THE FAMILY FIRO MODEL: A MODEST PROPOSAL FOR ORGANIZING FAMILY TREATMENT

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This paper presents a model for organizing family issues and family treatment. Schutz's FIRO model is offered as a framework for organizing family issues into inclusion, control and affection categories. Following Schutz's theory of group development, we propose that inclusion, control and affection constitute a logical hierarchy of core issues to be dealt with in treating multiproblem families—exclusion first, then control, and then affection (intimacy). Furthermore, we propose that the FIRO model can be used to organize theories of family therapy. We attempt to demonstrate that different family therapies are best suited for one of the three core issues of family interaction. We advocate an "intelligent eclecticism" based on the premise that when an issue is appropriately matched with a therapy, therapeutic effectiveness should be enhanced. We also discuss implications of our Family FIRO model for clinical practice.

This paper applies a social psychological framework—Schutz's Fundamental Interpersonal Relations Orientation (FIRO) theory—to family therapy theory. Our goals are fairly ambitious: We aim to develop a typology of family problems or issues, to organize family therapy models according to the issues they specialize in, and to propose a system for assigning treatment priorities in family therapy.

Although the FIRO model (Schutz, 1958) has attracted a good deal of attention in small group research, it has been little noticed in the family field. Exceptions are Robbins and Toomey's (1976) paper on the use of the FIRO-B instrument in couple counseling, and Hof and Miller's (1981) use of the FIRO model in organizing their marriage enrichment program. As others have noted before us, the road linking small group theory and family therapy is strewn with land mines representing misapplications of each field to the other. However, the time seems ripe for careful interdisciplinary explorations.

In order to accommodate readers who are unfamiliar with the FIRO model, the paper begins with a fairly detailed introduction to Schutz's theory. The second section shows how family issues can be categorized into the FIRO dimensions. The third section discusses the implications of the Family FIRO model for assigning treatment priorities. The fourth section organizes the most prominent schools of family therapy along the FIRO issues they are most suited to address. The final sections then discuss implications of the Family FIRO model and present a case example.

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SCHUTZ’S THREE DIMENSIONAL THEORY OF INTERPERSONAL BEHAVIOR

William C. Schutz introduced his FIRO theory in 1958 in his book, FIRO: A Three Dimensional Theory of Interpersonal Behavior (revised in 1966 as The Interpersonal Underworld). The theory was expanded in subsequent books: Joy (1967), Here Comes Everybody (1971), Elements of Encounter (1973), and Leaders of Schools (1977). During intervening years, the FIRO Awareness Scales were designed to test the theory. In his seminal work on FIRO in 1958, Schutz presented a number of postulates concerning the nature of interpersonal behavior. The two most relevant postulates to our thesis are Postulates 1 and 4. We will discuss them separately.

Postulate 1: The Postulate of Interpersonal Needs
Schutz’s first postulate states that:
(a) Every individual has needs: inclusion, control and affection.
(b) Inclusion, control and affection constitute a sufficient set of areas of interpersonal behavior phenomena.

Thus, FIRO conceptualizes three fundamental issues that are predominant in human relatedness. Schutz (1958) applies these concepts to individual personality dynamics as well as to group dynamics. For our purpose we will emphasize their applicability to group dynamics.

Schutz (1958) defines “interpersonal” as “relations that occur between people” (p. 14). Thus an interpersonal situation is “one involving two or more persons in which these individuals take account of each other for some purpose or decision” (p. 14). Need is defined as a “situation or condition of an individual the nonrealization of which leads to undesirable consequences. An interpersonal need is one that may be satisfied only through the attainment of a satisfactory relation with other people” (p. 15).

Inclusion. The interpersonal need for inclusion is defined by Schutz as the “need to maintain a satisfactory relationship with respect to interaction and association” (Schutz, 1958, p. 19). An elaboration of “satisfactory relation” includes a comfortable interaction with people with a balance of initiating and eliciting interactions, ability to take an interest in people as well as elicit an interest from others, and the need for self to feel significant and worthwhile. The need for inclusion manifests itself in a person’s efforts to attract attention and interest. An essential aspect of inclusion is that of identity (Schutz, 1958). An integral part of being recognized or receiving attention is that the individual is viewed as distinct from other people and therefore as an individual with a unique identity.

