FAMILY THERAPY AFTER TWENTY YEARS

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Family Therapy After Twenty Years

Family therapy came on the psychiatric scene in the mid-1950s. It had been developing in the private work of a few investigators for some years prior to that. The growth and development of family therapy has paralleled the ferment and change in psychiatry during the same period. There are psychiatrists who consider family therapy to be a superficial counseling method. A majority think of family therapy as a treatment method based on conventional psychiatric theory. A small percentage of family therapists think of family research as providing new dimensions for thinking about human adaptation and family therapy as pointing the way toward more effective ways of dealing with human problems. All three views are probably accurate, depending on the way the person thinks about the nature and origin of human mal- adaptation. In this chapter the author will present his view of how the family movement began, how it has developed during its first two decades of existence, and how this has been related to the changing psychiatric scene. There are many differences in method and technique in family therapy, based on a variety of theoretical premises. Each therapist is emotionally invested in his own approach and therefore has some degree of bias in the way he views the total field. With awareness of the differences, the author will present one version of the way the field has evolved in the past two decades. The author was one of the originators of the family movement and has continued to be active in the field. He began his family explorations in

the late 1940s from a psychoanalytic orientation. He has moved from psychoanalytic thinking toward a systems theory and systems therapy.

History of the Family Movement

The family movement in psychiatry began in the late 1940s and early 1950s with several widely separated investigators who worked privately without knowledge of each other. The movement suddenly erupted into the open in the 1955-56 period when the investigators began to hear about each other, and they began to communicate and to meet together. Growth and development was rapid after the family idea had come to the surface. After family therapy was well known, there were those who said it was not new and that it had developed from what child psychiatrists, or social workers, or marriage counselors had been doing for several decades. There is some evidence to support the thesis that the family focus evolved slowly as early psychoanalytic theory was put into practice. Freud's treatment of Little Hans in 1909, through work with the father, was consistent with methods later developed from family therapy. Flügel's 1921 book, *The Psycho-Analytic Study of the Family* (1960), conveyed an awareness of the family, but the focus was on the psychopathology of each family member. The child-guidance movement passed close to some current family concepts without seeing them. The focus on pathology in the child prevented a view of the family. Psychiatric social workers came on the scene in the 1930s and 1940s, but their work with

families was oriented around the illness in the patient. Sociologists and anthropologists were studying families and contributing to the literature, but their work had no direct application to psychiatry. Marriage counseling began its growth in the 1930s, but the dynamic formulations came from conventional psychiatry. Also, general-systems theory had its beginning in the 1930s before there was a recognizable connection between it and psychiatric theory. There is little evidence that these forces played more than an indirect role in ushering in the family movement.

Most of the evidence favors the thesis that the family movement developed within psychiatry, that it was an outgrowth of psychoanalytic theory, and that it was part of the sequence of events after World War II. Psychoanalysis had finally become the most accepted of the psychological theories. It had theoretical postulations about the full range of emotional problems, but psychoanalytic treatment was not clearly defined for the more severe emotional problems. After World War II, psychiatry suddenly became popular as a medical specialty and hundreds of young psychiatrists began experimenting in an effort to extend psychoanalytic treatment to the full range of emotional problems. This includes those who began experimenting with families. A psychoanalytic principle may have accounted for the family movement remaining underground for some years. There were rules to safeguard the personal privacy of the patient-therapist relationship and to prevent contamination of the transference by contact with the patient's

relatives. Some hospitals had a therapist to deal with the carefully protected intrapsychic process, another psychiatrist to handle reality matters and administrative procedures, and a social worker to talk to relatives. In those years this principle was a cornerstone of good psychotherapy. Failure to observe the principle was considered inept psychotherapy. Finally, it became acceptable to see families together in the context of "research."

The investigators who started family research with schizophrenia were prominent in starting the family movement. This included Lidz in Baltimore and New Haven (1965), Jackson in Palo Alto (1969), and Bowen in Topeka and Bethesda (1960). Family therapy was so associated with schizophrenia in the early years that some did not think of it as separate from schizophrenia until the early 1960s. Ackerman (1958) developed his early family ideas from work with psychiatric social workers. Satir (1964), a psychiatric social worker, had developed her family thinking through work with psychiatrists in a state hospital. Bell (1961) and Midelfort (1957) were examples of people who started their work very early and who did not write about it until the family movement was well under way. The pattern suggests there were others who never reported their work and who were not identified with the family movement. The formation of the Committee on the Family, Group for the Advancement of Psychiatry, provides other evidence about the early years of the family movement. The committee was formed in 1950 at the suggestion of William C. Menninger who considered the family to be important for

psychiatric study. The committee was not able to find psychiatrists working in the field until the family investigators began to hear about each other in the 1955-1956 period (Spiegel, verbal).

Spiegel, Chairman of the Committee on the Family, helped organize the first national meeting for psychiatrists doing family research. It was a section meeting at the annual meeting of the American Orthopsychiatric Association in March 1957. It was a quiet meeting. All the papers were on family research, but the notion of "family therapy" or "family psychotherapy" was discussed. Some investigators had been working toward methods of family therapy for several years, but I believe this was the first time it was discussed as a definite method at a national meeting. That was the beginning of *family therapy* on a national level. Dozens of new people, attracted by the promise of *therapy,* and with little knowledge of the family research that had led to the development of family therapy, rushed into the field and began their own versions of family therapy. Another section meeting for family papers at the American Psychiatric Association annual meeting in May 1957 helped amplify the process set in motion two months before. All the papers were on research, but the meeting was crowded and there was more audience urgency to talk about family therapy. The national meetings in the spring of 1958 were dominated by new therapists eager to report experiences with family therapy. Family research and theoretical thinking that had given birth to family therapy was lost in the new rush to do therapy. New therapists entered

the field in numbers. Many dropped out after initial therapeutic failure, but there was a rapid net gain in the total field. The 1957-58 period was important in determining the future course of the family movement. In that year family research became known nationally, and in the same year the new family therapists began what the author has called the "healthy unstructured state of chaos." It was considered healthy on the premise that clinical experience would bring an awareness of the theoretical dilemma implicit in family therapy, and awareness would result in efforts to clarify the dilemma. This has not evolved to the degree it was predicted. Some of the newer generations of family therapists have worked toward establishing some theoretical order and structure to the field. A majority of family therapists see family therapy as a method based on conventional, individual theory or as an intuitive, experiential method conducted by therapists who are guided by their own feelings and subjective awareness toward the "use of self' in therapy. Others fall between the two extremes. The range of clinical methods and techniques will be discussed later.

There is suggestive evidence that family therapists come largely from childhood situations in which they had more than average awareness of discord among relatives, some ability to see both sides of an issue, and some motivation to modify the situation. The author uses the term "family movement" in psychiatry to include the theoretical thinking, the family research, and family therapy as they have evolved together and as continue to

grow in psychiatric thinking and practice. This is in contrast to the more popular use of the term "family therapy" as it is used to connote a treatment method.

Common Differences Between Individual and Family Theory and Therapy

The one main difference between an individual and a family approach is a shift of focus from the individual to the family. The nuances of difference between the two approaches are more subtle and far reaching than is evident on the surface. The total fabric of society, as it pertains to human illness, dysfunction, and misbehavior, is organized around the concept of man as an autonomous individual who controls his own destiny. When the observing lens is opened to include the entire family field, there is increasing evidence that man is not as separate from his family, from those about him, and from his multigenerational past as he has fancied himself to be. This in no way changes what man is or has always been. He is as autonomous as he has always been, and he is as "locked in" to those about him as he has always been. The family focus merely points to ways that his life is governed by those about him. It is simple enough to say that the family therapist considers the illness in the patient to be a product of a total family problem, but when this simple concept is extended to its ultimate, then all mankind becomes responsible for the ills of all mankind. It is easy to say this in a philosophical, detached kind of way, but man becomes anxious about the notion of changing

himself to help modify the ills of mankind. It is easier for man to fight his wars, inflation, social ills, and pay his money for non-effective corrective action, than to contemplate changing himself. From family therapy, we know it is relatively easy for family members to modify their part in the creation of emotional illness once they clearly see what has to be done, but this does not decrease initial anxiety and evasive action at the mere contemplation of it. This section of the chapter is not designed as a theoretical treatise on the ultimate implications of family theory, but it is to indicate that the deeper implications are there, and they are more far reaching than is easily realized. The following differences between individual and family theory point up a few of the more obvious examples of the differences.

