalized mental patients from their families?

3. What are some of the motives for blaming parents (especially mothers) for the problems of their children? What are some of the clinical consequences of this type of thinking?

4. List the various early leaders of family therapy on individual note cards -- Gregory Bateson, Theodore Lidz, Lyman Wynne, Milton Erickson, Nathan Ackerman, John E. Bell, Murray Bowen, Don Jackson, Jay Haley, Salvador Minuchin, Virginia Satir, and Carl Whitaker, etc. Break the class into groups of 3-4 students each and divide the note cards among groups. Have students identify and discuss the major contributions of each leader to the field of family therapy. How have their ideas fared in the current climate of family therapy?

5. What are some of the "basic assumptions" (in Bion's terms) operating in some of the groups of which your students have been a part?

6. What roles did students play in their families growing up? What potential roles went unfulfilled or unnoticed?

7. To what extent does it make sense to treat couples therapy as just a form of family therapy rather than a specific discipline in its own right?

8. Discuss the major concepts in early communication theory that have been incorporated into other schools of family therapy (i.e., complementarity, cybernetics, homeostasis, metacommunication, positive and negative feedback loops, symptom functionality, etc.). Which have had the greatest impact on the direction in which the field is developing?

9. Trace the demise of group family therapy. What were its major contributions to the field? What were its major failings? In which settings under which conditions, with which types of families and family problems might group family therapy show greater effectiveness?

10. Discuss Speck and Attneave's network therapy. For what situations might this approach be particularly useful (e.g., families with chronic illness, ethnic minority families, non-traditional families such as single parent families and gay and lesbian families), and why?

11. Discuss the pros and cons of manipulating people to change. Do the ends justify the means? Is it ethical or clinically indicated to change someone outside of his or her awareness?

Role Plays/Observations

1. Have students break into groups of 2-3. One student (a client), should describe a problem (e.g., frequent fights with partner; difficulty getting along with co-workers; parent of an adolescent child who is acting out; workaholic, etc.), and the others should ask questions about what he or she has done in response to the problem. The goal of the exercise is to discover problem-maintaining behavior, and maybe suggest that the client try something different. Reverse roles until all students have played both client and interviewer.

2. Divide the class into groups of 3 or 4. Ask two students to play a couple and to choose an emotional topic for discussion, something on which they are likely to disagree (e.g., finances, housekeeping responsibilities, frequency of visits with parents, sex, communication problems). Instruct one or both partners to deliberately talk

about "you" and the way things "are" and "should be," rather than saying "I think," "I wish," "I feel." Stop after 10 minutes -- observers should notice and comment on how destructive this habit is. Next instruct each member of the "couple" to speak in the first person singular (e.g., I feel..., I think..., My thought is that....); making personal statements about personal matters (e.g., "I would like to visit my family..." versus "You should want to visit with my family during the holidays"), and speaking directly to, not about, each other. Discuss the contrasting experiences of the students who were role-playing across the first and second role play. Discuss observers' perceptions of these differences. Ask students to consider implications for treatment.

3. Divide the class into small groups, perhaps 4-5 each, and have students conduct two types of role plays, approx. 15 minutes each, using communications family therapy techniques. Instruct two students to play a couple with relationship difficulties, one to play the therapist, and one or two students to observe. In the first role play, instruct the therapist to use a direct approach in treating the couples' presenting difficulties by making their rules of communication explicit and teaching them principles of clear communication (e.g., using the first person singular--I, me, mine--when referring to one's thoughts and feelings about an issue, making personal "I" statements, speaking directly to and not about the other).

   In the second role play, two students should role play a couple with relationship difficulties. This time instruct the therapist to use a more indirect strategy by attempting a paradoxical intervention (e.g., prescribing the symptom, reframing the problem, creating a therapeutic double-bind, etc.). Encourage the therapist to call a time-out during the role play session in order to confer with observers and design an effective paradoxical intervention. Following the role plays, instruct the groups to discuss the effectiveness of the direct vs. indirect style of intervention. What were the couples' experiences as targets of the interventions? Which felt more effective? In each case, was the therapist able to induce change in the couples' style of communicating, ways of thinking about the problem, etc.? Which intervention style fits best with students' own personal styles?

4. Have students break into groups of 3-4. Have two students role-play a conversation in which each reacts with emotional responses to the other's statements. Observers should take note of what happens. Next have them role-play a similar conversation, but this time instruct them to acknowledge what the other said before they respond. Have the group discuss each role play. What impact did acknowledgment of the other's perspective have on the quality of the interaction? Discuss the implications for conducting couples therapy.

Supplemental Readings

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Test Bank Questions

Contents

Chapter 1: The Evolution of Family Therapy

1.1 Multiple-Choice Questions

1) Lyman Wynne's term for the facade of family harmony that characterized many schizophrenic families is

A) pseudocomplementarity
B) pseudomutuality
C) pseudoharmony
D) pseudohostility

2) Hospital clinicians began to acknowledge and include the family in an individual's treatment when

A) they noticed when the patient got better, someone in the family got worse
B) they realized the family was footing the bill for treatment
C) they realized the family continued to influence the course of treatment anyway
D) A and C
E) none of these choices

3) Kurt Lewin's idea of _____ can be seen in action in Minuchin's promotion of crises in family lunch sessions, Norman Paul's use of cross-confrontations, and Peggy Papp's family choreography.