Schutz (1958) views inclusion as a common issue at the outset of interpersonal relationships; there is usually a certain amount of testing of the relation as individuals attempt to “identify” themselves to one another and find out which facet of themselves others will be interested in (p. 22).

Control. The interpersonal need for control is defined by Schutz (1958) as the need to establish and maintain a satisfactory relation with people with respect to influence and power. Satisfactory control relations include a balance between controlling and being controlled in relation to others, as well as the ability to offer and receive respect. In relation to self, control is the need to feel that one is competent and responsible. The need for control manifests on one end as a desire for power and authority over others and at the other end as a willingness to have control or responsibility taken away. It differs from inclusion behavior in that it does not require attention or prominence.

Affection. The interpersonal need for affection is defined by Schutz (1958) as the need to “establish and maintain a satisfactory relation with others with respect to love and affection” (p. 20). Satisfactory affection relations include a balance of initiating and receiving close, personal interactions. There is the need to love and be loved as well as the need to see the self as lovable.

In the FIRO model affection refers to close personal, emotional feelings between two people. Schutz stresses that “affection is a dyadic relation; it can occur only between pairs of people at any one time, whereas both inclusion and control relations may occur either in dyads or between one person and a group of persons” (p. 23). An affection relation is viewed as dyadic because it involves a strong differentiation between people. In order to make a strong differentiation, one usually confides innermost anxieties, fears, wishes and feelings as part of the emotional attachment. Affection relations differ from inclusion and control in that they focus on emotional closeness rather than on prominence (recognition) or power.

In summary, affection in the FIRO model is concerned primarily (but not solely) with the formation of the relation, while control and affection are concerned with relations already formed. Inclusion in Schutz’s small group model is concerned with whether or not a relation exists. (Recall that a person must feel some sense of identity in order to feel part of a relation.) Assuming a relation exists, control represents the issue of who dominates and makes decisions for whom, while affection focuses on how emotionally close or distant a particular relation becomes. “Thus generally speaking, inclusion is concerned with the problem of in or out, control with top or bottom, and affection with close or far” (Schutz, 1958, p. 24).

Postulate 4: The Postulate of Group Development
Schutz’s fourth postulate states that the formation and development of two or more people into an interpersonal relation (a group) always follows the same sequence (i.e., the inclusion phase, then the control phase, then the affection phase). This cycle of phases may recur during the life of the group, with the group moving from affection issues back to inclusion issues and then to control issues, and so forth. The phases of inclusion, control and affection in groups are not distinct stages per se. “The group development postulate asserts that these problem areas are emphasized at certain points in the group’s growth. All three problem areas are always present but not always of equal salience” (Schutz, 1958, p. 171).

The following will give a brief discussion of the interpersonal relation phases in a group setting. These phases are primarily an application of the three basic interpersonal needs to the level of group development.

Inclusion phase in group development. The inclusion phase begins with formation of a group. The typical issues or concerns at the inclusion phase involve being in or out of the group (i.e., will I actually participate in this group), and establishing one’s self as an individual differentiated from others. A basic problem here is that of commitment to the group, or how much each member is willing to invest in the group. Some of the key questions for each person include “How much of myself will I devote to the group? How important will I be in this setting? Will they know who I am and what I can do, or will I be indistinguishable from many others—the problem of identity?” (Schutz, 1958, p. 109). Schutz summarizes the inclusion (formative) process for groups as concerns with entering, belonging and establishing boundaries.

Control phase in group development. The control phase follows when issues of inclusion are sufficiently resolved. It is important to keep in mind that a group will probably never fully resolve inclusion issues (or control or affection for that matter) but that a group can achieve a critical level of resolution so that there can be a shift in emphasis. The control phase is characterized by concern with distribution of control and power. “Characteristic behavior at this stage includes a leadership struggle, competition, discussion of orientation to the task, structuring, rules of proceedings, methods of decision making, and sharing responsibility for the group’s work” (Schutz, 1958, p. 171).

