Family and Marital Therapy

Combined with Individual Psychotherapy

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Introduction

Family therapy, i.e. conjoint treatment of the family unit by one or more therapists, is of quite recent origin. Although Midelfort (1) treated families of schizophrenic patients some forty years ago, this was an isolated experiment until some fifteen years later, when studies of the family environment of schizophrenic patients at several different centers rendered treatment of these families a necessity. Seeing such troubled families routinely over time could not be accomplished without having a therapeutic impact (2-5).

Somewhat earlier Ackerman began treating families with disturbed children as units instead of having different clinic staff members see individual family members in the then traditional pattern (6). Although marital counseling has a long history, marital therapy along psychoanalytic concepts has been practiced only for the past few decades (6, 7).

Before presentation of indications and techniques of family therapy with or without simultaneous psychotherapy for one or more individuals in the group, some principal differences of families compared with other groups, and consequently differences between family treatment and other psychotherapies, must be understood.

Because the family as a human group and institution is ubiquitous and a part of everybody's experience, it has been difficult to conceptualize and formulate what the essential nature, characteristics and functions of this group are.

The family is the link between every individual and the larger society. Therefore, physicians and psychiatrists must consider this unit not only for therapeutic reasons, but also because social and preventive medicine and psychiatry must focus on the family as the relevant basic system (8-10).

Individual therapy, actually a dyadic system, is rooted in the ancient doctor/patient relationship, with a long tradition of confidential, private and privileged communication. Sigmund Freud, clearly the central figure in the development of psychotherapy, came to his discoveries as a physician by working with individual patients, and decided to exploit this dyadic field for investigation and therapeutic intervention centered on the evolving relationship of the patient to his or her physician. Although much of what he discovered was about familial experiences, and early in his venture into psychoanalysis he seemed to feel no compunction about having all sorts of contacts with family members or friends and, in one instance, treating a child by advising the father, he increasingly eschewed such contacts (11, 12). Apparently he never sought to confirm his findings or influence patients' clinical course by meeting with their families. Furthermore, despite his appreciation of the complexities of the human mind and the over-determination of all behaviors, he remained steeped in an essentially cause-and-effect-philosophy characteristic of his era and reinforced by the concurrent "single cause'' discoveries in infectious disease medicine.

Group therapy is also rooted in medical tradition in that an inventive physician, Joseph H. Pratt, discovered that patients with like diseases, e.g. tuberculosis, have sufficiently similar problems to make it therapeutically effective to converse about these problems in groups (13). Although group therapy has long since been used primarily with psychiatric patients or even non-patient groups, incorporating psychoanalytic principles and formulations, it remains a technique for help-seeking persons who come to a therapist to join with strangers in such a group for therapy (14, 15).

The family has existed as a group long before help is sought, often help for

one particular member, and the remainder of the family may not consider themselves in need of help or therapy or may even resist such involvement. Yet, as Richardson (16) pointed out many years ago, treating a patient as if he or she had no family is like treating an organ as if there were no body. In other words, the existence of a sick family member affects the entire group, has consequences for the entire group, and the sickness may have roots in the previous behavior and functioning of the family.

The Family as a System

A systems view obviates the phenomenological specification of deviance or abnormality as such because it addresses relationships and energy transformation within the system, thereby specifying the nature and effectiveness of relevant functions regardless of whether or not they will be found abnormal, deficient or excessive. But considering only energy transformation and making diagrams of relationships are abstractions useful to mathematical systems analysts, but hardly to a clinician. We propose, therefore, to examine this system, the family—or other human organizations, according to five system sectors or parameters which have clinical and managerial relevance. These five are: Governance or leadership; Boundary management; Affectivity or sentient forces; Communication; and Task performance or system mission. The family is minimally a two-generation system, with the children usually biologically related, but can be multi-generational and include collateral nuclear families in so-called extended family systems. We shall confine our discussion mostly to the nuclear family consisting of two generations, that is, one or two parents and a child or children living as a unit.

Unlike other human systems, the family lives through an extraneously given bio-psychosocial cycle which determines its internal individual and collective needs and tasks, while serving society by providing it with new adult members prepared to participate in the life of the community. Implicit in society's expectation is that the family produce adults who will not only participate in the

community's work, but also adhere to and preserve its culture and values.

