Family Constellations in Practice: Facilitation Structure and Professional Boundaries

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ABSTRACT

Family constellation work is a systemic, experiential and facilitator-guided method in which members of a person's relational system are represented in space by other people or by objects. It is widely practised in counselling, personal development, coaching and organisational settings, often by practitioners outside regulated health professions and often in a single, emotionally intensive group session. The empirical evidence is limited and methodologically heterogeneous: randomised trials against wait-list conditions report mixed results, evidence syntheses reach different conclusions, and the mechanism of representative experience remains unresolved.

This conceptual article examines how facilitation procedures and professional boundaries can be specified more clearly in family constellation practice while taking these limitations into account. It draws on Natseva's scholarly overview of the method, including its nine-stage description of a typical constellation and its practice standards, and on independent literature on systemic practice, group facilitation, informed consent, psychological safety, trauma-informed care, memory suggestibility, negative effects of psychological interventions and referral. The original contribution is the Facilitation Boundary and Risk Control (FBRC) framework, which organises professional safeguards into nine sequential components, from pre-session review of the request to documentation and data protection, and maps the principal risks, controls and stop signals onto each stage of the facilitation process.

A central element is a three-register language rule that separates what is observed, what representatives report and what the facilitator offers as an interpretive hypothesis. The article also proposes graded criteria for pausing, stopping and referral, quality criteria for practice and a plan for future content-validity and reliability studies. The framework is a conceptual proposal; it is not a validated clinical protocol and does not establish the effectiveness or safety of the method.

Keywords: family constellations; systemic practice; facilitation; professional ethics; informed consent

INTRODUCTION

Family constellation work emerged as a named practice in German-speaking Europe in the early 1990s, mainly through the work of Bert Hellinger and its documentation by Weber (1993), and has since spread internationally into group, individual, organisational, online and virtual-reality formats (Konkolÿ Thege et al., 2021; Natseva, 2026). Practitioners come from psychotherapy, counselling, social work, coaching, medicine and organisational consulting, and many work outside regulated health professions (Natseva, 2026).

In some countries the method has entered public health and judicial settings, which has prompted guidance from professional bodies; in Brazil, for example, the Federal Council of Psychology issued a technical note identifying ethical incompatibilities between the practice and the professional exercise of psychology (Conselho Federal de Psicologia, 2023).

The method combines several features that make professional standards important regardless of its effectiveness. Sessions are often brief and emotionally intensive; they frequently take place in groups of strangers; they address losses, exclusions, violence and family secrets; and they involve representatives who report bodily and emotional experiences that some practitioners interpret as information about the client's family. The first English-language systematic review noted that this intensity may facilitate improvement but can also temporarily destabilise people with less stable mental health, and recommended screening and access to professional support (Konkolÿ Thege et al., 2021). Critics have raised concerns about contracting, confidentiality, aftercare and directive facilitation (Talarczyk, 2011).

Natseva's (2026) scholarly overview provides a working definition of the method, a nine-stage description of a typical constellation, an analysis of representative experience, a summary of the empirical literature and a set of practice standards. Among other gaps, the overview notes that most studies do not specify the variant of the method used and that follow-up practices vary widely. What remains underdeveloped is an explicit specification of how professional boundaries and risk controls should operate at each point of the facilitation process.

This article addresses the question: How can facilitation procedures and professional boundaries be specified more clearly in family constellation practice while accounting for the limitations of current scientific evidence? Its contribution is a conceptual framework for boundary and risk control. It does not evaluate the effectiveness of the method and reports no empirical data.

Approach

This is a conceptual article based on an integrative, non-systematic review. Natseva's (2026) overview was read in full and used as the principal source for the definition, history, procedure, formats, core concepts, evidence and existing practice standards of the method. Independent literature was selected purposively in seven areas: family systems and systemic practice; group facilitation and psychological safety; informed consent; trauma-informed practice; suggestion, expectancy and memory; negative effects of psychological interventions; and referral and scope of practice.

