CHAPTER 1

The Evolution of Family Therapy

Essential Points in This Chapter

- Hospital psychiatry, group dynamics theory, the child guidance movement, and marriage counseling were forerunners of family therapy.
- Research on family dynamics and schizophrenia led directly to the development of family therapy.
- Family therapy was founded independently by John Bell, Don Jackson and Jay Haley, Nathan Ackerman, and Murray Bowen.
- In the 1960s through the 1980s the classic schools of family therapy were developed.

As You Read, Consider

- What insights from the family therapy forerunners do you think were most useful?
- Which of the concepts from research on schizophrenia are of most value?
- Which of the pioneers of family therapy were you most drawn to?
- What are some of the motives for blaming parents (especially mothers) for the problems of their children?

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In this chapter, we explore the antecedents and early years of family therapy. There are two fascinating stories here: one of personalities, one of ideas. The first story revolves around the pioneers—visionary iconoclasts who broke the mold of seeing life and its problems as a function of individuals and their personalities. Make no mistake: The shift from an individual to a systemic perspective was a revolutionary one, providing a powerful tool for understanding human problems.

The second story in the evolution of family therapy is one of ideas. The restless curiosity of the first family therapists led them to ingenious new ways of conceptualizing the joys and sorrows of family life.

As you read this history, stay open to surprises. Be ready to reexamine easy assumptions—including the assumption that family therapy began as a benevolent effort to support the institution of the family. The truth is, therapists first encountered families as adversaries.

THE UNDECLARED WAR

Although we came to think of asylums as places of cruelty and detention, they were originally built to rescue the insane from being locked away in family attics. Accordingly, except for purposes of footing the bill, hospital psychiatrists kept families at arm's length. In the 1950s, however, two puzzling developments forced therapists to recognize the family's power to alter the course of treatment.

Therapists began to notice that often when a patient got better, someone else in the family got worse, almost as though the family *needed* a symptomatic member. As in the game of hide-and-seek, it didn't seem to matter who was "It" as long as someone played the part. In one case, Don Jackson (1954) was treating a woman for depression. When she began to improve, her husband complained that she was getting worse. When she continued to improve, her husband lost his job. Eventually, when the woman was completely well, her husband killed himself. Apparently this man's stability was predicated on having a sick wife.

Another strange story of shifting disturbance was that patients frequently improved in the hospital only to get worse when they went home.

CASE STUDY: SALVADOR MINUCHIN AND OEDIPUS REVISITED

In a bizarre case of Oedipus revisited, Salvador Minuchin treated a young man hospitalized several times for trying to scratch out his own eyes. The man functioned normally in Bellevue but returned to self-mutilation each time he went home. He could be sane, it seemed, only in an insane world.

It turned out that the young man was extremely close to his mother, a bond that grew even tighter during the seven years of his father's mysterious absence. The father was a compulsive gambler who disappeared shortly after being declared legally incompetent. The rumor was that the Mafia had kidnapped him. When, just as mysteriously, the father

returned, his son began his bizarre attempts at self-mutilation. Perhaps he wanted to blind himself so as not to see his obsession with his mother and hatred of his father.

But this family was neither ancient nor Greek, and Minuchin was more pragmatist than poet. So he challenged the father to protect his son by beginning to deal directly with his wife and then challenged the man's demeaning attitude toward her, which had made her seek her son's proximity and protection. The therapy was a challenge to the family's structure and, in Bellevue, Minuchin worked with the psychiatric staff toward easing the young man back into the family, into the lion's den.

Minuchin confronted the father, saying, "As a father of a child in danger, what you're doing isn't enough."

"What *should* I do?" asked the man.

"I don't know," Minuchin replied. "Ask your son." Then, for the first time in years, father and son began talking to each other. Just as they were about to run out of things to say, Dr. Minuchin commented to the parents: "In a strange way, he's telling you that he prefers to be treated like a young child. When he was in the hospital he was twenty-three. Now that he's returned home, he's six."

What this case dramatizes is how parents use their children as a buffer to protect them from intimacy. To the would-be Oedipus, Minuchin said, "You're scratching your eyes for your mother, so that she'll have something to worry about. You're a good boy. Good children sacrifice themselves for their parents."

Families are made of strange glue—they stretch but never let go. Few blamed families for outright malevolence, yet there was an invidious undercurrent to these observations. The official story of family therapy is one of respect for the family, but maybe none of us ever quite gets over the adolescent idea that families are the enemy of freedom.

SMALL GROUP DYNAMICS

Those who first sought to treat families found a ready parallel in small groups. **Group dynamics** are relevant to family therapy because group life is a complex blend of individual personalities and superordinate properties of the group.

In 1920, the pioneering social psychologist William McDougall published *The Group Mind*, in which he described how a group's continuity depends on the group being an important idea in the minds of its members; on the need for boundaries and structures in which differentiation of function could occur; and on the importance of customs and habits to make relationships predictable.