Marriage

The family begins as a sub-system—the marriage or marital coalition, a relationship undertaken by two adults, by their choice or by interfamilial arrangement, in which latter case the spouses may still be quite young. These two people who join or are joined for a lifetime must establish life as a dyad for their mutual satisfactions and care and prepare themselves to function as parents, that is, leaders in the family system if this is created. Until they produce children or become parents through adoption of a child, their marital task is to serve each other, establish effective communication and a sense of belonging to each other in special ways, thus creating at least an eidetic boundary as a couple and a basically positive-feeling atmosphere toward each other. These issues entail respect for personal divergences and a willingness to reconcile negative feelings instead of one demanding submission of the other or allowing conflicts to fester and produce a significant rupture in the relationship, be that overt or covert.

A special sub-system relationship of this couple with regard to intimacy and sex must be preserved throughout the family's life cycle and, eventually, in Western societies must serve again for them to live as a couple when children have left the nuclear family system.

Among the important leadership functions in established families are the role and task divisions parents work out for each other, basic arrangements for rearing and guiding their children, representing each other, i.e. the other parent, to children positively but realistically, and serving as gender- and culture-typical models for their offspring.

Marital Therapy

Indications for therapeutic intervention in the marital sub-system derive from the foregoing outline of the nature and function of marriage and parenthood. Regardless of what indications there may be for individual psychotherapeutic treatment of one spouse based on clear formulation and understanding of an intrapsychic problem or mal-development related to a complaint or complaints, such treatment should not be recommended and undertaken without some consideration of its effect upon the marital and family systems. Nor can we any longer forego considering to what extent and in what way the marital relationship or the entire family situation may have contributed to the distress or may have ameliorated or delayed symptomatic expression. Such delay may have occurred at the expense of other system functions or because the marital or family systems had achieved a relatively comfortable equilibrium because of the disturbed and possibly disturbing behavior of one member, be that parent or child (17, 18).

Because marriages are undertaken at a certain stage of personality development and because further growth or change is a personal and family life cycle necessity, it is as possible that people will continue their personal development in a direction that fosters greater closeness, mutual understanding and empathy enhancing familial task sharing as it is that they grow apart, becoming increasingly estranged with the likelihood that whatever neurotic traits they brought into the marriage will become increasingly fixed in their interaction and relationship, resulting in disharmony, strife and defective leadership within the family.

If one partner had a stake in the spouse's immaturity or lack of full personal independence, then that spouse's development must either not occur or if it occurs the marriage may no longer be satisfactory to the other spouse. This is particularly cogent if such development is furthered or brought about (as it should be) by psychotherapy of the immature spouse. The therapist, therefore, has a clinical responsibility in all instances to evaluate whether the marital system can tolerate this change and, if not, at least to see to it that the "more

mature spouse" receives some help in accepting the change, be that in individual treatment or marital therapy. On the whole, if a discrepancy of this type is ascertained in clinical investigation, it is preferable to undertake marital therapy first and individual therapy subsequently, if at all.

This preference is based on the experience that one relatively minor change in a human system can have consequences of a much more incisive nature than a simple and brief intervention would lead one to expect. The case of an elderly diabetic patient living with his wife may illustrate this. He had been in good metabolic control for quite a number of years, although he had slowly lost his eyesight. Yet he had managed to carry on his job as furnace supervisor with the help of special glasses and lighting. Over a period of several months his diabetes was repeatedly out of control, which led to some altercations with the clinic staff, who had been very proud of this model patient. Then he quit his job, although there had been no clear indication of any significant change in his eyesight or basic physical condition; he was therefore referred for psychiatric consultation while hospitalized to regulate his diabetes. Upon examination, it appeared that the reason for his diabetic discontrol was that his wife had stopped preparing lunches for him as she had done for many years. He claimed he had no explanation for the change, but it meant that he had to either forego lunch and adjust his insulin accordingly or eat lunch out, which he could not do very well within the limits of his diet near or at his place of work. The wife was then contacted, and she had little trouble explaining her dissatisfaction and her refusal to prepare his lunches, which she found a nuisance at best. She was suspicious, if not convinced, that he was unfaithful because he had "claimed" that he had become impotent. Even though this had not developed suddenly, she was preoccupied in her own mind that he had some other woman. After it was explained to her and subsequently to both of them that impotence is a common symptom of long-standing diabetes, both felt relieved, she reassured and he less guilty and ashamed about this problem, and they could resume their previous more cooperative equilibrium and he his job.