The principal controlled studies and the 2021 systematic review were consulted directly. Where the overview reports a study or preprint that could not be consulted directly, it is cited as reported in the overview. No search protocol, screening procedure or risk-of-bias assessment was applied.

Throughout the article, three types of statement are kept apart: empirical findings reported in the cited literature; theoretical assumptions of the method, which are described but not endorsed; and the author's own proposals, which are identified as such and have not been tested.

Nature and Historical Context

Natseva (2026) defines family constellation work as a systemic, experiential and facilitator-guided method in which the elements of a person's relational system are represented in physical space, by people or by objects, so that the person can observe and explore perceived relationships, positions and recurring dynamics and try out alternative configurations.

The method draws on earlier traditions with different degrees of documented influence: psychodrama, which introduced group members as stand-ins for significant others (Moreno, 1946); family sculpture and Satir's family reconstruction (Duhl et al., 1973; Satir et al., 1991); contextual therapy, with its concepts of invisible loyalties and intergenerational indebtedness (Boszormenyi-Nagy & Spark, 1973); and Bowen's account of multigenerational transmission (Bowen, 1978).

Hellinger's role is best described as codifying and popularising a format rather than originating its components, and his directive style, some of his public statements and large public demonstrations without follow-up attracted criticism (Natseva, 2026; Talarczyk, 2011). The German Society for Systemic Therapy and Family Therapy issued a statement distancing systemic therapy from certain forms of constellation practice (Deutsche Gesellschaft für Systemische Therapie und Familientherapie [DGSF], 2003).

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Many later practitioners kept the procedure while revising its framing. A key analytical point in Natseva's overview is the separation of three levels: the method (the observable procedure), the theory (practitioner concepts such as belonging, order and entanglement, none of which has been established as an empirical law) and the interpretation given to a particular session. This separation is the foundation of the boundary framework proposed below.

Formats Of Practice

Table 1. Formats of constellation practice and salient boundary issues

Format (Natseva, 2026)	Main features	Salient boundary issues (present analysis)
Group with representatives	Unrelated participants; one-time seminar of one to three days; representatives report experiences	Group pressure; representative distress; confidentiality among strangers; limited aftercare
Individual with figures or floor markers	Objects replace representatives; often within ongoing counselling	Greater facilitator influence on interpretation; largely unstudied
Online and virtual reality	Remote participation; avatars or digital figures	Containment of distress at a distance; recording and data protection
Organisational	Teams, leadership, succession and strategy	Employment relationships; sponsor interests; confidentiality of personal information

Note. Formats as described by Natseva (2026); boundary issues are analytical identifications of this article.

Constellation work is practised in several formats that differ in their risk profiles. Table 1 summarises the main formats described by Natseva (2026) together with the boundary issues that this article identifies as most salient for each. The group format with representatives is the original and best-studied one; almost all controlled research concerns it (Konkolÿ Thege et al., 2021).

Individual formats with figures or floor markers remove representative reports and group influence, which changes the method and leaves it largely unstudied. Online and virtual-reality formats raise questions about emotional containment at a distance and about data protection; a randomised feasibility study of a virtual-reality format has so far been published only as a protocol (van Bebber et al., 2024). Organisational constellations transfer the method to teams and leadership questions, where employment relationships add power and confidentiality concerns (Scholtens et al., 2021).

Structure of the Facilitation Process

Natseva (2026) describes a typical group constellation in nine stages, summarised in Table 2: (1) formulation of the presenting issue; (2) identification of relevant system elements; (3) selection or creation of representations; (4) spatial positioning; (5) observation of relationships and positions; (6) representative reports; (7) facilitator interventions; (8) repositioning or alternative configurations; and (9) completion and integration. The original presents this sequence as a descriptive model of the procedure as practised, not as a demonstrated mechanism of change. The present article adopts it unchanged as the structure onto which boundary controls are mapped.