A more scientific approach to group dynamics was ushered in during the 1940s by Kurt Lewin, whose *field theory* (Lewin, 1951) guided a generation of researchers and agents of social change. Drawing on the Gestalt school of perception, Lewin developed the notion that a group is more than the sum of its parts. This transcendent property of groups has obvious relevance to family therapists, who must work not only with individuals but also with family systems—and their famous resistance to change. Analyzing what he called *quasi-stationary social equilibrium*, Lewin pointed out that changing group behavior first requires "unfreezing." Only after something shakes up a group's beliefs are its members likely to accept change. In individual therapy this process is initiated by the disquieting experiences that lead people to seek help. Once someone accepts the status of patient, that person has already begun to unfreeze old habits. When families come for treatment, it's a different story.

Family members may not be sufficiently unsettled by one member's problems to consider changing their own ways. Furthermore, family members bring their primary reference group with them, with all its traditions and habits. Consequently, more effort is required to unfreeze, or shake up, families before real change can take place. The need for unfreezing foreshadowed early family therapists' concern about disrupting family **homeostasis**, a notion that dominated family therapy for decades.

Wilfred Bion was another student of group dynamics who emphasized the group as a whole, with its own dynamics and structure. According to Bion (1948), most groups become distracted from their primary tasks by engaging in patterns of *fight–flight*, *dependency*, or *pairing*. Bion's **basic assumption theory** is easily extrapolated to family therapy: Some families skirt around hot issues like a cat circling a snake. Others use therapy to bicker endlessly, never really contemplating compromise, much less change. Dependency masquerades as therapy when families allow therapists to subvert their autonomy in the name of problem solving. Pairing is seen in families when one parent colludes with the children to undermine the other parent.

The **process/content** distinction in group dynamics likewise had a major impact on family treatment. Experienced therapists learn to attend as much to *how* families talk as to the content of their discussions. For example, a mother might tell her daughter that she shouldn't play with Barbie dolls because she shouldn't aspire to an image of bubble-headed beauty. The *content* of the mother's message is "Respect yourself as a person." But if the mother expresses her point of view by disparaging her daughter's wishes, then the *process* of her message is "Your feelings don't count."

Unfortunately, the content of some discussions is so compelling that therapists get sidetracked from the process.

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Suppose, for example, that a therapist invites a teenage boy to talk with his mother about wanting to drop out of school. Say the boy mumbles something about school being stupid, and his mother responds with a lecture about the need for an education. A therapist who gets drawn in to support the mother's position may be making a mistake. In terms of content, the mother might be right: A high school diploma can come in handy. But maybe it's more important at that moment to help the boy learn to speak up for himself—and for his mother to learn to listen.

Role theory, explored in the literature of psychoanalysis and group dynamics, had important applications to the study of families. The expectations that roles carry bring regularity to complex social situations.

Roles tend to be stereotyped in most groups. Virginia Satir (1972) described family roles such as "the placater" and "the disagreeable one" in her book *Peoplemaking*. If you think about it, you may have played a fairly predictable role in your family. Perhaps you were "the good child," "the moody one," "the rebel," or "the successful child." The trouble is, such roles can be hard to put aside.

One thing that makes role theory so useful in understanding families is that roles tend to be reciprocal and complementary. Say, for example, that a woman is slightly more anxious to spend time together with her boyfriend than he is. Maybe he'd call twice a week. But if she calls three times a week, he may never get around to picking up the phone. If their relationship lasts, she may always play the role of the pursuer and he the distancer. Or take the case of two parents, both of whom want their children to behave at the dinner table. But let's say that the father has a slightly shorter fuse—he tells them to quiet down five seconds after they start getting rowdy, whereas his wife would wait half a minute. If he always speaks up, she may never get a chance. Eventually, these parents may become polarized into complementary roles of strictness and leniency. What makes such reciprocity resistant to change is that the roles reinforce each other.

It was a short step from observing patients' reactions to other members of a group—some of whom might act like siblings or parents—to observing interactions in real families. Given the wealth of techniques for exploring interpersonal relationships developed by group therapists, it was natural that some family therapists would apply a group treatment model to working with families. After all, what is a family but a collective group of individuals?

From a technical viewpoint, group and family therapies are similar: Both are complex and dynamic, more like everyday life than individual therapy. In groups and families, patients must react to a number of people, not just a therapist, and therapeutic use of this interaction is the definitive mechanism of change in both settings.

On closer examination, however, it turns out that the differences between families and groups are so significant that the group therapy model has only limited applicability to family treatment. Family members have a long history and, more importantly, a future together. Revealing yourself to strangers is safer than exposing yourself to members of your own family. There's no taking back revelations that might better have remained private—the affair, long since over, or the admission that a woman cares more about her career than about her husband. Continuity, commitment, and shared distortions all make family therapy very different from group therapy.