The Medical Model

This cornerstone of sound medical practice requires the physician to examine, diagnose, and treat the pathology in the patient. The medical model also applies to conventional psychiatry and the social institutions that deal with human dysfunction, including the courts, social agencies, and insurance companies. There is an emotional process in the family through which the family helps to create and maintain the "illness" in the "patient." The process is more intense when anxiety is high. The process also operates in the family-therapy sessions. The family members point to the sickness in the patient and try to confirm this by getting the therapist to label the patient the sick one.

The therapist tries to avoid diagnosing the patient, and to focus on the family emotional process that creates the patient. The family problem is intensified when the medical records and insurance companies require a diagnosis to comply with the medical model. Each therapist has to find his own way to oppose, neutralize, or deflect the intensity of the family emotional process. The situation is usually less dramatic than presented here, but this illustrates the counterforces as the therapist tries to change the family process and also meet the minimal requirements of the institutions. Some therapists explain the situation to the family that medical-model principles are necessary for records, but a different orientation is used for the therapy. Also, the institutions are a bit less strict in requiring adherence to the medical model. Therapists have come to use the terms "designated patient" or "identified patient" to refer to the symptomatic family member. The mere use of the term implies an awareness of the basic process in the family, in the therapy, and in society. The issues that go around the medical model have ramifications that involve the lives of all the people connected with the problem.

Clinical Responsibility

Members of the mental-health professions have second-nature awareness of the nuances of clinical responsibility for a single "patient." The welfare of the patient comes first and the welfare of the family is outside the realm of direct responsibility. The principles of medical responsibility are

changed when the focus is on the entire family instead of the patient. There are situations in which an improvement in the former patient is followed by serious symptoms in another family member. A conventional therapist might send the second family member to another therapist. A family therapist would operate with the premise that the best interests of the family would be served with a single therapist who could deal with the total family problem. There are other similar situations. A conventional therapist could more easily conclude that the patient should be separated from the family, which he considers inately pathogenic to the patient. A family therapist would believe the total family situation would be advanced if the patient were kept at home while he attempted to deal with the overall family anxiety. Family therapists are less likely to consider family members hurtful to each other. They have experience to support the premise that family members want to be responsible and helpful to each other and that it often requires very little help to shift the family climate from a hurtful to a helpful one. The general direction of family therapy is toward helping the family to be responsible for its own, including the "sick" one. It is far more difficult for the impaired family member to begin to assume responsibility than it is for healthier family members. In an effort to more quickly work toward family responsibility, the author developed an approach to work with the "healthiest family member" and to exclude the "sick" family member from the therapy. It has been possible to do an entire course of family therapy with the focus on family

health without ever seeing the "sick" family member.

Confidentiality and Secrets

A basic principle of medicine and individual psychotherapy requires that the physician and psychotherapist not divulge confidential information. Family therapists are forced to reevaluate this principle. There are situations in which keeping the confidence of one family member can be detrimental to the total family. From family research we have learned that the higher the level of anxiety and symptoms in a family, the more the family members are emotionally isolated from each other. The greater the isolation, the lower the level of responsible communication between family members, and the higher the level of irresponsible underground gossip about each other in the family and the confiding of secrets to those outside the family. Through pledging a confidence, a person becomes part of the emotional network around the family problem. The basic problem is the relationship pattern in the family rather than the subject matter of the secrets and confidences. A goal in family therapy is to reduce the level of anxiety, to improve the level of responsible, open communication within the family, and to reduce the irresponsible, underground communication of secrets and gossip to others. When a family therapist becomes entangled in the secrets and confidences, he becomes part of the emotional web-work and his effectiveness as a therapist is lost. Each family therapist has to find his own way of dealing with confidences within

the family without becoming part of the emotional entanglements. Most family therapists employ some kind of working rule about not keeping secrets, and they find ways to communicate secrets in the family sessions, rather than err on the side of becoming a part of the family intrigue. From family-therapy experience, we know it can be as detrimental on one side to blindly keep individual secrets as it is detrimental on the other side for the therapist to gossip to outsiders about private matters in a family. The goal of a family therapist is to be a responsible person who knows the difference between underground secrets and valid, responsible, private communication and who respects the difference.

From family therapy we have learned much about the function of secret communication in situations that range from the avowed privacy of the individual psychotherapy hour to the function of secrets and gossip in society. The higher the avowed intent of secrecy in individual psychotherapy, the greater the chance the patient will gossip to others about the therapist, or the therapist will gossip to others about the patient, all done in strictest confidence. In larger social systems, a gossip is one who came from an anxious, gossipy family. The higher the level of anxiety in a social system, the lower the level of responsible communication, and the higher the level of irresponsible gossip and the keeping of irresponsible secret files about individual members. Family-therapy research, with its emphasis on open communication within the family, has been the most observed, audiotaped,

filmed, and videotaped of all the psychotherapies. The research points up the emotional problems that result from rigid adherence to conventional rules about confidentiality.

The Spectrum of Methods and Techniques in Family Therapy

The best survey of the family field thus far is *The Field of Family Therapy,* a report by the Committee on the Family, Group for the Advancement of Psychiatry, published in March 1970. It was based on the analysis of a detailed questionnaire completed by some 300 family therapists from all the professional disciplines and all levels of experience. Experience since 1970 indicates that the basic pattern of theory and practice is still very much as it was then. The questionnaire responses represented such wide diversity in theory and practice that it was difficult to find a format to report the results. Finally, a scheme was devised to characterize therapists on a scale from *A* to Z.

Therapists toward the A end of the scale are those whose theory and practice is the same as individual psychotherapists. They use family therapy as a technique to supplement individual psychotherapy or as the main technique for a few families. The A therapists are usually young or they have just started experimenting with family techniques. The overwhelming majority of family therapists are toward the A end of the scale. The A

therapist thinks in terms of individual psychopathology, and he views the therapeutic relationship between the therapist and patient as the modality for emotional growth. He sees family therapy as a technique to facilitate his psychotherapy with the patient, and he speaks of indications and contraindications for family therapy. It is impossible to know how many individual therapists now do occasional family interviews. They characteristically do not make formal reports about their work.

Therapists toward the Z end of the scale use theory and techniques that are quite different. They think in terms of systems, relationships, emotional fields, and breakdown in communication. They tend to "think family" for all emotional problems, and they usually end up seeing a number of family members even if the initial problem in the patient is one for which others would clearly recommend individual psychotherapy. The therapy of a Z-scale therapist is directed toward restoring communication, improving relationships in the family, and toward helping family members toward higher levels of differentiation. There are few therapists toward the Z end of the scale. They are the ones more oriented to research and theory or who have been in practice a long time.

Between the two extremes are therapists with theoretical orientations made up of a mixture of individual and family concepts, and with a wide variety of techniques. The place of therapists on the scale seems to be

determined by the therapist's motivation for theory and research, and the professional environment in which he works. The research- oriented therapist is guided more by theory than approval from the professional environment. He usually moves steadily toward the Z end of the scale. The therapy-oriented therapist is more sensitive to the approval of colleagues. He is guided toward a philosophy of treatment that includes a mix of individual and family concepts. When he finds the best "fit" between himself and the professional environment, and between himself and the clinical problem, there is little movement on the scale. The therapy-oriented therapist tends more to try to "sell" his viewpoint and to be critical of others with another viewpoint.

Popular terminology in the field is determined by the usage of terms by a majority of therapists. Most therapists are toward the A end of the scale. They tend to think of family therapy as a method and technique for the application of individual theory. Designations of the type of therapy are determined more by the configuration of family members who attend the sessions than by the theory. The term "family therapy" popularly refers to any psychotherapy session attended by multiple family members. The terms "couples therapy" or "marital therapy" are used when most sessions are attended by both spouses. The term "individual therapy" is used to designate sessions with only one family member. Some use the term "conjoint family therapy" for psychotherapy sessions attended by family members from two

or more generations. It often refers to parents and child together. From this orientation it would be possible for a single family to have individual therapy for the patient, couples therapy for the two parents, and conjoint therapy for parents and patient. The author is at the extreme Z end of the scale. For him the terminology is based on the theory. The term "family therapy" is used for the effort to modify the family-relationship system, whether that effort is with one or with multiple family members. Since 1960 he has spoken of "family therapy with one family member," which is consistent with his orientation but can be considered inaccurate by most family therapists. The author objected to the title *The Field of Family Therapy,* for the 1970 survey of the family field on the grounds that it did not recognize the thinking and research that helped create the field. A majority of the committee members insisted on this title on the grounds that it best represented the field as it exists.

Specific Methods and Techniques of Family Therapy

The following is a brief summary of some of the most prominent, different methods of family therapy. The list is designed to communicate the author's view of the overall pattern to the growth and development of family therapy. It is not designed to present the work of any one therapist or any group of therapists. Most therapists tend to use a combination of the methods.