Table 2. The nine stages of a typical group constellation (after Natseva, 2026)

Stage	Description	Purpose
1. Issue	Short interview on the concern and key family facts	Define a focus
2. Elements	Decide which persons, roles or abstract elements to include	Define the system to be represented
3. Representations	Choose representatives or objects	Make each element available in space
4. Positioning	Client arranges representations in the room	Externalise the client's inner image
5. Observation	Silent observation of the arrangement	Notice spatial relations before discussion
6. Reports	Representatives describe sensations, emotions and impulses	Gather experiential information
7. Interventions	Facilitator moves or adds elements and proposes sentences	Test changes in the system image
8. Reconfiguration	Iterative changes towards a more settled arrangement	Offer an alternative image
9. Completion	Client takes in the final image; roles are released	Close the process

Note. Condensed from Natseva (2026, Table 2); stage names and sequence unchanged. Descriptive process model, not a demonstrated mechanism of change.

Two features of this sequence matter for boundaries. First, the facilitator exercises considerable influence at several stages: deciding which elements to include, asking representatives what they notice, moving representatives and proposing sentences for them to say. Schools differ in how directive these interventions are (Natseva, 2026). Second, the stages compress, within a short time, the elicitation of family history, the evocation of strong emotion, the offering of meaning and the ending of the process. In ordinary psychological practice these functions are usually separated by time, assessment and follow-up.

Preparation and Informed Consent

Informed consent requires that a person understands the nature, purpose, risks and alternatives of an intervention and agrees voluntarily (Beauchamp & Childress, 2019). For constellation work, Natseva (2026) specifies that participants should be told what will happen, that strong reactions are possible, that the evidence base is limited, that the method is not a substitute for medical or psychological treatment and that they may stop at any time; representatives must also consent to their role and be free to decline.

The present analysis proposes three additions. Consent should cover the status of interpretations, making clear that what representatives report and what the facilitator suggests are not established facts about the family. It should cover group confidentiality, including information about absent family members who have not consented to being discussed. And it should be renewed, not merely obtained once, when the work moves into material that the participant had not anticipated, such as abuse or a family secret.

Facilitator Competence and Responsibility

Natseva (2026) notes that in the studies that assessed harm, facilitators were psychologists or psychiatrists with long experience of constellation work, and that it is not known whether harms are more frequent with less trained facilitators. The group facilitation literature emphasises that facilitators shape norms, manage member interactions and are responsible for the emotional safety of the group (Yalom & Leszcz, 2020). Psychological safety, the shared belief that a team is safe for interpersonal risk-taking, has been associated with learning behaviour in work teams (Edmondson, 1999); in an emotionally intensive group it can be expected to influence whether participants feel able to decline, stop or disagree with an interpretation. On this basis, the present article proposes that facilitator competence in constellation work should include at least four elements: training in the method; competence in recognising and responding to acute distress, dissociation and crisis; group facilitation skills; and knowledge of the limits of one's professional qualifications and of local referral routes. Facilitators also carry responsibility for representatives, who may experience distress in a role they did not take on for their own benefit.

Voluntariness, Confidentiality and Sensitive Family Themes

Voluntariness can be undermined by group pressure, by a facilitator's authority and by the expectation that a constellation must be completed once started. Classic research shows that group consensus can shape individual judgements (Asch, 1956) and that participants respond to the perceived expectations of a situation (Orne, 1962). These effects make it important that declining a role, pausing or stopping are presented as normal options rather than as failures. Confidentiality in groups cannot be guaranteed by the facilitator alone; it depends on a group agreement and on reminders that information about the participant and about absent relatives should not be passed on (Natseva, 2026). Where sessions are recorded or held online, data protection law applies, which in the European Union means the General Data Protection Regulation (Regulation (EU) 2016/679).