Marital therapy is indicated whenever clinical investigation reveals significant disturbance in the system. It is not possible to present an exhaustive list of such indications, but the following should include the more common system problems.

In the course of family investigation or therapy the original problem of a disturbed or disturbing child can often be traced to a significant, if not primary, marital conflict or maladjustment. In such instances, marital therapy may be instituted either in addition to or instead of therapeutic work with the family. For instance, in one family the initial contact between the family and the mental health system occurred because of the elopement of a teenage daughter, the older of two children in this family. In the course of family work it became apparent that although everybody in the family was suffering to some extent, the basic problem resided in the parents' marriage. Although the mother had originally sought psychotherapeutic help on her own and had worked effectively in this situation, it resulted in a deterioration of the marital relationship in that the husband became more withdrawn and depressed as his wife became less dependent and more assertive. However, none of the family recognized this consciously or overtly until work with the entire group was begun following the elopement. The parents were then taken into marital treatment, with considerable improvement and a reasonable hope for eventual resolution of their difficulties and the father's depression.

In younger couples, especially before children have been born, one of the common symptoms and problems is insufficient emotional if not psychosocial emancipation from one or the other spouse's family of origin. In some instances, marriage is carried on as if it were a continued courtship rather than the establishment of a fully adult and therefore relatively independent life situation (at least in Western societies) and the opportunity, if not desire, to create a new generation. But pregnancy and the birth of a child in and of themselves do not automatically change motivation or capacity for parenthood, nor necessarily influence a conflictual marital bond for the better. Some marriages are

undertaken to “regain” a family, one of the spouses having been either rejected by his or her own family or having lost them through death.

Any clinical investigation, therefore, must include information about how spouses got together, what sort of coalition they established for themselves, and how they decided to reproduce, if indeed such a decision was ever made. Over half first-ever pregnancies are conceived without clear intention to assume parenthood, however this responsibility may be perceived or understood. Such data have relevance to treatment indications, as do data derived from observing interspousal and familial interactions and transactions.

Incomplete emancipation of spouses from their respective parents interferes not only with the marital relationship, but even more with parenthood and family leadership. Moreover, guilt over leaving a needy parent or unresolved mourning over a deceased parent or even transmission of such unresolved guilt or mourning across the generation boundary is a common source of family difficulties and requires marital or family therapy with or without individual treatment for the directly affected spouse (19, 20). Sexual difficulties are common and probably indicate marital therapy more often than so-called sex therapy despite the current vogue for the latter.

Couples in severe chronic conflict are often referred for treatment by lawyers in an attempt to prevent, or ascertain the necessity for, a divorce. In some states, such referrals for counseling are mandated by law prior to the implementation of a legal separation. Such referrals can constitute a treatment indication, but more often they result from the effort of one spouse to save or repair a relationship in which the other spouse no longer has any investment and indeed may already have made an emotional commitment to another prospective spouse.

If divorce occurs or is imminent in the context of an established family, children will suffer and family treatment may be indicated to minimize suffering

and its consequences. Such ameliorative and preventive treatments have been well presented by J. Wallerstein et al. (21, 22).

Family Pathology

1. System deficiencies other than primarily marital ones, which require treatment, almost always also reflect leadership deficiencies. Such is the interdependency of system vectors and functions.

2. Boundaries may be drawn either too rigidly and narrowly or too loosely. The evolvement of ego boundaries for each child is difficult to trace because it normally is a subtle, discrete and essentially intrapsychic process. Yet interferences with this normative development of the self-sense can be gross and the resultant defects are well known to psychotherapists as constituting indications for treatment. The severe boundary defects seen in schizophrenic patients have been described in detail by Lidz et al. (2, 8), Stierlin (23), Wynne et al. (24), and others. Such patients often have experienced both intrusive penetrations and impervious distance perpetrated by one or both parents instead of consistent boundary contiguity. Certain patients with severe psychosomatic problems may have experienced similar boundary violations especially, on the part of their mothers (25).

Violations of the generation boundary can produce or prolong incestuous proclivities, fears and conflicts (26). These pathological situations call for individual as well as family therapy.