Family Group Therapy

A high percentage of family therapy should more accurately be called family-group therapy since many of the basic principles were adapted from group psychotherapy. It is noteworthy that specialists in group psychotherapy have had no more than a secondary interest in family therapy. There were no group psychotherapists among the originators of the family movement. Some group therapists became interested in developing family therapy a few years after family therapy was introduced. That group has grown gradually, but it has been relatively separated from the main body of family therapists. The group therapists doing family therapy attend the group-therapy meetings and they publish in group-therapy journals with relatively little overlap between the groups. If one can consider this as a fact without value judgment about why it came to be, it can say something about the nature of the family movement.

Most of the influence of group psychotherapy on family therapy has come from people who had some early professional training in group psychotherapy, but who did not consider themselves to be group therapists. In 1957 when new therapists began developing their own version of family therapy, without much knowledge of family research, the already defined methods of group psychotherapy offered more guidelines than any of the other existing methods. In addition, the psychodynamic formulations of group

psychotherapy were reasonably consistent with training in individual psychotherapy. I believe this may account for the strong influence of group psychotherapy on family therapy.

Methods of family-group therapy vary from therapist to therapist, but there are some common denominators. The basic theory, the psychodynamic formulations, and the interpretations are reasonably consistent with individual therapy and also with group therapy. The therapeutic method and encouraging family members to talk to each other come from principles of group therapy. Family-group therapy comes closer to the popular stereotype of family therapy than any other. This involves all the family meeting together to discuss problems. Family-group therapy is one of the easiest of the methods for the relatively inexperienced therapist. It requires that the therapist develop some facility for relating to people in a group without taking sides and without becoming too entangled in the family emotional system. Beyond this, most professional people can operate with skills learned in training. As a method it yields very high initial results with comparatively little effort by the therapist. Most families with symptoms are out of emotional contact and are not aware of what each is thinking and feeling. The higher the level of anxiety, the more family members are isolated from each other. With a family therapist acting as chairman of the group and the facilitator of calm communication, much can be accomplished in a short time. Parents can profit from hearing the thoughts and feelings of each other.

Children can be fascinated at hearing the parental side of issues and learning that parents are human, too. Parents can be amazed at the astute observations of their children about the family, and the child is grateful for an opportunity to say what he thinks and for the forum that values his ideas. The family can eagerly look forward to such sessions, which they cannot manage at home because of emotions and communication blocks. The process can reach a point of pleasant exhilaration, with parents increasingly aware of each other and the children increasingly able to accept the foibles in the parents. When communication improves, family symptoms subside and the family can report much more fun and togetherness. Of course, there are situations where the process is not as smooth as described here. These are the very impaired, chaotic families and those in which it is difficult to bring family members together without emotional explosions. However, if the therapist is able to keep the communication calm for the volatile family and if he is able to stimulate communication for the more silent family, the net result is on the favorable side.

The main advantage in family-group therapy is the striking, short-term result. The main disadvantage develops when the family-group therapy becomes a longer-term process. At this point, the family begins to act out the same problems they had at home. The parents begin to expect the children to assume more responsibility in the family. The more adequate children become bored by the repetition of issues and they look for reasons not to

attend. If forced to attend, the formerly talkative children can become silent. The maximum results with short-term family-group therapy come within about ten to twenty sessions, depending on the intensity of the problem and the skill of the therapist.

A fair percentage of families tend to terminate at the point of feeling good about the family. If they terminate before they reach the impasse of underlying problems, the family feels confident it has learned to solve its own problems, the family praises the magic of family therapy, and the therapist is positive about his accomplishment. This may account for the use of family-group therapy as a short-term method. Some therapists terminate at this point and arrange follow-up visits for the future. If the family goes into the emotional impasse of longer-term therapy, they may terminate feeling that little was accomplished. It is usually not possible for parents and children to continue together beyond a certain point. It often results in the parents and one child or the two parents continuing without the others.

Family-group therapy is not as effective for long-term family therapy as some of the other methods. The continuation of it as a long-term method, to a reasonable resolution of the underlying problem, depends on the intensity of the problem and the skill of the therapist. Very impaired families may continue for a long time, using the therapy much as an individual psychotherapy patient uses therapy, for support. Therapists tend to develop

other methods and techniques if the goal is to get through the emotional impasses.

Couples Therapy—Marital Therapy

These terms help to point up the ambiguity in the field and specifically imply that the spouses are in some kind of therapy in which the focus is on two people and their relationship. The terms convey nothing about the problem for which the therapy is used, or the theory or method of therapy. Some therapists restrict use of the terms to problems in the marital relationship, such as marital conflict or marital disharmony. A high percentage of marriages have some degree of conflict or disharmony. Other therapists have a broader view of marital problems and use marital therapy for an additional range of problems, such as impotence and frigidity. From experience, the focus on the relationship aspects of such problems can more quickly resolve the problems than focusing on the individual aspects of the problems. Others use marital therapy for problems outside the marital relationship, such as problems in a child. Such considerations say nothing about the theory, the method, or the technique of therapy. In general, theory is determined by the way the therapist thinks about the nature of the family problem; method is determined by broad principles for implementing the theory into a therapeutic approach; and techniques are the specific ways or strategies for implementing the method. Therapists trained in individual

theory, and who accept the assumptions of individual theory as fact, are usually not much aware of theory. Terms such as theory, hypothesis, assumption, formulation, and concept are used loosely and inaccurately. It is not uncommon to hear someone say, "I have a theory," when it would be more accurate to say, "I have an idea." It would be improbable that anyone could have a theory about marital relationships that is not part of a larger theory. Marital therapy might accurately apply to a method if it is based on a theory about the nature of the problem to be modified. The general use of the terms, couples therapy or marital therapy, implies merely that both spouses attend the sessions together. The use of the terms is a good example of the wide divergence of practice in the family field.

Psychoanalytic Marital Therapy

This term has not been used widely. If it were generally used, it would be one of the more specific terms in the family field. The theory would be consistent with psychoanalytic theory, the method would be reasonably consistent with the theory, and therapy techniques would have a reasonable resemblance to psychoanalytic techniques. This is a method used frequently by family therapists who formerly practiced psychoanalysis. One of the main differences in techniques would be the analysis of the relationship between the spouses rather than the transference relationship with the therapist. This method involves the process of learning more about the intrapsychic process

in each spouse, in the presence of the other spouse, with access to the emotional reactiveness of each spouse to the other. The approach provides access to the unconscious through the use of dreams. A new dimension is added when spouses can analyze the dreams of each other. Readings on the intrapsychic process in each are obtained through simultaneous dreams. This is one of the most effective long-term methods of family therapy. It works best when the initial problem was in one spouse or the marital relationship. The author used it a number of years before moving to a systems approach to the entire family-relationship system.

Child-Focused Family

This term refers to a well-defined family problem rather than a therapy approach, but it is used frequently enough to warrant discussion here. The child-focused family is one in which sufficient family anxiety is focused on one or more children to result in serious impairment in a child. The child-focused energy is deeply imbedded, and it includes the full range of emotional involvements from the most positive to the most negative. The higher the anxiety in the parents, the more intense the process. For instance, a mother in her calmer periods can *know* that nagging makes the child's problem worse. She may resolve to stop the nagging, only to have it recur automatically when anxiety rises. The usual approach in family therapy is to soften the intensity of the focus on the child and to gradually shift the emotional focus to the

parents, or between parents and families of origin. This might be relatively easy if the problem is not intense, or it can be so intense that little is accomplished beyond symptomatic relief and easing the pressure for the child. There are differences about what to do with the child. Child psychiatrists tend to focus major attention on the child and supportive attention on the parents. Family therapists tend to focus on the emotional process in the family with parents and child together. This approach may bring good initial results, but there are difficulties when it becomes a long-term process. Some family therapists will see the child separately or have someone else see the child. This can result in parents becoming complacent, expecting the problem to be solved in the child's "therapy." There is no single highroad to success in these families. Finding a way through the problem depends on the therapist's concept of the problem and his skill in keeping the family motivated. My own approach is to remove the focus from the child as quickly as possible, remove the child from the therapy sessions as early as possible, and give technical priority to getting the focus on the relationship between the parents, at the risk of a temporary increase in the child's symptoms. This broad spectrum of differences around a single clinical problem conveys some idea of the differences in the field, and this does not even touch the differences about what goes on in the individual sessions.

Transactional Analysis, Games Theory, Gestalt Theory

These three theoretical concepts are grouped together because all three, though each different in its own right, occupy similar positions in the total scheme of family therapy as it is practiced. These concepts and the therapeutic approaches that go with them were either developed before family therapy or they were developed independent of family therapy. These approaches are not incompatible with individual theory, they provide ingenious ways of conceptualizing relationship systems, and they represent a step toward systems theory. For the therapist attempting to extend his knowledge of family process, these concepts provide ready-made concepts that are more precise for understanding the family and for improvements in therapy. Success with these therapy methods, as with most other methods, depends on the skill of the therapist.