Sensitive family themes require particular care. Trauma-informed approaches emphasise safety, trustworthiness, choice, collaboration and empowerment, and the avoidance of re-traumatisation (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). Natseva (2026) specifies that facilitators should work at a pace the person can manage, avoid pressure to confront a perpetrator or accept an interpretation, avoid framings that place responsibility on a victim and never present reconciliation with a perpetrator as a required outcome. Resolving sentences that acknowledge a person or a loss are a common facilitator intervention (Natseva, 2026); where violence or abuse is involved, such sentences carry a specific risk of implying forgiveness, loyalty or acceptance that the person has not chosen.

Risks of Suggestion, Misinterpretation and Overclaiming

Representative experience is the most distinctive and least understood feature of the method. Natseva (2026) distinguishes three claims: that representatives report experiences (observed); that similar positions evoke similar experiences (supported by limited research, notably Schlötter, 2005); and that reports reveal unknown facts about a specific family (not established). Plausible ordinary explanations include interpersonal cues from the client, embodied and spatial cognition (Barsalou, 2008), response expectancy (Kirsch, 1985), demand characteristics (Orne, 1962) and social influence within the group (Asch, 1956). According to Natseva (2026), no blinded study has tested whether reports correspond to verified family facts unknown to participants and facilitators.

This evidential situation creates a specific professional risk. If a facilitator presents a representative's reaction as revealing a hidden event, such as an unacknowledged death, abuse or infidelity in an earlier generation, the client may adopt this as fact. Research on memory shows that suggestion and imagination can lead people to report false or distorted memories of events that did not occur (Loftus, 2005), and some psychological treatments have been identified as potentially harmful, including through the induction of false beliefs about the past (Lilienfeld, 2007). An interpretation offered in a vivid, emotionally charged group setting by an authoritative facilitator could therefore have lasting effects on family relationships. A professional framework must prevent interpretations from being presented as discoveries. Similarly, claims that the method cures illness, reveals hidden facts or has been proven effective are not supported by the available evidence (Natseva, 2026).

Professional Limits and Referral

Natseva (2026) distinguishes personal development, in which healthy adults explore relationships and patterns; counselling, in which people seek help with specific life difficulties; and psychotherapy, in which a mental disorder is treated within a regulated profession. Using constellation work to treat a diagnosed disorder is a form of psychotherapy and should be undertaken only by a qualified clinician within that clinician's professional code. Referral is indicated for signs of serious mental illness, suicidal thoughts, severe distress persisting after a session or safety concerns such as ongoing violence, and a referral route should be in place before a seminar begins (Natseva, 2026). Controlled studies have mainly recruited self-selected, non-clinical participants; the 2024 randomised trial, for example, excluded people with a current diagnosed mental disorder (Konkolÿ Thege & Szabó, 2024). Evidence about clinical populations is therefore especially limited.

Negative effects of psychological interventions are now recognised as a legitimate object of measurement. Linden and Schermuly-Haupt (2014) distinguish unwanted events, adverse treatment reactions and side effects, and Herzog et al. (2019) found that existing instruments for assessing negative effects cover a wide range of domains without consensus on the most important ones. In constellation research, the reported frequency of negative effects depends strongly on how harm is measured (Natseva, 2026). The 2021 review identified seven studies that assessed iatrogenic effects; four of them reported minor or moderate negative effects in 5–8% of participants (Konkolÿ Thege et al., 2021). Routine practice rarely includes any structured monitoring of such effects (Natseva, 2026).

Evidence, Controversies and Research Limitations

The empirical literature is summarised in detail by Natseva (2026); only the points relevant to professional boundaries are noted here. The first randomised controlled trial, with 208 adults from the general population, found improved psychological functioning after a three-day seminar compared with a wait-list ($d = 0.45$ at two weeks and 0.46 at four months), with no reported adverse events (Weinhold et al., 2013). A second report from the same trial found improvements in experience in personal social systems relative to the wait-list ($d = 0.53$ at four months; Hunger et al., 2014), and a follow-up of the intervention group without a control condition found that improvements in psychological functioning were maintained at eight and twelve months ($d = 0.41$ and 0.40; Hunger et al., 2015). A randomised trial of a single-day, pandemic-adjusted format with 80 participants found within-group improvements ($d = 0.41$ at one month and 0.31 at six months) but no significant time × group interaction, and the authors noted limited statistical power (Konkolÿ Thege & Szabó, 2024). A naturalistic study without a control group reported reductions in psychopathological symptoms (Konkolÿ Thege et al., 2022).