Therapy groups are designed to provide an atmosphere of warmth and support. This feeling of safety among sympathetic strangers cannot be part of family therapy, because instead of separating treatment from a stressful environment, the stressful environment is brought into treatment. Furthermore, in group therapy, patients can have equal power and status, whereas democratic equality isn't appropriate in families. Someone has to be in charge. Furthermore, the official patient in a family is likely to feel isolated and stigmatized. After all, he or she is "the problem." The sense of protection in being with a compassionate group of strangers, who won't have to be faced across the dinner table, doesn't exist in family therapy.

THE CHILD GUIDANCE MOVEMENT

It was Freud who introduced the idea that psychological disorders were the consequence of unsolved problems of childhood. Alfred Adler was the first of Freud's followers to pursue the implication that treating the growing child might be the most effective way to prevent adult neuroses. To that end, Adler organized child guidance clinics in Vienna, where not only children but also families and teachers were counseled. Adler offered encouragement and support to help alleviate children's *feelings of inferiority*, so they could work out a healthy lifestyle, achieving confidence and success through social usefulness.

Although child guidance clinics remained few in number until after World War II, they now exist in every city in the United States, providing treatment of childhood problems and the complex forces contributing to them. Gradually, child guidance workers concluded that the real problem wasn't the obvious one—the child's symptoms—but rather the tensions in families that were the source of those symptoms. At first, there was a tendency to blame the parents, especially the mother.

The chief cause of childhood psychological problems, according to David Levy (1943), was *maternal overprotectiveness*. Mothers who had themselves been deprived of love growing up became overprotective of their children.

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Some were domineering, others overindulgent. Children of domineering mothers were submissive at home but had difficulty making friends; children with indulgent mothers were disobedient at home but well behaved at school.

During this period, Frieda Fromm-Reichmann (1948) coined one of the most damning terms in the history of psychiatry, the **schizophrenogenic mother**. These domineering, aggressive, and rejecting women, especially when married to passive men, were thought to provide the pathologic parenting that produced schizophrenia.

The tendency to blame parents, especially mothers, for problems in the family was an evolutionary misdirection that continues to haunt the field. Nevertheless, by paying attention to what went on between parents and children, Levy and Fromm-Reichmann helped pave the way for family therapy.

John Bowlby's work at the Tavistock Clinic exemplified the transition to a family approach. Bowlby (1949) was treating a teenager and making slow progress. Feeling frustrated, he decided to see the boy and his parents together. During the first half of a two-hour session, the child and parents took turns complaining about each other. During the second half of the session, Bowlby interpreted what he thought each of their contributions to the problem were. Eventually, by working together, all three members of the family developed empathy for each other's point of view.

Although he was impressed with the usefulness of this conjoint interview, Bowlby remained wedded to the one-to-one format. Family meetings might be a useful catalyst, but only as an adjunct to the *real* treatment, individual psychotherapy.

What Bowlby tried as an experiment, Nathan Ackerman saw to fruition—family therapy as the primary form of treatment. Once he saw the need to understand the family in order to diagnose problems, Ackerman soon took the next step—family treatment. See Figure 1.1 for an analysis of the lessons that were learned from early models.

Then let us examine parallel developments in marriage counseling and research on schizophrenia that led to the birth of family therapy.

MARRIAGE COUNSELING

For many years, people with marital problems talked with their doctors, clergy, lawyers, and teachers. The first professional centers for marriage counseling were established in the 1930s, in Los Angeles, New York, and Philadelphia (Broderick & Schrader, 1991). At the same time, although most analysts followed Freud's prohibition against contact with a patient's family, a few broke the rules and experimented with therapy for married partners.

In 1948, Bela Mittleman of the New York Psychoanalytic Institute became the first to publish an account of concurrent marital therapy in the United States. Mittleman suggested that husbands and wives could be treated by the same analyst and that by seeing both it was possible to reexamine their irrational perceptions of each other (Mittleman, 1948).

Meanwhile, in Great Britain, Henry Dicks and his associates at the Tavistock Clinic established a Family Psychiatric Unit. Here couples referred by the divorce courts were helped to reconcile their differences (Dicks, 1964).

In 1956, Mittleman wrote a more extensive description of his views on marital disorders and their treatment. He described a number of complementary marital patterns, including aggressive/submissive and detached/demanding. These odd matches are made, according to Mittleman, because courting couples see each other's personalities through the eyes of their illusions: She sees his detachment as strength; he sees her dependency as adoration.

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The most important contribution from group studies to family therapy was the idea that when people join together in a group, relational processes emerge that reflect not only the individuals involved but also their collective patterns of interaction, known as *group dynamics*. A group therapy approach to families was widely used in the 1960s, but today we realize that families have unique properties that cannot be effectively treated with a group therapy model.