Behavior-Modification Therapy

Almost every experienced family therapist has done some version of behavior-modification therapy, which has now become a well- defined method. The family presents a near-perfect model of a "system" in operation. The family is a system in that each member of the system, on cue, says his assigned lines, takes his assigned posture, and plays his assigned role in the family drama as it repeats itself hour by hour and day by day. This process operates without intellectual awareness. When any principal member of the family can observe and come to know his own part in the family and

purposely change his part, the others will immediately change in relation to it. Family members who can become adept at knowing their roles can bring about predictable change in the action-behavior patterns in others. The disadvantage is in the short-term nature of the change. There are two main variables that limit the long-term result. First, the other family members rather quickly catch on and they start their own versions of adapting to it, or they initiate their own changes. Then the process can become "game playing." Secondly, the whole system of reacting and counter-reacting is imbedded in the emotional system, and the initiator has to keep on consciously and purposely initiating the change. When there is a lapse, the family system returns to its former level. Long-term change requires a modification in the intensity of the emotional level, at which time such changes can become permanent.

Cotherapist Therapy

The use of two therapists, or several therapists, began very early in the family movement. A high percentage of family therapists have had some experience with it. Originally, it was used to help the therapist become aware of his own emotional overinvolvement with family members. Whitaker (1967) routinely used a cotherapist in psychotherapy with schizophrenia long before he started family therapy. He also has become well known for using co-therapists in his long career in family therapy. Others have

developed it as a method for including both male and female therapists who serve as a model for the family. Boszormenyi-Nagy (1973) is one who has been prominent in perfecting this model in his method of therapy. Still another use of co-therapists is the team approach in which several therapists, representing the various members of the mental-health professions, work together as a team. MacGregor (1964) and his group made a major effort to perfect this during his work in Galveston in the early 1960s. He now teaches and trains family therapists with the team approach. Some version of the family-therapy, team approach is now used in most centers that do family therapy. In the broad spectrum of family therapy, cotherapist therapy exists as one of the major innovations and developments in family therapy. It is used both as a method and technique.

Sculpting and Simulated Families

These two innovations are the modern-day descendants of drama therapy. Sculpting is listed first because it has more application to therapy. The simulated family was developed in the early 1960s, more for teaching than for therapy. In teaching, it involves professional people who playact hypothetical family situations. Role playing helps family process become more real to the participants. In therapy, one or more members of a real family have outside people role play the parts of absent family members. People who participate in simulated families discover an uncanny sense of

realness to the role-played situation. Sculpting was developed in the late 1960s to help family members become more aware of self in relation to their own families. The therapist helps the family members decide on the functioning position of each family member in relation to the others, following which the family members are put into physical apposition. The sculpting sessions in which family members debate the position of each, plus the living sculpture in which they assume positions such as bossy, meek, clinging, and distant provide both a cognitive and feeling experience that is one of the more rapid ways of helping family members become aware of each other. The sculpting may be repeated during therapy for awareness of change and progress. These two methods are examples of other innovative developments in the field.

Multiple-Family Therapy

The most popular version of this was developed by Laqueur (1964) for members of several families who meet together in a form of family- group therapy for discussion of individual and shared family problems. It is most useful for severely impaired or fragmented families. Multiple-family groups have been started around groups of inpatients and families on visiting days at mental hospitals, around families and patients attached to mental-health centers, and families and patients discharged from mental hospitals. This method provides a unique and effective method of support and a relationship

system that enables patients to be discharged earlier and to be maintained at home and in the community. New families can replace those who discontinue, while the group continues to serve as an ongoing resource for former families who wish to return. This method has also been used successfully with less impaired people. It is least effective in helping individual family members toward defining a self. The author has devised a method of multiple-family therapy specifically designed to help individual family members toward higher levels of functioning. The therapist works with each family separately, dividing the time between the three or four families and avoiding communication or emotional exchange between the families. The focus on the family emotional process in each family can permit beginning individuation in that family. Emotional exchange between the families encourages group process, which overshadows family process, and individuation is impaired or blocked. Advantages of the method are faster progress in each family from observing the others and a net saving in time. Disadvantages are additional work in scheduling and the energy required of the therapist in maintaining structure.

Network Therapy

This method was devised by Speck (1973) in the mid-1960s. It was designed to help "create" families for fragmented, disorganized families. The goal is to include people from the friendship network in addition to relatives.

The isolated family may have few available relatives and few close friends. The therapist encourages the family to invite relatives and close friends, and friends of friends, and friends of friends, etc. The meetings often include fifteen to forty people, but Speck has had meetings with up to 200 people. Meetings are held in homes or in other appropriate places in the neighborhood. The therapist begins with discussion about the problem in the central family for which the network was assembled. Discussions soon shift to other problems in the network. Theoretical premises about networks are that people have distorted ideas about problems of others, that distortions are often worse than reality, that friends become distant during stress, and open discussion of problems can stimulate more real relationship activity and helpfulness to network members. Experience with networks tends to support the premises. Some remain to talk for hours after meetings have ended, some do become more helpful around the central problem, and network attitudes about the central problem are modified. When regular network meetings continue, a fair percentage lose interest, attendance at meetings dwindles, and continuation requires enthusiasm by the therapist and those who organize the network. On the negative side, the logistical problems of organizing time-consuming, evening meetings, and the clinical expertise necessary for managing large meetings with divergent emotional forces, makes this a difficult therapeutic method. The network idea has a potential both for the understanding of social networks and the development of

therapeutic methods. In practice, the network has come to be a short-term method, or one to achieve a specific goal. One successful application has been for new admissions to mental hospitals. One or two meetings are held to include the family, friends, and people who had contact with the patient before admission (Kelly, 1971). Meetings ease the impact of admission and facilitate discharge. Additional meetings may be called at nodal points during hospitalization.

Encounters, Marathons, Sensitivity Groups

These methods are examples of a trend that has increased in the past decade. Therapists who practice the method are usually not members of the family movement, and the method lends itself to unstructured use by people with little training. The methods are short-term and are based on partial theoretical notions that suppressed feelings are responsible for symptoms, and that the awareness of feelings and the expression of feelings in relation to others is therapeutic. For some, such methods can result in temporary periods of feeling good and exhilaration, which is called growth. For others, the sessions are followed by an increase in anxiety and symptoms. This movement is antithetical to the efforts of the majority of family therapists.

Experiential and Structured Family Therapy

An increasing number of family therapists are beginning to classify the various family-therapy methods into experiential and structured methods. This is a modification of the A to Z scale in *The Field of Family Therapy.* The experiential approaches put a high premium on becoming aware of feelings, in being able to express feelings directly to others, and in becoming more spontaneous in relationship systems. Most therapists agree that a spontaneous, open relationship system is a desirable result for family therapy, but there is disagreement about the best way to help families achieve this. The structured approach uses theoretical concepts about the nature of the family problem and a therapeutic method that is based on the theory. The method contains a built-in blueprint to guide the course of the therapy. The method knows the problems to be encountered during therapy; it has a methodology for getting through the difficult areas; and it knows when it approaches its goal. This is in contrast to the experiential approaches that emphasize the subjective experience of therapy, that rely on the subjective awareness and intuition of the therapist to guide the therapy, and that consider the development of more open spontaneity in relationships to be the goal. A structure-oriented therapist makes decisions based on theory, and he stays on course in spite of any feelings of his against it. An experiential therapist uses feelings and intuitive, subjective awareness to make his decisions. If all approaches are put on a continuum, the encounter-marathon approaches would be at one end of the continuum. Farther along the

continuum would be approaches that offer more and more structure, with less and less emphasis on the expression of feelings as a guiding principle. There is no such thing as an all-feeling situation, or an all-structured situation. The human animal is a feeling being and any approach has to somehow deal with feelings and, also, the realities of relationships with others. The type of approach is not a positive index of success in therapy. There are Indian scouts better qualified to lead an expedition through the wilderness than inexperienced novices with scientific instruments. The structure-oriented therapists believe that knowledge and structure, in addition to experience, will eventually produce a better result. To summarize this point, the experiential orientation says, "Know and express your feelings and the process will break down the unhealthy structure that interferes with your life." The structured orientation says, "Problems are the result of a poorly structured life. The surest approach is the modification of the structure, which will automatically result in free and spontaneous relationships."