The 2021 systematic review included 12 studies based on 10 samples (568 participants); nine studies reported improvement, and a meta-analysis of five studies yielded a moderate pooled effect on general psychopathology ($g = 0.53$), while the quantity and quality of the evidence were rated as low (Konkolÿ Thege et al., 2021). A 2026 systematic review and meta-analysis, posted as a preprint that had not been peer reviewed, restricted itself to randomised trials, judged all of them at high risk of bias and rated all comparisons as very-low-certainty evidence (Souza et al., 2026, as cited in Natseva, 2026). The two syntheses answer different questions and apply different eligibility criteria. Common limitations include wait-list rather than active comparators, self-selected non-clinical samples, self-report outcomes, highly experienced facilitators and the absence of independent replication. Positive change after participation is consistent with benefit, but also with expectancy, regression to the mean and the common factors shared by many psychological interventions (Cuijpers et al., 2019; Wampold & Imel, 2015). For professional practice, the implication is that safety and boundary standards cannot be derived from the evidence of effectiveness; they must be specified independently.

The Facilitation Boundary and Risk Control Framework

Status and structure

The Facilitation Boundary and Risk Control (FBRC) framework is the original contribution of this article. It builds on the practice standards formulated by Natseva (2026), which cover informed consent, facilitator competence, scope of practice, screening, trauma-sensitive practice, strong emotional responses, confidentiality,

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referral and unsupported claims, and on the independent literature reviewed above. The FBRC framework differs from these standards in three respects. First, it organises safeguards into nine sequential components that span the whole engagement, from the first contact to documentation after the session (Table 3). Second, it maps specific risks, controls and stop signals onto each of the nine facilitation stages described by Natseva (Table 4). Third, it introduces a three-register language rule for separating observation from interpretation, together with quality criteria and a validation plan. The framework is a conceptual proposal for professional development and research. It is not a clinical protocol, has not been validated and does not imply that the method is effective or safe when the framework is followed.

Table 3. Components of the Facilitation Boundary and Risk Control (FBRC) framework

Component	Content	Minimum documentation
C1. Pre-session review of the request	Brief screening conversation on the concern, current treatment, crisis indicators and recent trauma	Intake note; screening outcome
C2. Scope assessment	Classification as personal development, counselling or psychotherapy; decision whether constellation work is appropriate and within the facilitator's qualification	Scope decision and rationale
C3. Informed consent	Information on procedure, possible reactions, evidence status, status of interpretations, confidentiality and right to stop; separate consent of representatives	Signed or recorded consent; renewal points
C4. Structured facilitation	Nine-stage sequence with stage-specific controls (Table 4)	Session outline; format used
C5. Separation of observation and interpretation	Three-register language rule: observation, report, client-owned hypothesis	Fidelity rating from recordings (research)
C6. Handling adverse reactions	De-roling; time to settle; attention to representatives; named contact person	Record of reactions and actions taken
C7. Pause, stop and referral	Graded criteria; established referral route; emergency procedures	Decision record; referral made
C8. Follow-up	Structured contact after the session, including questions on unwanted effects	Follow-up note
C9. Documentation and data protection	Minimal records; secure storage; retention schedule; no recording without consent	Data-protection procedure

Note. Original framework proposed in this article, building on the practice standards in Natseva (2026). Not a validated clinical protocol.

Mapping risks and controls to the facilitation stages

Table 4 maps the principal risks and corresponding controls onto each of the nine stages. The risks are analytical identifications of this article, informed by the literature on suggestion, group influence, trauma and negative effects; they are not empirical estimates of frequency.