Affection phase in group development. The affection phase follows the sufficient resolution of concerns of control. By now individuals presumably have come together as a group (inclusion), have made some accommodations in the areas of power and respon-
sibility (control) and are now "ready" to become emotionally incorporated. The primary issues and anxieties at the affection phase have to do with each member's comfort with the degree of closeness and intimacy with other members (Schutz, 1958).

Schutz's ideas on the development of groups were mainly inferential. He observed group processes (Schutz, 1958) and interviewed group members about what they perceived to have happened in groups. These observations seemed to confirm not only the presence of the three issues but their order as well. Schutz also looked to group theorists (e.g., Benne & Sheats, 1948; Bion, 1961; Carter, 1955; Leary, 1957) for further confirmation.

In an earlier version of this paper (Doherty & Colangelo, 1982), we discussed the close correspondence of Schutz's theory with other prominent theories of group development, many of which propose phases and developmental sequences consistent with those of the FIRO model.

CAN FAMILY ISSUES BE CATEGORIZED INTO THE FIRO DIMENSIONS?

In this section we will show how family issues can be meaningfully assigned to one of the inclusion, control or affection categories of the FIRO model. Because families are different from the ad hoc groups that Schutz studied, we will adapt the FIRO model for our purposes. One adaptation will be to substitute the term "intimacy" for "affection," in order to distinguish in-depth interpersonal sharing (e.g., intimacy) from the nurturing and caretaking aspects of family interaction (which belong to the inclusion domain). We think "intimacy" conveys Schutz's original idea better in the family group than does the more general term "affection."

Family Inclusion Issues

Inclusion issues in families are those which center around membership and boundaries, i.e., the extent to which family members are part of but at the same time apart from the family as a subsystem. Who is included in or excluded from family subsystems? What is the balance between belonging to the family and maintaining a separate identity? How does the family cope with the addition or loss of members? For married partners, commitment to the relationship is a core inclusion issue, as are the partners' relative commitments to jobs, extended family, friends and other outside interests. For children, inclusion frequently centers around the sense of belonging to the family, of being part of a group which is irrevocably committed to one's well-being, while at the same time having a sense of being recognized as an individual. Adoptive families and stepfamilies face important challenges to their members' sense of inclusion or belonging, since family members tend to make distinctions between "real" parents and stepparents or adoptive parents. Generational separation in families can also be thought of as an inclusion issue: Which subsystems—marital, parental or sibling—are part of in addition to my membership in the whole family? For example, a girl who takes on extensive parental responsibilities may face inclusion problems in both the parental subsystem (because she is not an adult) and in the sibling subsystem (because she is not being treated like a child). In general, inclusion in families concerns members' level of involvement in one another's lives, ranging from boundary-less enmeshment on the one extreme to uncommitted disengagement on the other.

Family Control Issues

Issues of responsibility, discipline, power, decision making and role negotiation fall under the control concept. Family interactions continually involve overt and covert influence attempts. These interactions range from positive to negative in affective tone and from autocratic to democratic to anarchistic in political tone. Control issues often center around particular content issues such as money and privileges. Control issues, of course, also manifest themselves in more subtle interactional processes such as symmetrical escalation of conflict or in complementary one-up/down patterns by which family members regulate one another's behavior.

Family Intimacy Issues

The intimacy issue in families is seen in areas such as open self-disclosure, appreciating each other's unique personalities, and friendship. At one end of the intimacy continuum would be family members who relate to each other primarily in their normatively prescribed family roles—a husband and wife, mother and father. At the opposite end of the continuum would be partners who frequently interact with each other as intimate and confidants in an "I-Thou" relationship that transcends prescribed family roles. Intimacy as used here should not be confused with the notions of fond feelings and attachment. The sense of being cared for in a family is primarily an inclusion issue. Intimacy in the FIRO model relates more narrowly to in-depth sharing—usually in dyads—of thoughts, feelings and desires that are considered private and vulnerable parts of the self. When family affection issues become a source of difficulty, they might be manifested in complaints that the partners have grown apart and do not understand each other any more, that the excitement has gone out of the relationship, that they do not understand one another's feelings, that sex has lost its spontaneity and responsive quality, or that although the partners may be talking enough with each other (inclusion), they are not "really" communicating their feelings (intimacy).