The following are some examples of therapists who have worked toward theoretical structures that are different from conventional individual theory. Jackson (1969) began working on communication theory in the 1950s. Before his death he had extended his thinking into well-defined systems concepts that clustered around his communication model. His therapy reflected his theoretical thinking. In more recent years, Minuchin (1974), in association with J. Haley who formerly worked with Jackson, has

developed a structured approach with theoretical concepts so well-formulated that he has automatic therapeutic moves for any clinical situation. His theoretical concepts view man, and his intrapsychic self, in the context of the relationship system around him. Through his relationships man influences those about him and man, in turn, is influenced by those about him. His therapeutic approach, consistent with his theory, is designed to modify the feedback system of the relationship system through which the whole family is modified. His therapy specifically avoids a focus on the intrapsychic forces. The author has worked toward a family-systems theory of human adaptation and a method of therapy designed to modify the relationship system by modifying the part the individual plays in the relationship system. The therapy also avoids focus on the intrapsychic forces. No one is ever really accurate in describing the work of another. The author's approach will be presented in more detail later.

Conclusions

This survey represents one view of the diversity in theory and practice as it has evolved in the family field during the past two decades. In i960, the author used the analogy of the six blind men and the elephant to describe a similar situation in the family field. Each blind man felt a different part of the elephant and the assumption of each was accurate within his own frame of reference. The same analogy is accurate today as different family therapists

view the family through different frames of reference. The family is a complex organization that remains relatively constant no matter who observes and defines it. At the same time, there can be a wide variety of different concepts that accurately describe the family. Early in the family movement most therapists viewed the family through familiar theories about intrapsychic forces within the individual. This was accurate within limits, but the theory was awkward and inaccurate for conceptualizing the relationship patterns through which the intrapsychic forces in one person were interlocked with the intrapsychic forces in others. Family therapists began using a variety of different concepts to account for the interpersonal forces. This resulted in one theory for the intrapsychic forces and another for the interpersonal forces. A majority of therapists still use this combination of theories, each finding the most compatible combination for himself. There are problems in using two different kinds of theories for the same overall phenomenon. Most of the relationship theories used the functional concepts of systems theory. In the past decade, the term "systems" has been misused to the point of simplistic meaninglessness, but the trend toward systems thinking points to a definite direction. The world of systems thinking has sent men to the moon and back, but systems concepts are poorly defined in areas that apply to man and his functioning. Systems thinking has a tremendous potential for the future, but the "elephant" of systems thinking is far bigger and more complex than the "elephants" of the past. The author’s effort at developing a systems theory

represents the serious effort of another "blind man." It is presented in the following sections of this chapter.

A Systems Theory of Emotional Functioning

The main problem in defining a systems theory is in finding a workable collection of functions that can be integrated into a functional whole. The number of choices in the selection of pieces for such a theory is almost infinite. Selection is governed by some overall framework. It is easier to do a theory about a small area of functioning than a large area. Without a framework one can emerge with multiple concepts, each accurate within itself, that do not fit together. The universe is our largest conceptualized system. From a systems model we know there are logical connections between the atom and the organization of the universe and between the smallest cell and the largest known collection of cells, but the development of workable theories are still far in the future. Large areas of specific knowledge are lacking. The conceptual integration of new knowledge can take longer than the original scientific discovery. Into the far distant future man must be content with his lack of knowledge and discrepant, partial theories.

The following are some of the basic notions about the nature of man that guided the selection of the various concepts in this systems theory. Man is conceived as the most complex form of life that evolved from the lower

forms and is intimately connected with all living things. The most important difference between man and the lower forms is his cerebral cortex and his ability to think and reason. Intellectual functioning is regarded as distinctly different from emotional functioning, which man shares with the lower forms. Emotional functioning includes the automatic forces that govern protoplasmic life. It includes the force that biology defines as instinct, reproduction, the automatic activity controlled by the autonomic nervous system, subjective emotional and feeling states, and the forces that govern relationship systems. There are varying degrees of overlap between emotional and intellectual functioning. In broad terms, the emotional system governs the "dance of life" in all living things. It is deep in the phylogenetic past and is much older than the intellectual system. A "feeling" is considered the derivative of a deeper emotional state as it is registered on a screen within the intellectual system. The theory postulates that far more human activity is governed by man's emotional system than he has been willing to admit, and there is far more similarity than dissimilarity between the dance of life in lower forms and the dance of life in human forms. Emotional illness is postulated as a dysfunction of the emotional system. In the more severe forms of emotional illness, the emotions can flood the intellect and impair intellectual functioning, but the intellect is not primarily involved in emotional dysfunction. There are varying degrees of fusion between the emotional and intellectual systems in the human being. The greater the

fusion, the more the life is governed by automatic emotional forces, despite man's intellectual verbalization to the contrary. The greater the fusion between the emotion and intellect, the more the individual is fused into the emotional fusions of people around him. The greater the fusion, the more man is vulnerable to the emotional forces around him. The greater the fusion, the more man is vulnerable to physical illness, emotional illness, and social illness, and the less he is able to consciously control his own life. It is possible for man to discriminate between the emotions and the intellect and to slowly gain more conscious control of emotional functioning. The biofeedback phenomenon is an example of conscious control over autonomic functioning.

A major concept in this systems theory is developed around the notion of fusion between the emotions and the intellect. The degree of fusion in people is variable and discernible. The amount of fusion in a person can be used as a predictor of the pattern of life in that person. In developing any systems theory it is not possible to develop concepts to cover each piece of the total puzzle. In developing this theory an effort has been made to make each concept harmonious with the overall view of man described here and, above all, to avoid concepts that are discrepant with the overall view.

The Theoretical Concepts

The theory is made up of a number of interlocking concepts. A theory of

behavior is an abstract version of what has been observed. If it is accurate, it should be able to predict what will be observed in other similar situations. It should be able to account for discrepancies not included in the formulations. Each concept describes a separate facet of the total system. One may have as many different concepts as desired to describe smaller facets of the system. These concepts describe some overall characteristics of human relationships, the functioning within the nuclear family system (parents and children), the way emotional problems are transmitted to the next generation, and the transmission patterns over multiple generations. Other concepts about details in the extended family and the ways family patterns are interlinked with larger social systems will be added to the theory at a later time. Since the total theory has been described in other publications (Bowen, 1966; Bowen, 1971), the concepts will not be described in detail here.

Differentiation of Self Scale

This concept is a cornerstone of the theory. It includes principles for estimating the degree of fusion between the intellect and emotions. The term "scale" conveys the notion that people are different from each other and that this difference can be estimated from clinical information. It is not a scale to be used as a psychological instrument by people not familiar with the theory and the variables in a relationship system. The scale refers to the level of solid self that is within self, which is stable under stress and which remains

uninfluenced by the relationship system. The solid self is easily confused by the pseudo-self that is determined by the relationship system and can fluctuate from day to day or year to year. The pseudo-self can be increased by a congenial relationship and emotional approval and decreased by a negative relationship or disapproval. An index of the pseudo-self is the degree to which people act, pretend, and use external appearances to influence others and to feign postures that make them appear more or less adequate or important than they really are. The degree of pseudo-self varies so much that it is not possible to make a valid estimate of solid self except from estimating the life patterns over long periods of time. Some people are able to maintain fairly even levels of pseudo-self for several decades. With all the variables, it is possible to do a reasonably accurate estimate of the degree of differentiation of self from the fusion patterns in past generations and from the overall course of a life in the present. Estimates of scale levels provide important clues for family therapy and for predicting, within broad limits, the future adaptive patterns of family members.

Triangles

This concept describes the way any three people relate to each other and involve others in the emotional issues between them. The triangle appears so basic that it probably also operates in animal societies. The concept postulates the triangle or three-person system as the molecule or

building block of any relationship system. A two-person system is basically unstable. In a tension field the two people predictably involve a third person to make a triangle. If it involves four or more people, the system becomes a series of interlocking triangles. In a multiple-person system, the emotional issues may be acted out between three people, with the others relatively uninvolved, or multiple people clump themselves on the poles of the emotional triangle. Psychoanalytic theory, without specifically naming it, postulates the oedipal triangle between parents and child, but the concept deals primarily with sexual issues, and it is awkward and inaccurate to extend this narrow concept. There are two important variables in triangles. One deals with the level of "differentiation of self"; the other with the level of anxiety or emotional tension in the system. The higher the anxiety, the more intense the automatic triangling in the system. The lower the level of differentiation in the involved people, the more intense the triangling. The higher the level of differentiation, the more the people have control over the emotional process. In periods of low anxiety, the triangling may be so toned down that it is not clinically present. In calm periods, the triangle consists of a two-person togetherness and an outsider. The togetherness is the preferred position. The triangle is rarely in a state of optimum emotional comfort for all three. The most uncomfortable one makes a move to improve his optimum level of emotional closeness-distance. This upsets the equilibrium of another who attempts to adjust his optimum level. The triangle is in a constant state of

motion. In tension states the outside position is preferred, and the triangle moves are directed at escaping the tension field and achieving and holding the outside position. The predictable moves in a triangle have been used to develop a system of therapy designed to modify the triangular emotional system. The moves in a triangle are automatic and without intellectual awareness. The therapy focuses on the most important triangle in the family. It is designed to help one or more family members to become aware of the part that self plays in the automatic emotional responsiveness, to control the part that self plays, and to avoid participation in the triangle moves. When one person in the triangle can control self while still remaining in emotional contact with the other two, the tension between the other two subsides. When it is possible to modify the central triangle in a family, the other family triangles are automatically modified without involving other family members in therapy. The therapy also involves a slow process of differentiation between emotional and intellectual functioning and slowly increasing intellectual control over automatic emotional processes.