Communications theorists regarded families as goal-directed systems, and analyzed their interactions using *cybernetics* and *general systems theory*. Practitioners focused on the *process* of communication, rather than its *content*. Negative (*homeostatic*) feedback mechanisms were thought to account for the stability of normal families and the inflexibility of dysfunctional ones. Communications analysis was so well received that it has been absorbed into the entire field of family therapy.

FIGURE 1.1 Lessons from the Early Models

At about this time Don Jackson and Jay Haley were exploring marital therapy within the framework of communications analysis. As their ideas gained prominence, the field of marital therapy was absorbed into the larger family therapy movement.

RESEARCH ON FAMILY DYNAMICS AND THE ETIOLOGY OF SCHIZOPHRENIA

Gregory Bateson—Palo Alto

One of the groups with the strongest claim to originating family therapy was Gregory Bateson's schizophrenia project in Palo Alto, California. The Palo Alto project began in the fall of 1952 when Bateson received a grant to study the nature of communication. All communications, Bateson contended (Bateson, 1951), have two different levels—*report* and *command*. Every message has a stated content, as, for instance, "Wash your hands, it's time for dinner," but in addition, the message carries how it is to be taken. In this case, that the speaker is in charge. This second message—**metacommunication**—is covert and often unnoticed. If a wife scolds her husband for running the dishwasher when it's only half full and he says OK but turns around and does exactly the same thing two days later, she may be annoyed that he doesn't listen to her. She means the message. But maybe he didn't like the metamessage. Maybe he doesn't like her telling him what to do as though she were his mother.

Bateson was joined in 1953 by Jay Haley and John Weakland. In 1954, Bateson received a two-year grant from the Macy Foundation to study schizophrenic communication. Shortly thereafter, the group was joined by Don Jackson, a brilliant psychiatrist who served as clinical consultant.

The group's interests turned to developing a **communications theory** that might explain the origin and nature of schizophrenia, particularly in the context of families. Worth noting, however, is that in the early days of the project, none of them thought of actually observing schizophrenics and their families. Once they agreed that schizophrenic communication might be a product of what was learned inside the family, the group looked for circumstances that could lead to such confused and confusing patterns of speech.

In 1956, Bateson and his colleagues published their famous report "Toward a Theory of Schizophrenia," in which they introduced the concept of the **double bind**. Patients weren't crazy in some meaningless way; they were an extension of a crazy family environment. Consider someone who receives two contradictory messages on different levels but finds it difficult to detect or comment on the inconsistency (Bateson, Jackson, Haley, & Weakland, 1956); that person is in a double bind.

Because this difficult concept is often misused as a synonym for paradox or simply contradiction, it's worth reviewing all the features of the double bind as the authors listed them:

1. Two or more persons in an important relationship.
2. Repeated experience.
3. A primary negative injunction, such as "Don't do X or I will punish you."
4. A second injunction at a more abstract level conflicting with the first, also enforced by punishment or perceived threat.
5. A tertiary negative injunction prohibiting escape and demanding a response. Without this restriction the victim won't feel bound.
6. Finally, the complete set of ingredients is no longer necessary once the victim is conditioned to perceive the world in terms of double binds; any part of the sequence becomes sufficient to trigger panic or rage.

Most examples of double binds in the literature are inadequate because they don't include all of the critical features. Robin Skynner (1976), for instance, cited: "Boys must stand up for themselves and not be sissies"; but "Don't be rough . . . don't be rude to your mother." Confusing? Yes. Conflict? Maybe. But these two messages don't constitute a double bind; they're merely contradictory. Faced with two such statements, a child is free to obey either one, alternate, or even complain about the contradiction. This and similar examples neglect the specification that the two messages are conveyed on different levels.

A better example is one given in the original article. A young man recovering in the hospital from a schizophrenic episode was visited by his mother. When he put his arm around her, she stiffened. But when he withdrew, she asked, "Don't you love me anymore?" He blushed, and she said, "Dear, you must not be so easily embarrassed and afraid of your feelings." Following this exchange, the patient assaulted an aide and had to be put in seclusion.

Another example of a double bind is a teacher who urges his students to participate in class but gets impatient if one of them actually interrupts with a question or comment. Then a baffling thing happens. For some strange reason that scientists have yet to decipher, students tend not to speak up in classes where their comments are disparaged. When the professor finally does get around to asking for questions and no one responds, he gets angry. (*Students are so passive*!) If any of the students has the temerity to comment on the professor's lack of receptivity, he may get

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even angrier. Thus the students will be punished for accurately perceiving that the teacher really wants only his own ideas to be heard and admired. (This example is, of course, purely hypothetical.)

We're all caught in occasional double binds, but the schizophrenic has to deal with them continually—and the effect is maddening. Unable to comment on the dilemma, the schizophrenic responds defensively, perhaps by being concrete and literal, perhaps by speaking in metaphors. Eventually, the schizophrenic may come to assume that behind every statement lies a concealed meaning.