The family-community boundary can be mismanaged, although this is usually not as devastating in itself to young children's personality formation as interferences with ego boundary development.

Overly rigid family boundaries will interfere with children's experiences and relationship opportunities in the community. School phobias are an early manifestation of such mismanagement, often rooted in parental anxiety and

deficient separation mastery. At later stages, insufficiently permeable boundaries are often found in families with disturbed adolescents for whom increasing independence and emancipation then becomes problematic, a common family treatment indication.

Unduly loose family-group boundaries interfere with both personal and familial development. Children may feel uncared for if not unwanted, and this latter sense may even be a realistic appraisal of parental attitudes involved in such uncaring boundary management, e.g. not telling and expecting children when they are to return from playgrounds, visiting neighbors, dates, etc. Such children become dependent on peers and substitute parents in the neighborhood, if they are available, and a sense of family unity and belonging is stunted. Although there is an indication for family treatment for such families, lacking a sense of unity they often are not available for conjoint treatment.

3. Aberrations in familial affects are probably involved in all personal and family pathology. Even if primary, these also cannot exist without some functional decrement in other system parameters. Symptomatically, the outstanding example is probably the scapegoated member described in detail first by Ackerman (27). This occurrence constitutes a clear indication for family treatment, especially because it has been frequently observed that if the "scapegoat" is treated alone, or removed, the family may scapegoat another member to re-establish the earlier equilibrium (27). Other manifestations of affect disturbance and family treatment indications are misuse of power to further parental or sibling hostility, or the reverse: failure to set limits or enforce any discipline. These may be two sides of the same hostile coin.

4. Communication difficulties characterize all disturbed families to some extent, and have been studied and analyzed more than other system sectors (28, 29). Communication itself is not usually presented as the problem or complaint, but it is very important in clinical assessment and in arriving at treatment indications. The nature of the aberrant communication may reveal quite specific

clues as to individual pathology, e.g. Wynne and Singer's family Rorschach method. In and of itself, communicative disturbance in the family does not indicate what form treatment should take, because that decision must be based on considerations of all system functions. Yet a finding of amorphous or fragmented communication styles, usually in families with a schizophrenic member, requires family treatment as it is not likely that the patient can be helped with his thought disorder without some shift and improvement in the familial communication style.

Communication in the broadest sense provides an essentially cross-sectional view of the family, as it does in any therapeutic situation, but may also reveal many clues about antecedent events and problems, gleaned and inferable in family interviews.

There may be culture-deviant language, for instance, when parents have persisted in and insisted on familial communication in a foreign language. This need not be a problem; in fact, growing up as a bilingual child can be advantageous, provided there is tolerance for both languages. However, some immigrants consciously or unconsciously resist integration into their new environment and denigrate the language of the surrounding community and also its values. In such families, children may be handicapped because they may feel guilty and constrained with regard to the language of their peers; indeed they may not easily think and conceptualize in that language.

However, even without adhering to a foreign language, parents' thinking and verbal expression may be so disordered that children do not, in fact cannot, acquire the syntax and the symbolic meanings of the language of the outside world. Such children not only are handicapped in formal learning, especially when they are expected to move from concrete to abstract forms of thinking, but will also be handicapped in interpersonal relationships and will find themselves distant and estranged from peers and other persons in their community. In reverse, if such offspring do manage to identify with extra-familial figures, they

may be in serious conflicts with their own family and thus feel extremely threatened by such disloyalty. This type of situation is now known as a seedbed for schizophrenic disturbances. In addition to verbal communication aberrations, there may also be in such families a striking deviance between non-verbal and verbal communication, as well as frequent use of doublebinding (30).

There are families in which communication is extremely sparse, although not particularly deviant. Their communication is not practiced as a means of expressing feelings or sharing feelings, and if children attempt expressiveness they may feel thwarted by non-response or even negative responses. In particular, in some families the expression of hostility or angry feelings is suppressed or denied, creating an atmosphere of pseudo-pleasantry and harmony. Such suppression and eventual repression of anger and hostility are, of course, well known in individual psychopathology as an important component of depression—not only a communication impediment, but also an affect disorder. Whether seen in one form or another, i.e. as depression or communicative blockage, it is an important indication for family therapy to break up such circularity of depression in one member leading to inhibition and repression in another or to destructive behavior in children. Children who have grown up in such an atmosphere often are seen later clinically as severely neurotic or so-called borderline patients who more likely need individual therapy even though the family roots of their difficulties may be striking. For example, a suicidal college student drop-out could not discuss with either of her parents or other family members the fatal metastatic illness of her father. She had to be hospitalized and treated individually, as the family could not be engaged as a unit, which would have been preferable.