CAN FAMILY TREATMENT ISSUES BE PRIORITIZED ACCORDING TO THE FIRO DIMENSIONS?

Extending Schutz's theory of group development, we propose that if the family has not dealt successfully with inclusion, then control and intimacy issues will be more difficult to handle in a satisfying way, and that to the extent that control issues are unresolved in family relationships, a limit is placed on the family's level of interpersonal intimacy. We further suggest, following Schutz, that although all three issues are always present in families, the emphasis changes according to the family's life cycle stage and other circumstances. For example, inclusion would be paramount when the family adds new members or launches young adults. The family may need to recycle through the inclusion, control and intimacy phases when it experiences major additions, losses and other disruptions such as divorce, serious chronic illness, or prolonged unemployment.

A cyclical image of family development conveys the idea that the Family FIRO issues are never dealt with definitively and permanently; they cycle back again. The cycle begins with inclusion as the primary issue at the family formation (or re-formation) stage, with control and intimacy following. Once the family group has been established over time, however, problems can "originate" in any FIRO area and spread to others. For example, control struggles may lead to diminished intimacy and to less commitment, or a marital commitment problem may stem from a decline in marital intimacy. For ongoing relationships, if such, we make no claim for a specific causal sequence among the FIRO issues; in other words, intimacy problems do not always stem from control problems which in turn do not always derive from inclusion problems. But we do propose that when more than one FIRO problem area exists in the family, the therapist should consider following a specific treatment sequence.

Why Inclusion Comes First in Treating Multiproblem Families

We believe that lack of resolution of inclusion problems of membership, commitment and boundaries in a family militates against effective treatment of any other family problems. When a family possesses with a symptomatic child, one of the therapist's first tasks is to clarify inclusion issues such as which adults are responsible for the child and whether the child is inappropriately participating in the parents' marriage. If the
noncustodial father participates in child rearing only occasionally to undermine the mother's authority, then this problem should be tackled before the mother has much hope of dealing successfully with the child's behavior. A parental child must be returned to membership in the sibling subsystem before parental control can be reestablished. When a child discipline problem is associated with lack of separate identity for the child, the therapist should work on this boundary issue early in the treatment.

In marital therapy as well as in family therapy, when inclusion issues are present they should generally take first precedence. When a couple presents with three troubled issues such as power struggles over money, complaints that they don't talk about their feelings anymore, and questions about whether to separate, the latter issue should come first in the treatment? Why? Because the commitment or inclusion problem generally must be resolved to some minimum degree before the couple will take the risk of trying to change other aspects of the relationship. Specifically, the partners must be committed at least to work on the relationship in order for progress to be made in control and intimacy areas. (Such a tentative commitment, of course, may be based on the partners' hope or expectation that control and intimacy problems can be satisfactorily resolved.) Disengaged partners, in particular, must be helped to clarify their levels of investment in working for change within the therapy context, since inclusion is the first core issue for the newly forming therapist/ family group.

At the opposition end of the marital inclusion continuum from the disengaged couple is the enmeshed, over-dependent couple who are experiencing repeated arguments over the amount of support the partners are giving each other and a decline in their previously intense level of positive emotional intimacy. Our model suggests that the first treatment priority would be to help them develop more individual identity in the relationship (inclusion) since couples who are too "stuck together"—like those who are too "far apart"—are not ready to effectively deal with control and intimacy problems.

Why Control Comes before Intimacy in Treating Multiproblem Families
Unresolved control issues poison the waters of emotional intimacy. When a couple presents with an intimacy issue, the wise therapist looks for the presence of underlying power struggles or for underlying inclusion issues such as lack of commitment to the relationship or the presence of an outside lover. Many couples readily admit that their sexual relationship is a barometer for the rest of the relationship; arguments over household chores end up in bed.