The discovery that schizophrenic symptoms made sense in the context of some families may have been a scientific advance, but it had moral and political overtones. Not only did these investigators see themselves as avenging knights bent on rescuing *identified patients* by slaying family dragons, but they were also crusaders in a holy war against the psychiatric establishment. Outnumbered and surrounded by hostile critics, the champions of family therapy challenged the orthodox assumption that schizophrenia was a biological disease. Psychological healers everywhere cheered. Unfortunately, they were wrong.

The observation that schizophrenic behavior seems to *fit* in some families doesn't mean that families *cause* schizophrenia. In logic, this kind of inference is called "Jumping to Conclusions." Sadly, families of schizophrenic members suffered for years under the implication that they were to blame for the tragedy of their children's psychoses.

Lyman Wynne—National Institute of Mental Health

Lyman Wynne's studies of schizophrenic families began in 1954 when he started seeing the parents of his hospitalized patients in twice-weekly therapy sessions. What struck Wynne about these disturbed families was the strangely unreal quality of both positive and negative emotions, which he labeled *pseudomutuality* and *pseudohostility*, and the nature of the boundaries around them—*rubber fences*—apparently flexible but actually impervious to outside influence (especially from therapists).

Pseudomutuality is a facade of harmony (Wynne, Ryckoff, Day, & Hirsch, 1958). Pseudomutual families are so committed to togetherness that there's no room for separate identities. The surface unity of pseudomutual families obscures the fact that they can't tolerate deeper, more honest relationships, or independence.

Pseudohostility is a different guise for a similar collusion to stifle autonomy (Wynne, 1961). Although apparently acrimonious, it signals only a superficial split. Pseudohostility is more like the bickering of a situation-comedy family than real animosity. Like pseudomutuality, it undermines intimacy and masks deeper conflict, and like pseudomutuality, distorts communication and impairs rational thinking.

The **rubber fence** is an invisible barrier that stretches to permit limited extrafamilial involvement, such as going to school, but springs back if that involvement goes too far. The family's rigid structure is thus protected by isolation. Instead of having its eccentricities modified in contact with the larger society, the schizophrenic family becomes a sick little society unto itself.

Wynne linked the new concept of *communication deviance* with the older notion of *thought disorder*. He saw communication as the vehicle for transmitting thought disorder, the defining characteristic of schizophrenia. Communication deviance is a more interactional concept than thought disorder and more readily observable. By 1978 Wynne had studied over 600 families and gathered incontrovertible evidence that disordered styles of communication are a distinguishing feature of families with young adult schizophrenics.

Role Theorists

The founders of family therapy gained momentum for their fledgling discipline by concentrating on communication. Doing so may have been expedient, but focusing exclusively on this one aspect of family life neglected individual intersubjectivity as well as broader social influences.

Role theorists, like John Spiegel, described how individuals were differentiated into social roles within family systems. This important fact was obscured by simplistic versions of systems theory, in which individuals were treated like interchangeable parts. As early as 1954, Spiegel pointed out that the system in therapy includes the therapist as well as the family (an idea reintroduced later as **second-order cybernetics**). He also made a valuable distinction between "interactions" and "transactions." Billiard balls *interact*—they collide but remain essentially unchanged. People *transact*—they come together in ways that not only alter each other's course but also bring about internal changes.

R. D. Laing's analysis of family dynamics was more polemic than scholarly, but his observations helped popularize the family's role in psychopathology. Laing (1965) borrowed Karl Marx's concept of **mystification** (class exploitation) and applied it to the "politics of families." Mystification means distorting someone's experience by denying or relabeling it. An example of this is a parent telling a child who's feeling sad, "You must be tired" (*Go to bed and leave me alone*).

Mystification distorts feelings and, more ominously, reality. When parents mystify a child's experience, the

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child's existence becomes inauthentic. Because their feelings aren't accepted, these children project a *false self*. In mild instances, this produces a lack of authenticity, but when the real self/false self split is carried to extremes, the result is madness (Laing, 1960).

FROM RESEARCH TO TREATMENT: THE PIONEERS OF FAMILY THERAPY

We have seen how family therapy was anticipated by developments in hospital psychiatry, group dynamics, the child guidance movement, marriage counseling, and research on schizophrenia. But who actually started family therapy?

Although there are rival claims to this honor, the distinction should probably be shared by John Elderkin Bell, Don Jackson, Nathan Ackerman, and Murray Bowen. In addition to these founders of family therapy, Jay Haley, Virginia Satir, Carl Whitaker, Lyman Wynne, Ivan Boszormenyi-Nagy, and Salvador Minuchin were also significant pioneers.

John Bell

John Elderkin Bell, a psychologist at Clark University in Worcester, Massachusetts, who began treating families in 1951, occupies a unique position in the history of family therapy. Although he may have been the first family therapist, he is mentioned only tangentially in two of the most important historical accounts of the movement (Guerin, 1976; Kaslow, 1980). The reason for this is that although he began seeing families in the 1950s, he didn't publish his ideas until a decade later. Moreover, unlike the other parents of family therapy, he had few offspring. He didn't establish a clinic, develop a training program, or train well-known students.