Another type of communication aberration usually seen in families of sociopathic patients is the striking use of communication as an instrument to influence others regardless of truth or facts, and an absence of any expressive use of communication. Although there may be an assertion of strong feelings by such patients and their families, especially contrition early in treatment contacts, it is

probably a contrived expression designed to influence others, e.g., the therapist. Such problems are probably best dealt with in a combination of family treatment and group treatment for the patient, possibly in a group-home for patients of this type, although not infrequently by the time these individuals come for treatment, often through court or police referral, regular contact among the family has been broken. It has also been our experience that such families often continue to aid and abet the asocial behavior for homeostatic reasons, as already discussed, resisting or interfering with therapy. Even treatment appointments are "forgotten" or cancelled with barely an excuse.

Family Task Performance and Deficiencies

Family tasks are determined by the life cycle and therefore must be assessed by obtaining historical data for the period of family life prior to the initial contact with a clinician. Only the present state of family functioning can be observed directly. Aside from the task to establish a marital coalition and parenthood readiness, already discussed at the beginning of this chapter, the life-cycle-related task can be divided, albeit somewhat arbitrarily, according to the phases outlined by Erikson (31). The first stage is that of nurturance, which includes weaning and teaching infants and young children body mastery. This is followed by the era of enculturation, during which the child learns to speak and how to behave in the family, as well as with peers in nursery school or similar play experiences, play being the child's work. The child and family then enter a period of ordering their relationships, passing through the oedipal phase in individual development terms or from a systems view establishing equidistant and comfortable relationships with both parents and with siblings, if there are any.

With the beginning of school, children should be ready for more significant peer relationships and friendships outside the family, and also should participate in family life during the next five years or so in increasingly reciprocal ways, assuming some responsibilities or chores. This is also the period of maximal

harmony in the family, a period in which the family can move, work and play as a unit, celebrate and mourn together, and engage as a unit with other families with children of comparable ages.

When children reach adolescence, family harmony is hardly the order of the day. Looming ahead is the ultimate emancipation of late adolescents or young adults from their families. Adolescents initiate this eventual separation by challenging family life and values, by testing and probing the limits of parental leadership, while almost simultaneously also expecting, even demanding, dependency gratification from the family.

As children leave the family, the parental generation eventually returns to dyadic living in mid-life or later, and issues of non-familial creativity and effectiveness for both parents become important. They must also shift to accepting their children as equals, and the latter must be ready to be equals in their relationships with parents. Only thus can a sense of familiness continue without undue conflict or interfering with the formation of children's own nuclear families.

As the life cycle continues and parents, likely grandparents by then, begin to age and withdraw from productive life, infirmity may also require a role reversal between parents and children, the latter becoming the leaders and decision-makers even though they may not actually live together.

Therapy indications can arise at all these stages, but must be considered in the context of the total system and not only in terms of a particular family task deficiency. Elderly people should be helped to live as couples or even with one of their children's families for as long as this can be reconciled with caring for each other and them without any significant handicap for anyone concerned.

Treatment indications stem from performance defects of the family or any sub-system. Probably the most common and clearest recommendations to seek help, not necessarily in the form of family treatment, often arise from outside the