Intimacy in families is like the top of the pyramid. For most people the foundation is trust that the partner is committed (inclusion issue) and trust that the partner will be fair when there is a conflict of interest (control issue). Perceived lack of commitment can stem from such inclusion issues as over-involvement with work or personal hobbies to the exclusion of the partner. Perceived unfairness can stem from the partner's apparent unwillingness to compromise or from the sense of being taken advantage of during arguments. If these underlying processes are ameliorated, many couples may regain their sense of intimacy, or at least they will be ready to learn to achieve the higher levels of intimacy they desire.

FAMILY THERAPIES AND THE FAMILY FIRO MODEL
We propose that the various theories or schools of family therapy tend to focus on one of the Family FIRO issues of inclusion, control and intimacy. Our purpose in analyzing family therapy models in this way is to delineate how different therapy approaches may be uniquely suited for certain kinds of family problems.

Table 1 links the major schools of family therapy with the FIRO issues with which they are most closely identified. We do not contend that the therapy models conceptualize and treat only one issue to the complete neglect of the others. Furthermore, we assume that good family therapists adapt their approaches to the unique problems presented by each family. However, we do believe that each family therapy model tends to focus its therapeutic spotlight on a relatively narrow band of family problems; for each family therapy model, some issues are figural and others are ground.

As Table 1 indicates, we propose that structural family therapy (Minuchin, 1974) most clearly focuses on issues of family inclusion. Minuchin's unique contribution lies in assessing and intervening in the boundary and role patterns of the family. Structural family therapy is concerned with issues of individual autonomy versus family enmeshment, clear boundaries around the marital/parental subsystem, and clear prescriptions for who is in the executive subsystem in the family and who is not. Consistent with this emphasis on inclusion, structural family therapists stress the importance of the therapist "joining" (becoming part of) the family in treatment. Structuralists tend to believe that control and intimacy problems in the family will more easily be resolved when the family organization is clarified and made more flexible.

Strategic (Haley, 1976, 1980), Interactional (Watzlawick, Weakland & Fisch, 1974) and Behavioral (Jacobson & Margolin, 1979) approaches to marital and family therapy emphasize control issues in families. These models stress the ways in which family members try to influence one another's behavior by overt or covert means. Therapy consists of changing the family's rule system for mutual regulation, either by overt therapeutic steps (such as putting the parents back in control of a child or teaching the couple new problem-solving skills) or covert therapeutic moves (such as paradoxical prescriptions) aimed at winning the power struggle between the family and the therapist. None of these therapies is explicitly concerned with affection or intimacy in FIRO terms. However, Haley (who works with hierarchies) and the behaviorists (who try to increase daily positive marital exchanges) are concerned with inclusion as an additional focus. We believe that these control-oriented therapies assume that couples and families will tend to achieve their own preferred level of intimacy when they have dealt successfully with control problems.

 Bowen's (1978) Family Systems Theory; Whitaker's Symbolic-Experiential model (Whitaker & Keith, 1981); Satir's humanistic approach (Satir, 1972) and therapies inspired by psychoanalytic theory (Franz, 1981) emphasize intimacy issues in families. Their approaches to treating inclusion and control issues are not as well developed as their approaches to intimacy issues. The former issues tend to be viewed as preliminary to helping family members learn to relate in intimate ways. Unlike other family therapy schools, these models offer goals for optimal individual and family functioning. In each case, optimal family functioning involves the capacity for dyadic intimacy outside of normative role patterns.

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<thead>
<tr>
<th>FIRO Issue</th>
<th>Family Therapy School</th>
<th>Major Emphases</th>
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<tbody>
<tr>
<td>Inclusion</td>
<td>Structural (Minuchin)</td>
<td>Membership, boundaries, commitment, separate identity</td>
</tr>
<tr>
<td>Control</td>
<td>Strategic (Haley)</td>
<td>Power, responsibility, influence, decision making</td>
</tr>
<tr>
<td>Affection</td>
<td>Bowen Family Systems Theory (Bowen)</td>
<td>Intimacy, self-disclosure, friendship, strong sense of differentiation</td>
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<tr>
<td>(Intimacy)</td>
<td>Symbolic-Experiential (Whitaker)</td>
<td>Humanistic (Satir)</td>
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Table 1