Bell's approach (Bell, 1961, 1962) was taken directly from group therapy. *Family group therapy* relied primarily on stimulating open discussion to help families solve their problems. Like a group therapist, Bell intervened to encourage silent participants to speak up, and he interpreted the reasons for their defensiveness.

Bell believed that family group therapy goes through predictable phases, as do groups of strangers. In his early work (Bell, 1961), he structured treatment in a series of stages, each of which concentrated on a particular segment of the family. Later, he became less directive and allowed families to evolve through a naturally unfolding sequence.

MEET THE THERAPIST

JOHN ELDERKIN BELL

One of the first family therapists was John Elderkin Bell, who began treating families in the early 1950s. His approach to family therapy involved a step-by-step plan to treat family problems in stages. His model was an outgrowth of group therapy and was aptly named *family group therapy*.

Palo Alto

The Bateson group stumbled into family therapy by accident. Once they began to interview schizophrenic families in 1954, hoping to decipher their patterns of communication, project members found themselves drawn into helping roles by the pain of these unhappy people (Jackson & Weakland, 1961). Although Bateson was their scientific leader, Don Jackson and Jay Haley were most influential in developing family treatment.

Jackson rejected the psychodynamic concepts he learned in training and focused instead on the dynamics of interchange between persons. Analysis of communication was his primary instrument.

Jackson's concept of **family homeostasis**—families as units that resist change—was to become the defining metaphor of family therapy's early years. In hindsight, we can say that the focus on homeostasis overemphasized the conservative properties of families. At the time, however,

MEET THE THERAPIST **DON JACKSON**

The vibrant and creative talent of Don Jackson led to his prominent place among the founders of family therapy. A graduate of Stanford University School of Medicine, Jackson rejected the psychoanalytic concepts of his training in favor of cybernetics and communication theory, which he used to develop a pragmatic, problem-solving model of therapy. Jackson described problematic patterns of communication in ways that are still useful today.

Jackson's particular genius was in describing how patterns of communication reflect unspoken rules that govern relationships. According to Jackson, the early stage of a relationship is a kind of bargaining game in which the partners work out the rules that will subsequently govern the nature of their relationship. These "marital quid pro quos" are the bases on which the marriage contract will be written. Jackson died in 1968.

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the recognition that families resist change was enormously productive for understanding what keeps patients from improving.

In "Schizophrenic Symptoms and Family Interaction" (Jackson & Weakland, 1959), Jackson illustrated how patients' symptoms preserve stability in their families. In one case, a young woman diagnosed as a catatonic schizophrenic had as her most prominent symptom a profound indecisiveness. When she did act decisively, her parents fell apart. Her mother became helpless and dependent; her father became impotent. In one family meeting, her parents failed to notice when the patient made a simple decision. Only after listening to a taped replay of the session *three times* did the parents finally hear their daughter's statement. The patient's indecision was neither crazy nor senseless; rather, it protected her parents from facing their own conflicts. This is one of the earliest published examples of how psychotic symptoms can be meaningful in the family context. This article also contains the shrewd observation that children's symptoms are often an exaggerated version of their parents' problems.

Another construct important to Jackson's thinking was the dichotomy between *symmetrical* and *complementary* relationships. (Like so many of the seminal ideas of family therapy, this one was first articulated by Bateson.) **Complementary relationships** are those in which partners are different in ways that fit together, like pieces of a jigsaw puzzle: If one is logical, the other is emotional; if one is weak, the other is strong. **Symmetrical relationships** are based on similarity. Marriages between two partners who both have careers and share housekeeping chores are symmetrical. (Incidentally, if you actually find a couple who share housekeeping equally, you'll know you're not in Kansas anymore, Dorothy!)

Jackson's **family rules** hypothesis was based on the observation that within any committed unit (dyad, triad, or larger group), there are redundant behavior patterns. Rules (as students of philosophy learn when studying determinism) can describe regularity, rather than regulation. A corollary of the rules hypothesis was that family members use only a fraction of behavior available to them. This seemingly innocent fact is what makes family therapy so useful.

Jackson's therapeutic strategies were based on the premise that psychiatric problems resulted from the way people behave with each other. In order to distinguish functional interactions from those that were dysfunctional (*problem maintaining*), he observed when problems occurred and in what context, who was present, and how people responded to the problem. Given the assumption that symptoms are homeostatic mechanisms, Jackson would wonder out loud how a family might be worse off if the problem got solved. An individual might want to get better, but the family may need someone to play the sick role. Even positive change can be a threat to the defensive order of things.