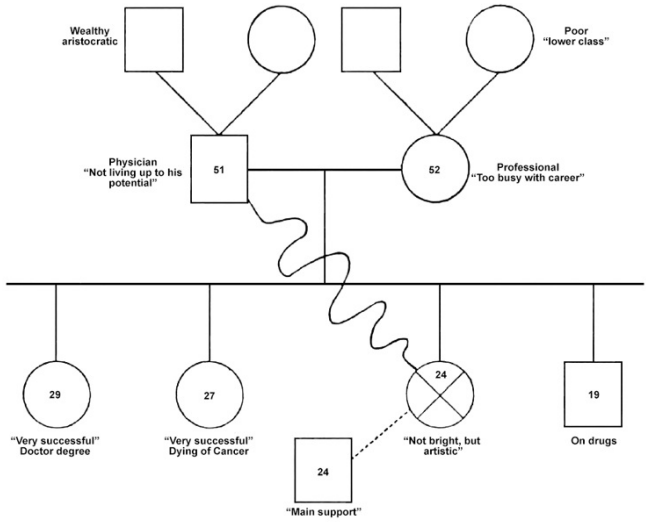
system. General physicians, pediatricians, school staffs and recreation workers, e.g. scout leaders, are all concerned with children's behaviors and performance—indirect or direct indices of family system functioning. Lags in physical development, underachievement in school, or conspicuous behavior on the playground, all these can be manifestations of family disturbance and often are that. R. Beavers (32) speaks of therapy as growth; in general this is what therapy is about regardless of specific technique or diagnosis. J. C. Whitehorn, many years ago, also referred to people seeking or being referred for help from us as "unfinished people" (33). As we examine and increasingly understand family functioning and family failures and their connection with and reflection in individual functioning and failures and vice versa, treatment techniques and formats and their combinations become less important than is our competence to think in terms of systems. Typhoid fever can be prevented by removing the agent from our environment and from food and water, or by raising specific body defenses to interfere with the agent's invasion of and spread in tissues, or by introducing chemicals into our bodies which neutralize or destroy the agent. In other words, through knowledge and understanding of the systems and subsystems involved in a problem, we can determine which of several points of attack or intervention is the most efficient, appropriate and applicable. Thus we can and should explore with a single patient, or a family, or a group the nature of pain and difficulties and consider ways and means of relief and resolution. Often this step or process entails removal of growth obstacles or barriers, or, in systems terms, converting stagnating energy—homeostasis—to movement and change. Initiating such change from stagnation to mobility can occur on a cellular level, i.e. with drug treatment, in the personality system, e.g. through some special relationship, identification with or transference to a therapist or leader, or on an interpersonal plane. Whichever is chosen for the first step, if change occurs in one system there will be correlated or reactive changes in the others.

It must also be appreciated that observations and study in one context, e.g. the traditional dyadic treatment system, may obscure or hide other systems

processes. The reverse is equally possible—some significant intrapersonal malfunction may be covered up or hidden in the family context.

For instance, the family of a young, single, art student who became psychotic when her boyfriend of long standing involved himself with another woman, on initial contact gave enough information to constitute the genogram in Figure 1, confirmed subsequently despite increasing resistance to any form of therapy by all concerned. The patient initially convincingly denied any significant family events or involvement in her difficulties. The epithets are quotes from family members about each other.

Figure 1


Wealthy aristocratic
Poor "lower class"
Physician "Not living up to his potential"
51
52
Professional "Too busy with career"
29
27
24
19
"Very successful" Doctor degree
"Very successful" Dying of Cancer
"Not bright, but artistic"
On drugs
24
"Main support"

One can glean from this diagram an ambitious mother, likely in need of improving herself, and an effective transmission of such values to two daughters, but not to the third (patient), who breaks down when her "main support" leaves her. She had never felt appreciated as her sisters were and thus felt unable to replace the dying sister. In addition, the father felt very close to the patient and overprotected her, trying to mend the rift with her boyfriend.

A summary list of clinical judgments about the five major family system components has been found useful in arriving at treatment indications. However, establishing the need for remedial measures in this way does not necessarily indicate what form or combination of treatments may be most suitable in any particular clinical situation. Assessments can be plotted along a continuum ranging from good or optimal, to mixed, to abnormal or deficient functioning, or for example from (1-Good) to (5-Aberrant). The following tentative list has been and is being tested in our center and its reliability among different clinicians validated.

Leadership	**Boundaries**	**Affectivity**	**Communication**	**Task/Goal Performance**
Parental personalities	Ego boundary development in children	Inter-parental intimacy	Clarity as to form and syntax	Nurturance and weaning
Marital coalition	Generation boundary	Equivalence of family triads	Responsiveness	Separation mastery
Parental role complementaries	Family-community permeability	Tolerance for feelings	Verbal/non-verbal consistency	Behavior control and guidance
Use of power (discipline)		Unit emotionality	Expressivity	Peer relationship management
			Abstract thinking	Unit leisure
				Crisis coping
				Emancipation
				Post-nuclear family adjustments

Techniques

We do not advocate a stereotype technique for family treatment. There are some ground rules we believe to be sound, but special technical maneuvers like "getting into the system" (34) or "reciprocal suggestions or tasks" (35), etc. are very successful if carried out by sensitive, experienced masters of the art, but are not necessarily so if attempted by others, even if there is conviction as to the soundness of a particular intervention.