Nuclear Family Emotional System

This concept describes the range of relationship patterns in the system between parents and children. Depending on the relationship patterns each spouse developed in their families of origin and the patterns they continue in marriage, the adaptive patterns in the nuclear family will go toward marital

conflict, toward physical or emotional or social dysfunction in one spouse, toward projection of the parental problems to one or more children, or to a combination of all three patterns.

Family Projection Process

This concept describes the patterns through which parents project their problems to their children. This is part of the nuclear family process, but it is so important that an entire concept is devoted to it. The family projection process exists to some degree in all families.

Multiple-generation Transmission Process

This concept describes the overall pattern of the family projection process as it involves certain children and avoids others and as it proceeds over multiple generations.

Sibling Position

This concept is an extension and modification of sibling-position profiles as originally defined by Toman (1969). The original profiles were developed from the study of "normal" families. They are remarkably close to the observations in this research except that Toman did not include the predictable ways that profiles are skewed by the family-projection process.

Knowledge gained from Toman, as modified in this concept, provides important clues in predicting areas of family strength and weakness for family therapy. This is so important that it has been included in a separate concept.

Family-Systems Therapy

This method of therapy evolved as the theoretical concepts were developed and extended. During the late 1950s, the term "family therapy" was used for the method when two or more family members were present. The deciding factor revolved around the therapeutic relationship when only one family member was present. In the years prior to family research, the author had operated on the premise that the most reliable method for emotional growth was the working out of psychopathology as it was expressed in the relationship with the therapist. Now this basic premise was changed. The new effort was to work out problems in the already existing, intense relationships within the family and to specifically avoid actions and techniques that facilitate and encourage the therapeutic relationship. A change of this magnitude, for one trained in psychoanalysis, is so great that many say it is impossible. The first few years it was difficult to avoid a therapeutic relationship with only one family member and the designation "individual therapy" was accurate for that situation. Gradually, it became impossible to see one family member without automatically thinking about

the part played by other family members in this person's life. Transference issues, formerly considered critical for the resolution of problems, were avoided until more family members could join the sessions. By 1960, the technique of working with one family member was sufficiently refined so that it was accurate to begin to talk about family therapy with one family member.

Family therapy for both parents and one child together illustrates another nodal point in the development of this theory and method. These are families faced with school and adolescent-behavior problems in the youngster. Most of the parental anxiety is focused on the symptom in the child. In the family-therapy sessions, in the physical presence of the child, it is difficult to get the parents to focus on themselves. The average good outcome of such therapy would come in about twenty-five to forty appointments covering about a year, with the aggressive mother becoming less aggressive, the passive father less passive, and the child's symptoms much improved. The family would terminate with high praise for family therapy, but with no basic change in the family problem. This experience led to rethinking the theory and developing new techniques to get the focus on the hypothesized problem between the spouses. The triangle concept was partially developed. Now parents were asked to accept the premise that the basic problem was between them, to leave the child out of the sessions, and to try to focus on themselves. The results were excellent and this technique has been continued since 1960. Some of the best results have been achieved when the

symptomatic child was never seen by the therapist. In other situations the child is seen occasionally to get the child's view of the family, but not for "therapy." The child's symptoms subside faster when the child is not present in the therapy, and parents are better motivated to work on their own problems. This experience led to the present standard method of family therapy in the triangle consisting of the two parents and the therapist.

Another effort began early in the family movement. This was directed at neutralizing the family emotional process to create the "sick patient" and to make the therapist responsible for treating the patient. Terms such as, "people," "person," and "family member" replaced the term "patient." Diagnoses were avoided, even in the therapist's private thinking. It has been more difficult to replace the concepts of "treatment," "therapy," and "therapist" and to modify the omnipotent position of the therapist to the patient. Most of these changes have to occur within the therapist. Changing the terms does not change the situation, but it is a step. When the therapist has changed himself, the old terms begin to seem odd and out of place. There is the continuing problem of using an appropriate mix of old terms and new terms both in relating to the medical and social institutions and in writing. It has been most difficult to find concepts to replace "therapy" and "therapist" in work with the families and to keep them in the profession. I have found terms such as "supervisor," "teacher," and "coach" helpful. The term coach is probably the best at conveying the connotation of an active expert coaching

both individual players and the team to the utmost of their abilities.

One of the most difficult changes has been in finding ways to relate to the healthy side of the family instead of the weak side. It is a slow, laborious task to improve the functioning of the weakest family member. It is many times more effective to work through the healthy side of the family. Opposing this are the family forces to create the patient and the popular notion that psychiatrists are to treat mental illness. One example from a period in the early 1960s will illustrate the point. This came from therapy with conflictual marriages in which each spouse would continue the cyclical, nonproductive report about what was wrong with the other, each trying to prove it was the other who needed to see a psychiatrist. It was effective for the therapist to say he would not continue the cyclical process, that they should decide who was healthiest and he would do the next sessions with the healthiest alone. The focus on both parents, no matter the location of the problem in the family, is a step toward work with the healthy side of the family. The search for the most responsible, most resourceful, and most motivated part of the family can be elusive. It is best determined from knowledge of the family emotional process and the functioning patterns in the past and present generations, in collaboration with the family. The potential source of family strength can be lost in an emotional impasse with a nonproductive family member.

More details about working with a single, motivated family member will

be presented later.

With this theoretical, therapeutic system, the term "family therapy" is derived from the way the therapist thinks about the family. It refers to the effort to modify the family-relationship system, whether the effort is with multiple family members, the two spouses together, or only one family member. The term "family-systems therapy" began after the theoretical concepts were better defined. It is more accurate than previous terms, but it is not well understood by those not familiar with systems concepts. The term "systems therapy" is now used more often to refer to the process either in the family or in social systems.

Family-Systems Therapy with Two People

This method is a standard approach for therapists who use this theoretical-therapeutic system. The concept about modifying the entire family in the triangle of the two most important family members and the therapist was well formulated by the mid-1960s. The method has been used with several thousand families by the staff and trainees in a large family training center. It has been used alongside other methods in the effort to find the most productive therapy requiring the least professional time. The major changes since the mid-1960s have been in a better understanding of triangles, clearer definition of the therapist's function in the triangle, and minor

changes in techniques. The method was designed as one that would be effective for short-term therapy and that could also go on to longterm therapy. It works best for people who are capable of calm reflection. It is for two people in the same generation with a life commitment to each other. For practical purposes this means husbands and wives. Other twosomes, such as parent and child, two siblings living together, a man and woman living together, or homosexual pairs, are not motivated for significant change in the relationship.

Theoretical Issues

A relationship system is kept in equilibrium by two powerful emotional forces that balance each other. In periods of calm the forces operate as a friendly team, largely out of sight. One is the force for togetherness powered by the universal need for emotional closeness, love, and approval. The other is the force for individuality powered by the drive to be a productive, autonomous individual as determined by self rather than the dictates of the group. People have varying degrees of need for togetherness, which constitutes the life style (level of differentiation of self) for that person. The greater the need for togetherness, the less the drive for individuality. The mix of togetherness and individuality into which the person was programmed in early life becomes a "norm" for that person. People marry spouses who have identical life styles in terms of togetherness-individuality.

People with lower levels of differentiation of self have greater needs for togetherness and less drive for individuality. The greater the need for togetherness, the harder it is to keep togetherness forces in equilibrium without depriving certain family members. Discomfort and symptoms develop when togetherness needs are not met. The automatic response to anxiety and discomfort is to strive for more togetherness. When this effort fails repeatedly, the family member reacts in ways characteristic to that person. The reactions include dependent clinging, seductiveness, pleading, acting helpless, denial of need, acting strong, dictatorial postures, arguing, fighting, conflict, sexual acting out, rejection of others, drug and alcohol abuse, running away from the family, involving children in the problem, and other reactions to the failure to achieve togetherness.