A father's drinking, for example, might keep him from making demands on his wife or disciplining his children. Unfortunately, some family therapists jumped from the observation that symptoms may serve a purpose to the assumption that some families *need* a sick member, which, in turn, led to a view of parents victimizing **scapegoated** children. Despite the fancy language, this approach was in the time-honored tradition of blaming parents for the failings of their children. If a six-year-old misbehaves around the house, perhaps we should look to his parents. But a husband's drinking isn't necessarily his wife's fault; and it certainly wasn't fair to imply that families were responsible for the schizophrenic symptoms of their children.

The great discovery of the Bateson group was that there is no such thing as a simple communication; every message is qualified by another message on another level. In *Strategies of Psychotherapy*, Jay Haley (1963) explored how covert messages are used in the struggle for control that characterizes many relationships. Symptoms, he argued, represent an incongruence between levels of communication. The symptomatic person does something, such as touching a doorknob six times before turning it, while at the same time denying that he's *really* doing it. He can't help it; it's his illness. Meanwhile, the person's symptoms—over which he has no control—have consequences. A person with a compulsion of such proportions can hardly be expected to hold down a job, can he?

Because symptomatic behavior wasn't reasonable, Haley didn't rely on reasoning with patients to help them. Instead, therapy became a strategic game of cat and mouse.

Haley (1963) defined therapy as a directive form of treatment and acknowledged his debt to Milton Erickson, with whom he studied hypnosis. In what he called *brief therapy*, Haley zeroed in on the context and possible function of the patient's symptoms. His first moves were designed to gain control of the therapeutic relationship. Haley cited Erickson's device of advising patients that in the first interview they may be willing to say some things and other things they'll want to withhold, and that these, of course, should be withheld. Here the therapist is directing patients to do precisely what they would do anyway and thus subtly gaining the upper hand.

The decisive techniques in brief therapy were *directives*. As Haley put it, it isn't enough to explain problems to patients; what counts is getting them to *do* something about them.

One of Haley's patients was a freelance photographer who compulsively made silly blunders that ruined every picture. Eventually, he became so preoccupied with

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avoiding mistakes that he was too nervous to take pictures at all. Haley instructed the man to go out and take three pictures, making one deliberate error in each. The paradox here is that you can't accidentally make a mistake if you are doing so deliberately.

In another case, Haley told an insomniac that if he woke up in the middle of the night he should get out of bed and wax the kitchen floor. Instant cure! The cybernetic principle here: People will do anything to get out of housework.

Another member of the Palo Alto group who played a leading role in family therapy's first decade was Virginia Satir, one of the great charismatic healers. Known more for her clinical artistry than for theoretical contributions, Satir's impact was most vivid to those lucky enough to see her in action. Like her confreres, Satir was interested in communication, but she added an emotional dimension that helped counterbalance what was otherwise a relatively calculated approach.

Satir saw troubled family members as trapped in narrow roles, like *victim*, *placater*, *defiant one*, and *rescuer*, that constrained relationships and sapped self-esteem. Her concern with freeing family members from the grip of such life-constricting roles was consistent with her major focus, which was always on the individual. Thus, Satir was a humanizing force in the early days of family therapy, when others were so enamored of the systems metaphor that they neglected the emotional lives of families.

Satir was justly famous for her ability to turn negatives into positives. In one case, cited by Lynn Hoffman (1981), Satir interviewed the family of a local minister, whose teenage son had gotten two of his classmates pregnant. On one side of the room sat the boy's parents and siblings. The boy sat in the opposite corner with his head down. Satir introduced herself and said to the boy, "Well, your father has told me a lot about the situation on the phone, and I just want to say before we begin that we know one thing for sure: We know you have good seed." The boy looked up in amazement as Satir turned to the boy's mother and asked brightly, "Could you start by telling us your perception?"

Murray Bowen

Like many of the founders of family therapy, Murray Bowen was a psychiatrist who specialized in schizophrenia. Unlike others, however, he emphasized theory more than techniques, and to this day Bowen's theory is the most fertile system of ideas in family therapy.

Bowen began his clinical work at the Menninger Clinic in 1946, where he studied mothers and their schizophrenic children. His major interest at the time was mother–child symbiosis, which led to his concept of **differentiation of self** (autonomy and levelheadedness). From Menninger, Bowen moved to the National Institute of Mental Health (NIMH), where he developed a project to hospitalize whole families with schizophrenic members. It was this project that expanded the concept of mother–child symbiosis to include the role of fathers and led to the concept of relationship **triangles** (diverting conflict between two people by involving a third).

Beginning in 1955, when Bowen started bringing family members together to discuss their problems, he was struck by their **emotional reactivity**. Feelings overwhelmed reason. Bowen felt the family's tendency to pull him into the center of this **undifferentiated family ego mass**, and he had to make a concerted effort to remain objective (Bowen, 1961). The ability to remain neutral and focus on the process, rather than the content, of family discussions is what distinguishes a therapist from a participant in a family's drama.

To control the level of emotion, Bowen encouraged family members to talk to him, not to each other. He found that it was easier for family members to listen without becoming reactive when they spoke to the therapist instead of to each other.