We would advocate that a leader/therapist meet with the family, establish him- or herself as a helper and the person to set boundaries and rules if necessary. The therapist should use the first session or two to obtain a marital and family history, in addition to allowing for some relatively unstructured family interaction. The family should be invited to state the problem, and agreement or disagreement on this statement should be established. This may encompass much of the first session. The therapist should avoid special or intensive involvement with any one member, but in an initial interview should invite some activity from each member (36).

After the initial sessions—perhaps up to four or five—the therapist should put into writing his or her formulation of the problem and how it is to be treated, not necessarily only through family therapy. The recommendation should be communicated to the family in language useful to them and with appropriate proposals for subsequent sessions and schedules.

Unless two therapists intend to work together as a team indefinitely and are willing to work at becoming a team, we recommend against cotherapists. If there is a problem of data overload with a very active family, especially for a beginning therapist, it is preferable to have a non-participant observer either in the room or behind a one-way mirror instead of crowding a beginner by coupling him or her with an experienced therapist who probably would and should dominate the therapeutic interaction.

Hospitalization

Because of the system's interdependence, the hospitalization of any family member for whatever reasons constitutes a family crisis requiring minimally sympathetic and supportive interaction between family and hospital staff. If the hospitalization is for psychiatric reasons, such a crisis is particularly severe because of the probable prior efforts on the part of the family to contain the problem within its midst. Furthermore, it is possible, if not likely, that that containment served to maintain system equilibrium and also that such homeostasis has been maintained by virtue of the patient's symptoms and maladaptive or aberrant behavior. In this case, considerable resistance to hospitalization or to its continuance may be encountered. Lastly, the hospitalization can also represent the family's need and effort to extrude the identified patient either after or without prolonged efforts to maintain him or her within the system (37).

Whichever of these contingencies may be particularly valid, system upheaval is very likely at the time of hospitalization, including a sense of conflict, guilt, shame and anger in the individuals and in the group. A sense of failure may be unavoidable under such circumstances as it is in any situation where system dysfunction and discomfort cannot be corrected from within the system; with that sense of failure, reactive and defensive stances are likely to be manifest. In the case of psychiatric illness, this most often is expressed in an effort to find blame outside the system, or results in a magic belief in and frantic search for some causative biological factor beyond human control. Therefore, the family of any newly hospitalized psychiatric patient deserves professional attention and help with the immediate crisis by being informed as much as possible about the nature of the hospital program, about the likely duration of the institutional care, and about whatever therapeutic program is planned for the patient and for the family respectively. Often families and patients attempt to collude for a time in blaming the hospitalization and hospital procedures for the patient's difficulties, instead of exploring with the therapist(s) antecedents of the illness and the family's functioning and history.

Further treatment indications essentially parallel those listed for family treatment in general, but obviously with a hospitalized patient, individual and other forms of treatment for the patient are also indicated.

From the earliest possible time in the hospitalization, the family should be helped with the admission crisis. A minimal program for working with patients' families should be arranged to keep the family abreast of the patient's development and his or her clinical course, and to prepare and work with the family for the eventual disposition and discharge of the patient. Even when such plans can be formulated only tentatively, one of the major decisions to be made early is whether it is envisioned, if not planned, that the patient join the family to continue living with them or whether the assessment of the family system and of the patient's age-appropriate needs will point to the patient's living apart from the family in the future. The reverse can, of course, also be a necessary consideration, i.e. whether patients who have attempted to live apart from their families of origin or procreation should return to living with them, at least temporarily if not permanently.