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The three-register language rule

Component C5 rests on a simple rule for how facilitators speak during and after a constellation. Every statement belongs to one of three registers. The observational register describes what everyone present can see: "The representative for your father is standing with his back to the group." The report register attributes a statement to the person who made it: "The representative says she feels heavy and wants to sit down." The hypothesis register offers a possible meaning, explicitly marked as tentative and owned by the client: "One possibility is that this distance reflects how close you felt to him. Does that fit for you, or not?" Statements that present a report as revealing a fact about the family, such as "this shows that there was a hidden child", are excluded. The rule operationalises Natseva's (2026) distinction between method, theory and interpretation at the level of facilitator language, and it is intended to reduce the risk of suggestion and false belief identified above. Whether it does so has not been tested. Because it concerns observable speech, adherence can in principle be rated from recordings.

Table 4. Stage-specific risks, controls and stop signals

Stage	Principal risk	Control	Stop or pause signal
1. Issue	Probing for secrets or trauma beyond what the client wishes to share	Client sets the focus; questions limited to what is needed	Disclosure of current abuse or crisis
2. Elements	Facilitator imposes elements, such as an unknown or excluded person, as fact	Additions proposed as options and agreed with the client	Client distress at an introduced element
3. Representations	Representatives pressured into roles	Explicit right to decline; brief role instruction	Representative reluctance
4. Positioning	Client overwhelmed by externalising the inner image	Pacing; option to use objects instead of people	Signs of overwhelm
5. Observation	Premature interpretation by facilitator or group	Observational register only	Signs of overwhelm in client or representatives
6. Reports	Suggestion through leading questions; emotional contagion in the group	Open, non-leading questions; report register	Representative overwhelm or dissociation
7. Interventions	Directive sentences implying forgiveness, loyalty or guilt; victim-blaming framings	Sentences offered, never imposed; avoided where violence is involved	Client refusal or marked distress
8. Reconfiguration	Pressure towards a predetermined "solution"; overclaiming resolution	Hypothesis register; client judges fit	Client disagreement with the proposed image
9. Completion	Insufficient de-roling; no aftercare; interpretations carried home as facts	De-roling; integration time; written support information; follow-up	Persistent distress at closing

Note. Analytical mapping proposed in this article onto the nine stages described by Natseva (2026). Risks are not empirical frequency estimates.

Criteria for pausing, stopping and referral

Component C7 specifies three graded decisions. Pausing is indicated when a client or representative shows signs of overwhelm, such as dissociation, panic or inability to continue speaking, or when unanticipated material such as current abuse emerges; the facilitator interrupts the process, attends to the person and renews consent before continuing. Stopping is indicated when the person cannot be stabilised within the session, when consent is withdrawn, or when continuing would require clinical intervention beyond the facilitator's qualification. Referral is indicated, in line with Natseva (2026), for suicidal thoughts, signs of serious mental illness, severe distress persisting after the session or safety concerns such as ongoing violence. It requires an established referral route and, where there is a risk to life, emergency procedures that take precedence over the session.

Quality criteria

The framework implies criteria by which the professional quality of constellation practice could be judged, independently of its effectiveness: (a) a documented pre-session review and scope decision for every active participant; (b) written information covering the evidence status of the method and the status of interpretations; (c) explicit consent from representatives; (d) facilitator speech conforming to the three-register rule; (e) no presentation of reports as facts and no outcome guarantees; (f) a defined stop and referral procedure known to all staff; (g) structured follow-up contact with active participants, including questions about unwanted effects; and (h) documentation limited to what is necessary and protected in line with data-protection law.