FIRO Issues and the Major Schools of Family Therapy

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All of the above-mentioned schools of family therapy deal in some way with how much separation or differentiation of self the family allows its members. However, we believe that the approaches which emphasize the intimacy issue treat differentiation of self in a qualitatively different way than approaches which emphasize inclusion and control. Minuchin and Haley, for example, are concerned that the family allow enough differentiation for members not to become symptomatic and for the children to be able to leave home and start their own families. There is relatively little emphasis on intrapsychic issues or on individual psychological development. Bowen and his associates, in contrast, are concerned with levels of personal differentiation that permit optimal individual and family development, as well as presumably making the family less apt to become symptomatic in the future. Similarly, intimacy-oriented therapies emphasize the personal development of the therapist more than do the inclusion-and-control-oriented therapies. Furthermore, the intimacy-oriented therapies tend to focus more often on the marital dyad as the primary unit of treatment of family problems—the marital relationship being the prime location of intimate relationships within the family—or on three generational units—the historical emphasis being consistent with the belief that intrapsychic processes and their corresponding interactional patterns are rooted in past events.

In sum, we propose that the various family therapies tend to specialize in either inclusion, control or intimacy. They have refined their conceptual and treatment armamentaria on issues viewed as most pressing and important by their founders and advocates. Although some approaches may be fully comprehensive in execution by individual therapists, we believe that none of the schools of family therapy is broad enough to do justice to all of the family problems that confront therapists in family treatment.

**IMPLICATIONS FOR CLINICAL PRACTICE**

Most of the clinical implications of our model involve goal setting and selecting appropriate therapy techniques. Here we will summarize the major points in the format of a “prescription” for family therapists, assuming for the moment the validity of our Family FIBO model.

1. Identify the major presenting issues and goals of the family and classify them into the inclusion, control and intimacy categories.

2. When families present with multiple issues that cut across the FIBO categories, make the theoretically prior category the first treatment goal, i.e., inclusion before control and control before intimacy. In practice, the therapist may intervene in such a way that other FIBO issues are addressed simultaneously, but the primary goal initially would stress the theoretically prior category. For example, getting a disengaged couple to agree on an outing together might help their problem-solving ability (control) and offer a chance for more emotional intimacy, but the primary goal would be to build their sense of togetherness (inclusion) as a prelude to further therapeutic work.

3. When addressing the inclusion issue with couples, the minimum resolution would consist of a commitment by the partners to work to improve their relationship and a willingness to participate in the therapy sessions. Note that spouses do not have to decide to commit permanently to the relationship in order to proceed to deal with control and intimacy issues, or with other aspects of inclusion. The therapist can set up criteria for minimally satisfying the inclusion issue, for example, giving up an extramarital affair during the course of therapy, or willingness to spend time together outside of the therapy hour. If spouses cannot make such commitments, our practice is to work with them individually to help them decide on whether to continue the relationship (the ultimate inclusion issue), but meanwhile to refrain from trying to treat other problems in the relationship.

4. When the first FIBO issue is resolved satisfactorily, see whether the next issue in the sequence resolves spontaneously before you initiate vigorous treatment for it. For example, an out-of-control child may start cooperating once the parental hierarchy is clarified, or a couple may achieve the greater intimacy they desire once commitment or power issues are settled.

5. Avoid focusing the therapy on “later” issues when “earlier” ones are unresolved, even if the family wants to concentrate on such issues. A common example is a couple wanting to work on their marital intimacy when they have a child who is out of control.

6. When therapy is not progressing well, consider whether an unresolved prior FIBO issue may be undermining the treatment, e.g., an uncommitted partner or a hidden power issue.

7. Practice “intelligent eclecticism” by selecting different therapy approaches for different Family FIBO issues. The selection would be based on the identified focus of the established family therapy schools and the goals of the family and the therapist. Gurman (1982) has highlighted the distinction between “model switching” and “technique switching.” A model in this context means a comprehensive theoretical perspective which can include one’s epistemology, value orientation, approach to problem etiology, and assumptions about how families change. Gurman observes that changing such a model to fit each new situation is nearly impossible, especially since therapists probably adopt their basic therapy model for complex personal, emotional, philosophical and political reasons (see also Liddle, 1982). If “model switching” is not feasible for most therapists, an alternative is the eclectic use of techniques developed by differing family therapy schools, with the therapist maintaining a coherent therapy model governing which techniques to use and how to interpret their results. For example, the therapist can use some behavioral techniques while still holding theoretically to the primacy of unconscious processes.