A common constellation is a breakdown in personal functioning of a young adult at the time of expected emancipation from his or her family of origin, either while facing this step or after a relatively brief period of having attempted to implement it. These considerations must also determine whether therapeutic work planned with the family is to be done with the entire family as a group, the patient included, or whether the parents or the parents and siblings should be treated in sessions without the patient. Often it is indicated that one proceed from one format to another, but the ultimate aim is to enable the family to accept and live with whatever disposition is considered optimal. Without therapeutic work and some essential change in the family equilibrium, for instance a rapprochement between the parents so that one or the other parent can forego the close bind to a child or delegating a particular role to this child as described in detail by Stierlin (38, 39), pathogenic forces will continue and re-hospitalization is likely to occur.

It is also important that the family not reestablish a similar equilibrium without the hospitalized patient, thereby creating a new "patient" in their midst. It is not an infrequent experience that following hospitalization of one child and amelioration of the immediate crisis, another child will develop symptoms. Therefore, family therapy can have immediate preventive impact; it should also have a more long-range, but possibly less obvious, preventive result for the entire system.

Indications for more formal family treatment exist if there is a clear assessment that it is not only the family stressed by the mental illness of one member, but also the established type of family system that contributes significantly to the development of the illness. We can point out four types of such etiological movement.

1) We have indicated in the foregoing section that the patient may serve as a kind of messenger for family disturbance. However, if this messenger "status" is not reached until the particular family member becomes so disturbed that he or she has to be hospitalized, there are obvious indications for individual therapy as well as family treatment. Most likely in such families, there is severe leadership aberration aside from other system defects pointing to marital conflict or some unresolved interpersonal or neurotic condition in one or both parents.

2) The identified patient may have served as a significant homeostabilizing element in the system. This phenomenon seems to occur in two ways (40):

a) One is in a family equilibrium where much concern and attention and emotional force are directed toward and attached to a problem-member, be it a delinquent child, an ailing possibly hypochondriacal parent, or a child with eating problems. As long as the overt problem continues as a daily preoccupation and concern, other more basic system deficits can be ignored, or indeed may exist and smolder because the "noisy" problem leaves no time or energy for more basic issues. Such a family pattern is often seen in patients identified as anorexia nervosa, and their treatment has been described in detail by Minuchin and Selvini (34,41). In such instances, family therapy is

a must and often very effective in addition to the possibly lifesaving treatment of a hospitalized patient of this type. Even in less pathological systems, homeostasis may be based on infantilizing growing children so that just by virtue of biopsychological development an impasse is reached when one or the other child is expected and needs for the sake of his or her personal growth to move increasingly outside the family.

b) The other hidden homeostatic maintenance role we have observed at a time of acute psychiatric illness or deterioration in a chronic psychiatric condition concerns families in which parents are contemplating separation or dissolution of the marriage. The illness then provides a focus for both parents; unless the basic conflict between the parents is resolved in whatever direction, the patient will retain a stake in remaining ill so as to keep his or her parents together, or at least to remain involved with both of them in significant ways. This does not mean that the treatment goal must be in the direction of maintaining the marriage as such, but rather that the problems be treated as indicated regardless of ultimate reconstitution or dissolution of the system (42).

3) A related, but also different problem leading to hospitalization arises when emancipation of a child from the family is resisted by the system, also a common finding. In such instances, there may have been relatively little psychiatric disturbance in the clinical sense on the part of any individual, but the system, especially in its boundary management, is overly rigid and parents may be unable to face the prospect of living as a dyad again. There may be more pathological themes, such as that a child may have been used to avoid confrontations between the spouses or between the parents and another child, or that one or the other parent, or both of them, will permit emancipation only in a constrained fashion—for instance, insisting on a career choice which may be anathema to the particular child. The hospitalization may, therefore, actually constitute for such a patient a step toward emancipation and separation, albeit a very circuitous and painful one. Again, this is a clear indication for family therapy in addition to whatever individual treatment may be indicated for the patient, but probably a family therapy plan that soon will move to working with the family

without the hospitalized patient.

4) Lastly, there is extrusion of the patient by a family that cannot accept or work out within its system a particular member's handicap, career choice, personality change, etc. Extrusion can be perpetrated upon either parent, siblings or children, and may have beneficial effects for the entire family, as for instance in the case of the hospitalization of an alcoholic parent with a stance that he or she will not be acceptable into the system unless the drinking stops. It may indeed be realistic in that the family system can function better with one parent than with a severely disturbed and disturbing second parent. It is, of course, well known that often only such a step inflicts sufficient pain on an addictive person for him to accept treatment and rehabilitation.

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