Proposed Validation

Three distinct questions must be addressed before the framework could inform training or professional standards. Content validity concerns whether its components and stage controls are relevant, complete and clear. A modified Delphi study could involve constellation facilitators from different schools, psychotherapists and counsellors who do not practise the method, researchers in psychotherapy outcomes, ethicists and, where feasible, former participants. Item-level and scale-level content validity indices and content validity ratios would be computed against thresholds defined in advance (Lawshe, 1975; Polit et al., 2007). Panel members with commercial interests in training should be identified and their ratings analysed separately. Reliability concerns whether independent raters can apply observable components, such as the three-register rule and consent procedures, consistently to recorded sessions; a fidelity checklist would be developed and inter-rater agreement estimated. Usefulness and safety concern whether practice that conforms to the framework is associated with fewer unwanted effects. This would require prospective monitoring with structured instruments for negative effects (Herzog et al., 2019; Linden & Schermuly-Haupt, 2014) and, ultimately, comparative designs with transparent intervention descriptions (Hoffmann et al., 2014). No such study has yet been conducted.

DISCUSSION

The analysis suggests that the central professional challenge of family constellation work is not the absence of ethical principles, which are already articulated in Natseva's (2026) overview and in professional statements, but the absence of a structure that connects those principles to the specific points in a session where risks arise. The FBRC framework is proposed as such a structure. Its most distinctive element, the three-register language rule, addresses the feature of the method that is both most characteristic and least understood: the interpretation of representative reports. By requiring that interpretations be offered as client-owned hypotheses, the rule is intended to allow facilitators to work with the experiential material of a constellation without making claims that the evidence does not support.

Several objections should be acknowledged. Some practitioners may argue that structured safeguards undermine the phenomenological, emergent character of the method. The framework does not prescribe what happens within a constellation; it constrains how outcomes are framed and when the process must be paused or stopped. Critics, conversely, may argue that no framework can make an insufficiently evidenced method acceptable. That objection is legitimate: the framework is not an argument for the method's use, and its quality criteria are compatible with the conclusion that the method should not be used for clinical conditions while evidence is

lacking. Finally, standards cannot enforce themselves in a largely unregulated field; their influence depends on training bodies, professional associations and clients being able to recognise them.

LIMITATIONS

This article is conceptual and based on a non-systematic literature selection. The FBRC framework, its stage-risk mapping and the three-register rule have not been reviewed by experts or tested in practice. The risks identified are analytical rather than empirically quantified. The account of the empirical evidence relies substantially on Natseva's (2026) overview, and a recent systematic review is cited only as reported there because it was a preprint that was not consulted directly. The framework is designed mainly for group constellations with representatives and would need adaptation for individual, online and organisational formats. Finally, the author's institutional and professional roles are connected to the author of the principal source, who also trains and certifies practitioners in the method; these relationships are disclosed below.

CONCLUSION

Family constellation work is widely practised, emotionally intensive and supported by limited and contested evidence. These conditions make a clear facilitation structure and professional boundaries necessary in their own right.

Building on Natseva's nine-stage description and practice standards, this article has proposed the Facilitation Boundary and Risk Control framework, which organises safeguards into nine sequential components, maps risks and controls onto each facilitation stage and introduces a three-register rule that keeps observation, report and interpretation apart. The framework does not establish that the method is effective or safe. It specifies what responsible practice would require while that question remains open, and it is formulated so that its content validity and reliability can be tested.

Declarations

Author contributions. J.M. is the sole author and was responsible for conceptualisation, methodology, development of the FBRC framework, writing of the original draft, and review and editing.

Conflict of interest. The author is affiliated with the Happy Life Institute for Direct Change Science, which was founded by Prof. Stoyana Natseva, the author of the principal source on which this article builds (Natseva, 2026). The author is also Director of Educational Activity at Happy Life Academy®, of which Prof. Natseva is Founder and CEO, and Deputy Managing Director of the International Association of Professional Therapists and Coaches (IAPTC®), of which Prof. Natseva is President. Happy Life Academy® offers professional training that includes family constellation work, and Prof. Natseva trains and certifies practitioners in the method. These relationships constitute a potential competing interest in relation to the subject of this article.

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Ethics statement. This conceptual article involved no human participants and no data collection, and ethical approval was therefore not required.

Data availability. No new data were generated or analysed in this study.

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