We propose, therefore, an eclecticism of method or technique based on the special attention paid to certain FIBO dimensions by different schools of family therapy (Table 1). A problem with an unruly child (control issue), for example, could be handled with structural techniques or Haley’s hierarchical approach, while marital intimacy (affection issue) problems in the family could subsequently be addressed with techniques derived from more insight-oriented approaches. The therapist’s master plan (based on his or her therapy model) would determine which approach to use in what circumstances.

Several cautions are in order here. First, some techniques may prove to be incompatible with one another within the same therapeutic relationship. For example, a therapist using paradoxical interventions for control issues may have difficulty switching to insight-oriented interventions for intimacy issues. Second, some techniques may be viewed by the therapist as inconsistent with his or her therapy model, as in the case of a therapist eschewing paradoxical techniques because of the importance of therapist self-disclosure in the therapist’s model. Third, we do not know much about the effect of technique switching on the family or on the course of treatment. Finally, if therapists specialize in one of the three major Family FIBO domains, then they may wish not to be eclectic in orientation. We suspect that a specialized, nonelectic approach is more common in tertiary care family therapy training centers that focus on a narrow band of family problems. However, for family therapists who treat a wide range of marital and family problems, we suggest that our model offers a framework for selecting appropriate therapeutic techniques.

**CASE ILLUSTRATION**

Several years ago Salvador Minuchin and Virginia Satir interviewed the same family on consecutive days at the Philadelphia Child Guidance Clinic. The interviews were conducted live as part of the Minuchin/Satir Dialogue. The family presented with
an out-of-control ten-year-old boy, an angelic six-year-old girl, and two overwrought parents who appeared to be ineffective with the boy and emotionally unsupportive of each other. Satir interviewed the family first. After several minutes of work with the whole family group, she asked the children to play elsewhere in the therapy room so that she could talk with the parents. Then she proceeded to work on the spouses' inability to reach each other emotionally. The wife at first teared up, then resolutely withheld her feelings; the husband appeared lost. Meanwhile, the boy was terrorizing one and all—picking on his sister, defying his father's efforts to quell him, yelling so loud the microphones couldn't pick up the parents' conversation, and finally pushing his hand over the video camera lens, thereby blinding several hundred people in the audience. It was a brusque performance. The boy's behavior was not effectively challenged, and Satir's work with the couple disintegrated. Afterwards, Satir was forthright in stating that the session had been unsuccessful. She told the audience that if she had not been trying to demonstrate her unique style of therapy, she would have dealt more vigorously with the boy's behavior. How did Minuchin do the next day with the family? In a therapeutic tour de force, he worked on the hierarchical control issue to the satisfaction of the family, the therapist and probably most of the audience. Minuchin even had the mother sit on the boy.

Does this mean that Minuchin is a better therapist than Satir? Of course not. From the perspective of the Family FIRO model, however, their relative success and failure with this family were predictable. In order to highlight what is distinctive in her style, Satir worked on an intimacy issue before the control issue was adequately addressed. Working within his own therapeutic specialty, Minuchin helped the parents to expel the boy from the hierarchy in the family (inclusion) and thereby to begin regaining control over his behavior. Presumably, if the family had presented primarily with an intimacy issue, Satir would have shined while Minuchin would have appeared more pedestrian—if they stayed within their therapeutic specialties.

This case example illustrates two main points of the Family FIRO model: the danger of addressing intimacy issues before control issues have been dealt with, and the limits of any one therapeutic modality for handling all family problems.

CONCLUSION

This paper represents our initial effort to develop a model that we hope will be theoretically plausible, empirically verifiable and clinically useful. The Family FIRO model borrows shamelessly from the rich tradition of small group research, while trying to be fair to the special nature of the family group. Presently we are developing research studies to test several predictions of the Family FIRO model, and we welcome the collaboration of our colleagues in refining and testing our ideas.

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