A) unfreezing
B) social equilibrium
C) group process
D) field theory

4) The first to apply group concepts to family treatment was

A) Murray Bowen
B) John Elderkin Bell
C) Virginia Satir
D) Carl Whitaker

5) Frieda Fromm-Reichmann's concept, "_____ mother," described a domineering, aggressive, rejecting, and insecure mother who was thought to provide the pathological parenting that produced schizophrenia.

A) undifferentiated
B) schizophrenogenic
C) reactive
D) symbiotic

6) Gregory Bateson and his colleagues at Palo Alto introduced this concept to describe the patterns of disturbed family communication which cause schizophrenia.

A) schizophrenogenesis

B) double bind
C) pseudohostility
D) none of these choices

7) The only means to effectively escape a double bind is to

A) withdraw from the relationship
B) metacommunicate
C) quid pro quo
D) A and B

8) According to Theodore Lidz, marital schism occurs when

A) one spouse with serious psychopathology dominates the other
B) there is a chronic failure of spouses to achieve role reciprocity
C) one spouse consistently engages in double-binding communication
D) there is a loss of autonomy due to a blurring of psychological boundaries between spouses

9) Jackson's concept, _____, that families are units that resist change, became the defining metaphor of family therapy's first three decades.

A) emotional reactivity
B) quid pro quo
C) family homeostasis
D) A and C

10) This family therapist's personal resolution of emotional reactivity in his family was as significant for his approach to family therapy as Freud's self-analysis was for psychoanalysis.

A) Salvador Minuchin
B) Jay Haley
C) Murray Bowen
D) Carl Whitaker

11) This family therapist believed in the existence of an interpersonal unconscious in every family.

A) Murray Bowen
B) Nathan Ackerman
C) Ivan Boszormenyi-Nagy
D) Virginia Satir

12) The group therapy model was not entirely appropriate for families for what reason?

A) family members are peers
B) families have a shared history
C) A and C

D) none of these choices

13) The Bateson group may be best remembered for the concepts of the double bind and

A) triangles
B) family structure
C) group process
D) metacommunication

14) The tendency of families to resist change in order to maintain a steady state is known as

A) homeostasis
B) the black box concept
C) paradox
D) complementarity

15) According to the text, one problem with treating families as though they were groups like any other group is that

A) it fails to consider the intrapsychic components of family problems
B) it fails to appreciate the need for hierarchy and structure
C) family members are released from their inhibitions
D) there is no problem with treating families like any other group

16) A conflict created when a person receives contradictory messages on different levels of abstraction in an important relationship, and cannot leave or comment is known as a

A) reframe
B) complementarity
C) quid pro quo
D) double bind

17) The goal of family group therapy was to

A) promote verbalization and understanding of unmet needs
B) promote individuation of family members
C) improve family relationships
D) all of these choices

18) Group-oriented therapists promoted communication by concentrating on _____ rather than _____.

A) process/content
B) solutions/problems
C) the system/the individual
D) positive feedback loops/negative feedback loops

19) The family theory of the etiology of schizophrenia which focused on disturbed patterns of communication was founded by Gregory Bateson, Theodore Lidz, and

A) Carl Whitaker
B) Lyman Wynne
C) Virginia Satir
D) Mara Selvini-Palazzoli

20) A relationship in which husband and wife both pursue careers and share housekeeping and childrearing responsibilities is

A) complementary
B) unrealistic
C) competitive
D) symmetrical

21) Communications family therapists hypothesized that normal families can maintain integrity in the face of environmental vagaries through

A) positive feedback
B) negative feedback
C) metacommunication
D) therapeutic double-binds

22) According to communications theory, healthy families are able to adapt to changing circumstances through use of

A) positive feedback
B) negative feedback
C) homeostasis
D) therapeutic double-binds

23) One of the major propositions put forth in Watzlawick et al. 's (1967) *Pragmatics of Human Communication*, was that all messages have a report and a _____ function.

A) semantic
B) pragmatic
C) paradoxical
D) command

1.2 Short Answer

1) Explain "homeostasis."

2) Discuss the advantages and disadvantages of using a systems metaphor to understand and treat families.

3) In communications family therapy, resistance and symptoms were treated with a variety of paradoxical techniques, known as therapeutic double-binds. Define and give an illustration of a therapeutic double-bind. Why were they considered so powerful?

4) Some argue that paradoxical instructions are insulting and should not be used. Others insist

Answer Keys

Multiple Choice Answer Key

Chapter 1.

1. B
2. D
3. A
4. B
5. B
6. B
7. D
8. B
9. C
10. C
11. B
12. D
13. B
14. D
15. A
16. B
17. D
18. D
19. A
20. B
21. D
22. B
23. A
24. D

Chapter 2.

1. A
2. D
3. D
4. B
5. C
6. C
7. D
8. B
9. C
10. B
11. C
12. D
13. B
14. D
15. C
16. D
17. B