When a family seeks psychiatric help, they have already exhausted their own automatic mechanisms for achieving more togetherness. Most family-therapy methods put emphasis on the family need for understanding and togetherness. The therapist tries to help the family toward more love, consideration, and togetherness by discarding counterproductive, automatic mechanisms in favor of calmer and more productive mechanisms. These methods are effective in achieving symptom relief and a more comfortable life adjustment, but they are less effective in modifying the life style of family members.

This method is designed to help the family move as rapidly as possible toward better levels of differentiation. It proceeds on the assumption that the forces for individuality are present beneath the emotional reactiveness around togetherness, that the individuality forces will slowly emerge in the favorable emotional climate of the therapy triangle, and that togetherness forces will automatically readjust on a higher level of adaptation with each new gain in individuality.

Method

The method was developed from experience with emotional forces in a triangle. Emotional tension in a two-person system immediately results in the twosome involving a vulnerable third person in the emotional issues of the twosome. From earlier family therapy with three family members present, the emotional issues cycled between the family members and evaded the therapist's efforts to interrupt the cycles. This method is designed to put the two most important family members into therapy with the therapist, which makes the therapist a target for family efforts to involve a third person. Progress in therapy depends on the therapist's ability to relate meaningfully to the family without becoming emotionally entangled in the family system.

At the beginning of therapy the two family members are involved in an emotional fusion manifested by a "we," "us," and "our" clinging together, or by

an opposite version of the same thing, which is an antagonistic posture against the other. If the therapist can relate to the family over time, without becoming too entangled in emotional issues, and if he can recognize and deal with his entanglements when they do occur, it is possible for two separate selfs to slowly emerge from the emotional fusion. As this occurs, the emotional closeness in the marriage automatically occurs, and the entire family system begins to change in relation to the change in the spouses.

Technique

The most important aspect of the therapy depends on the therapist's ability to stay neutral in an emotional field, and his knowledge of triangles. Each therapist has to find his own way to maintain emotional neutrality in the therapy situation. My best operating, emotional distance from the family, even when sitting physically close, is at the point where I can "see" the emotional process flowing back and forth between them. The human phenomenon is usually as humorous and comical as it is serious and tragic. The right distance is the point at which it is possible to see either the serious or the humorous side of things. If the family becomes too serious, I have an appropriate humorous remark to defuse the seriousness. If the family starts to kid and joke, I have an appropriate serious remark to restore neutrality. An example was a wife going into detail about her critical, nagging, bossy mother. The husband was indicating his agreement. If the therapist permitted them to

believe he also agreed, he would be in the emotional process with them. His comment, "I thought you appreciated your mother's devotion to you," was enough to change the seriousness to a chuckle and defuse the emotional tension. A calm tone of voice and a focus on facts rather than feelings is helpful in keeping an even, emotional climate. Moves toward differentiation of self are usually not possible in a tense situation.

It is necessary for the therapist to keep his focus on the process between the two. If he finds himself focusing on the content of what is being said, it is evidence that he has lost sight of the process and he is emotionally entangled on a content issue. It is necessary to listen to content in order to follow process, but to keep the focus on process. The greater the tension in the family, the more it is necessary for the therapist to stay constantly active to affirm his neutral position. If he cannot think of anything to say, he is emotionally entangled. Within narrow limits, the therapist may use learned comments for emotional situations. If he is only moderately involved, the comment may be effective. Over the years the "reversal" or "paradoxical comment" has come into use to defuse emotional situations. The reversal is a technique of picking up the opposite side of the emotional issue for a neutralizing comment. If the therapist is deeply involved in the family emotional system, the reversal is heard as sarcasm or hostility and the effort fails.

The principal technique of this method is a structure for each spouse talking directly to the therapist in a factual, calm voice. It is talking about emotional process rather than the communication of emotional process. The therapist avoids a structure in which family members talk directly to each other. Even when the emotional climate is calm, direct communication can increase the emotional tension. This one technique is a major change from earlier methods in which emotionally distant family members were encouraged to talk directly to each other.

A typical session might begin with a comment from the husband to the therapist. To respond directly to the husband involves risk in triangling with the husband. Instead, the therapist asks the wife what she was thinking when she heard this. Then he turns to the husband and asks what was going through his thoughts while the wife was talking. This kind of interchange might go back and forth for an entire session. More frequently, the husband's comment is too minimal for the clear presentation of an idea. The therapist then asks the husband as many questions as necessary to elaborate his thinking into a clearer presentation. Then the therapist turns to the wife for her thoughts while the husband was talking. If her comments are minimal, the therapist might ask a series of questions to more clearly express the wife's views. Then he turns to the husband for his response to the wife's comments. There are numerous other techniques for getting to the private thinking world of each and getting it expressed to the therapist in the presence of the

other spouse. For instance, the therapist might ask for a summary of private thoughts about the family situation since the last session, or ask for the most recent thinking about a particular family situation. The therapist asks for thoughts, ideas, and opinions, and avoids asking for feelings or subjective responses. In my opinion, this process of externalizing the thinking of each spouse in the presence of the other is the epitome of the "magic of family therapy." Therapists accustomed to emotional exchanges can find these sessions dull and uninteresting, but the families are interested, and motivated to attend the sessions. It is common for spouses to say how much they look forward to the sessions and how they are fascinated to hear how the other thinks. When asked how they could live with one another so many years without knowing what each thinks, they say they can listen and hear when one of them talks to the therapist in a way they could never listen when talking to each other. It is common to hear these comments about increasing fascination at discovering what goes on in the other after having been in the dark so long. Spouses experience a challenge in being as expressive and articulate as possible. People who have formerly been non-talkers gradually become talkers. Expressions of emotional closeness and increasing affection for each other occur at home. This occurs faster than when the effort is directed at emotional expression in the sessions. Other reports include the ability to deal calmly with children, the ability to listen to others for the first time, and new experiences about being able to work together calmly.

When tears or emotion erupts suddenly in a session, the therapist stays calmly on course, asking what was the thought that stimulated the tears, or asking the other what they were thinking when the feeling started. If feeling mounts and the other spouse responds directly to the first spouse, it is evidence of building emotional tension. The therapist increases the calm questions to defuse the emotion and to bring the issue back to him. The therapist is always in control of the sessions, asking hundreds of questions and avoiding interpretations. By considering each new family as a research project, the therapist always has so many questions there is never time to ask more than a fraction of them. The therapist avoids acting like a wise man who knows the answers. He asks questions and he listens. His ideas about the family are no more than educated guesses. He might tell the family about his guesses and ask for their ideas that support it or refute it. He might tell the family he thinks a particular area of investigation might be helpful, as a way of telling the family what he is thinking and a way of enlisting their effort in the exploration.

A fair percentage of the therapist's time may go to keeping himself disentangled from the family emotional process. The families use their automatic mechanisms in the effort to involve a third person in the triangle. This is more intense early in the therapy and at periods when anxiety is higher than usual. When the therapist knows the characteristics of triangles, and he is alert, he can often anticipate the triangling move before it occurs.

There are situations in which a spouse erroneously assumes the therapist has taken sides on an issue. The process of keeping the therapist emotionally neutral gets first priority in the therapy. The goal of the therapist is to keep active and to make statements or take actions that affirm his neutrality and to avoid transference-type interpretations to the family about it. Systems theory assumes that the triangling move is an automatic emotional response of the people involved, and not personally directed, as it might be interpreted to be in individual-relationship therapy. The casual comment or a calm reversal is effective in helping the therapist maintain his neutral position.

After the family anxiety subsides and the spouses are more capable of calm reflection, individuality forces begin to surface in one spouse. This occurs as the spouse begins to focus more on the part that self plays in the relationship problems, to decrease blaming of the other for one's own discomfort and unhappiness, and to accept responsibility for changing self. The other spouse increases the pressure on togetherness demands, which commonly results in the first spouse falling back into the old togetherness. This process proceeds through a number of false starts, with the differentiating one gradually gaining more strength and the other increasing the tempo of the togetherness pleas. The togetherness pressure includes accusations of lack of love, indifference, not caring, and lack of appreciation. When the differentiating one is sure enough of self to proceed calmly on course, in spite of the togetherness pleading of the other, without defending

self or counterattacking, and without withdrawing, the attack subsides and the differentiating process passes through its first major nodal point. It may require a year or two for the first spouse to reach this point. This is followed by a period of calm and a new, higher level of adjustment in both. Then the second spouse begins a similar differentiating effort to change self, and the first spouse becomes the promoter of togetherness. New cycles usually take less time and the steps are not as clearly defined as in the first step.

The individuality force emerges slowly at first and it takes very little togetherness force to drive it back underground for fairly long periods. An average life course of people is one that keeps the togetherness-individuality forces in neutralizing balance. The therapist can facilitate the differentiating process by focusing questions on this new area of family issues, by focusing on responsibility for self, and by avoiding any connotation that he is siding with the more righteous-sounding, togetherness pleading.

Teaching in Family-Systems Therapy

Some kind of didactic teaching is necessary for families who go on to long-term therapy with this method. This kind of knowledge provides the family with a way of understanding the problem, an awareness they are responsible for progress, and a framework in which they can direct their energy on their behalf. A very anxious family is unable to "hear" didactic

explanations, and the therapist who attempts such explanations becomes deeply entangled in the family emotional system, with inevitable distortions and impasses in the therapy. Teaching statements are used cautiously until after the family is calm. This applies to the rationale for sending spouses home for frequent visits with their families of origin, which is part of the effort of encouraging them to "differentiate a self" in their extended families. In the later stages of therapy, all kinds of conferences and didactic sessions can be helpful.

Conclusions

This method is effective as a short-term, midterm, or long-term process. The length of the therapy is determined by the family. There have been a fair percentage of striking "cures" in five to ten sessions, usually for symptoms that erupted from an overintense relationship. An example was a seven-session "cure" of severe frigidity in a young wife. Mid-term, good results often come in twenty to forty sessions when symptoms have subsided and the togetherness-oriented spouse exerts pressure to discontinue. No other approach has been as effective as this in producing good, long-term results. In 1966, this method was adapted for multiple-family therapy. The therapist does thirty-minute sessions with each of four families while the other families are nonparticipant observers. In these half-hour sessions the average family makes a little faster progress than in one-hour sessions for single families.

The difference appears related to the ability to "hear" and learn from the other families without reacting emotionally. When the differentiation of self is the goal, it appears to take a certain amount of time for motivated people to modify their life styles. There have been experiments to spread a given amount of therapy time over longer periods of time with less frequent appointments. A majority of multiple- family-therapy sessions are now held monthly, with results as good, or better, than with more frequent sessions. The families are better able to accept responsibility for their own progress and to use the sessions for the therapist to supervise their efforts. Long-term families continue for an average of five years, which includes about sixty multiple-family sessions and about thirty hours of direct time with the therapist.

Toward the Differentiation of Self in One's Own Family

The turning point in the method came in 1967 after an anonymous paper on the differentiation of self in one's own family was read at a national meeting (Framo, 1972). The method involved a detailed family history for multiple generations in the past and the developing of a personal relationship with all important living relatives. This activates old family relationships grown latent with neglect. Then, with the advantage of objectivity and the knowledge of triangles, the task is to disentangle themselves from old family triangles as they come to life.

In the spring of 1967, I began using material presented at that conference in teaching family therapy to psychiatric residents and other mental-health professionals. They began to see themselves in their own families and to go home to secretly try out the knowledge on their families. This was followed by reports of inevitable emotional impasses and further conference discussion to help understand the problem and make suggestions for the next trip home.

Also in 1967, the residents were better than previous residents as clinicians in family therapy. At first I thought this was related to the quality of residents that year, but according to them, it was experience with their own families that made the difference. There were comments, such as, "Family theory is just another theory until you see it work with your own family. It is easier to help other families with experience from your own family."

The next awareness came in 1968. The residents were doing so well in their clinical work that no attention had been devoted to personal problems with their spouses and children. The effort had been directed toward the training of family therapists. There had been no mention of problems in their nuclear families. In 1968, I discovered that these residents had made as much progress with spouses and children as similar residents in formal weekly family therapy with their spouses. There was a good sample for comparison. Since the early 1960s, I had been suggesting family therapy for residents and

their spouses instead of individual psychotherapy or psychoanalysis for personal problems. There was a volume of clinical experience with formal weekly family therapy for psychiatric residents to compare with residents who were going home to visit their families of origin and who were not in any type of formal psychotherapy. This professional experience with psychiatric residents and other mental-health professionals was the beginning of a new era in my own professional orientation.

There is some speculation about the more rapid change in working with the extended families than with the nuclear family. It is easier to "see" self and modify one's self in triangles a bit outside the immediate living situation than in the nuclear family in which one lives. In the years since 1968, this method of work with the extended family has been used in all kinds of conferences and teaching situations and also in private practice type "coaching." A person working actively can utilize coaching sessions about once a month. Some who have access to teaching sessions do not need private sessions, or they need them less often. Some who live at a distance are seen three or four times a year or as infrequently as once a year. This approach is so different, it is hard to compare results with other approaches. It bypasses the nuclear family and the infinite emotional detail in close-up relationships. It appears to produce better results than the more conventional family therapies.

This method has been used largely for those in training to be family

therapists, but it has been used with a growing number of others who hear about it and request it. The results are the same, except that there are few people who seek family therapy until they have symptoms. Once a family starts formal family- therapy sessions, it is harder to find motivation for serious work with the families of origin.

The method of defining a self in the extended family has been used as the only method of therapy for a broad spectrum of mental-health professionals, and for nonprofessional people who hear about the method and request it. Work with the extended family is urged for all families in other types of family therapy, but extended family concepts make little sense when people are anxious. After symptoms subside, it is harder for people to find motivation for serious work with their extended families. Any gain from the extended family is immediately translated into automatic gain with spouses and children. Success in working toward defining self in the family of origin depends on motivation and the family situation. It is easiest with highly motivated people with intact families that have drifted apart. At the other extreme are those who are repulsed by the idea of contacting an extended family and those whose families are extremely negative. In between are different levels of motivation and families with varying degrees of fragmentation and distance. It is not a serious problem when parents are dead if there are other surviving relatives. Reasonable results are possible with those who believe they have no living relatives.

Unique experiences with change in extended families are commonplace. This is in addition to change in the nuclear family. In a course in family therapy for freshman medical students and their spouses, there was a student whose father had been in a state hospital for about twenty years. The hospital was near his home town several hundred miles away. The family had been visiting the father about once a year. I suggested that the student visit his father alone, any time he was home, and that he try to relate through the psychosis to the man beneath the symptoms. I was guessing that the father might be able to leave the hospital by the time the son graduated from medical school. He visited the father about four times that year. The following year, about nine months after the course started, the father visited the son while on a furlough from the hospital. Exactly twelve months after the course started, as the son was starting his sophomore year, the father had been discharged from the hospital and was visiting the son. The father attended the twenty-second meeting of that class in family therapy. After having been in a state institution from the age of thirty to about fifty, he was having adjustment and employment problems, but the son, the father, and the family had come far in only one year.

Systems Theory and Societal Problems

The emotional forces in a triangle operate in the same way in society as in the family. Family therapists have been aware of this for a number of years,

but the specific mechanisms involved in this have been elusive and hard to define. The author has made one serious effort at this.* The larger societal field, with its multiple emotional forces, is a challenge for the concepts of systems theory.

Conclusion

This chapter presents an overall view of family therapy as it began almost twenty years ago and as it has developed as part of the changing psychiatric scene. An effort has been made to identify some of the forces that gave rise to the study of the family and other forces that seem to have determined the direction of the growth of family therapy. Family therapists represent such a diversity in theory and therapeutic method that it is difficult to find a frame of reference for either the common denominators or differences in the field. An effort has been made to focus on the broad direction rather than attempting to categorize the work of well-known people in the field. It is factual that the greatest number of family therapists operate from psychiatric theory learned in training, and that they use family therapy as a technique. Another large group of family therapists uses conventional theory for thinking about emotional forces in the individual but another theoretical scheme for thinking about the relationship system between family members. A smaller group of family therapists has moved into completely different theories for conceptualizing and working with families. These

differences in theory do not have common denominators in the clinical practice of family therapy. There are skillful therapists who would be masters with any therapeutic method. In this sense, family therapy is still more of an art than a science.

Presented here is the thesis that the study of the family opened the door for the study of relationships between people. There was no ready-made, conceptual scheme for understanding relationships. We are living in the computer age in which systems thinking influences the world about us, but systems concepts are poorly developed in thinking about man and his functioning. Most of the family therapists who have worked on relationships have developed systems concepts for understanding the subtle and powerful ways that people are influenced by their own families, by society, and by their past generations. Those who have developed the most complete systems concepts have developed therapeutic methods that bypass individual theory and practice, not because one is considered better than the other but to experiment with possible new potentials. The author is among those who have worked toward developing systems concepts for understanding emotional illness in the broader family framework. He has presented his theoretical, therapeutic system as one of the many ways that family and social systems may be conceptualized, and to provide the reader with the broadest possible view of the diversity in the practice of family therapy. If the present trend in systems thinking continues, we can reasonably expect even more

striking developments in the field in the next decade.

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