Bowen discovered that therapists weren't immune from being sucked into family conflicts. This awareness led to his greatest insight. Whenever two people are struggling with conflict they can't resolve, there is an automatic tendency to involve a third party. In fact, as Bowen came to believe, a triangle is the smallest stable unit of relationship.

A husband who can't stand his wife's habitual lateness, but who also can't stand up and tell her so, may start complaining to his children. His complaining may let off steam, but the very process of complaining to a third party makes him less likely to address the problem at its source. We all complain about other people from time to time, but what Bowen realized was that this triangling process is destructive when it becomes a regular feature of a relationship.

Another thing Bowen discovered about triangles is that they spread out. In the following case, a family became entangled in a whole labyrinth of triangles.

CASE STUDY: MRS. MCNEIL

One Sunday morning, "Mrs. McNeil," who was anxious to get the family to church on time, yelled at her nine-year-old son to hurry up. When he told her to "quit bitching," she slapped him. At that point her fourteen-year-old daughter, Megan, grabbed her, and the two of them started wrestling. Then Megan ran next door to her friend's house. When the friend's parents noticed that she had a cut lip and Megan told them what happened, they called the police.

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(Case Study continued)

One thing led to another, and by the time the family came to therapy, the following triangles were in place: Mrs. McNeil, who'd been ordered out of the house by a family court judge, was allied with her lawyer against the judge; she also had an individual therapist who joined her in thinking she was being hounded unfairly by the child protective workers. The nine-year-old was still mad at his mother, and his father supported him in blaming her for flying off the handle. Mr. McNeil, who was a recovering alcoholic, formed an alliance with his sponsor, who felt that Mr. McNeil was on his way to a breakdown unless his wife started being more supportive. Meanwhile, Megan had formed a triangle with the neighbors, who thought her parents shouldn't be allowed to have children. In short, everyone had an advocate—everyone, that is, except the family unit.

In 1966, an emotional crisis occurred in Bowen's family that led him to initiate a personal voyage of discovery that turned out to be as significant for Bowen's theory as Freud's self-analysis was for psychoanalysis.

As an adult, Bowen, the oldest of five children from a tightly knit rural family, kept his distance from his parents and the rest of his extended family. Like many of us, he mistook avoidance for emancipation. But as he later realized, unfinished emotional business stays with us, making us vulnerable to repeat conflicts we never worked out with our families.

Bowen's most important achievement was detriangling himself from his parents, who'd been accustomed to complaining to him about each other. Most of us are flattered to receive such confidences, but Bowen came to recognize this triangulation for what it was. When his mother complained about his father, he told his father: "Your wife told me a story about you; I wonder why she told me instead of you." Naturally, his father mentioned this to his mother, and naturally, she was not pleased.

Although his efforts generated the kind of emotional upheaval that comes of breaking family rules, Bowen's maneuver was effective in keeping his parents from trying to get him to take sides—and made it harder for them to avoid discussing things between themselves. Repeating what someone says to you about someone else is one way to stop triangling in its tracks.

Through his efforts in his own family, Bowen discovered that differentiation of self is best accomplished by developing person-to-person relationships with as many members of the family as possible. If visiting is difficult, letters and phone calls can help reestablish relationships, particularly if they're personal and intimate. Differentiating one's self from one's family is completed when these relationships are maintained without becoming emotionally reactive or taking part in triangles.

Nathan Ackerman

Nathan Ackerman was a child psychiatrist whose pioneering work with families remained faithful to his psychoanalytic roots. Although his interest in intrapsychic conflict may have seemed less innovative than the Palo Alto group's communication theory, he had a keen sense of the overall organization of families. Families, Ackerman said, may give the appearance of unity, but underneath they are split into competing factions. This you may recognize as similar to the psychoanalytic model of individuals who, despite apparent unity of personality, are actually minds in conflict, driven by warring drives and defenses.

Ackerman joined the staff of the Menninger Clinic and in 1937 became chief psychiatrist of the Child Guidance Clinic. At first he followed the child guidance model, having a psychiatrist treat the child and a social worker see the mother. By the mid-1940s, he began to experiment with the same therapist seeing both. Unlike Bowlby, Ackerman did more than use these conjoint sessions as a temporary expedient; instead, he began to see the family as the basic unit of treatment.

In 1955, Ackerman organized the first session on family diagnosis at a meeting of the American Orthopsychiatric Association. At that meeting, Jackson, Bowen, Wynne, and Ackerman learned about each other's work and joined in a sense of common purpose. Two years later, Ackerman opened the Family Mental Health Clinic of Jewish Family Services in New York City and began teaching at Columbia University. In 1960, he founded the Family Institute, which was renamed the Ackerman Institute following his death in 1971.

Although other family therapists downplayed the psychology of individuals, Ackerman was as concerned with what goes on inside people as with what goes on between them. He never lost sight of feelings, hopes, and desires. In fact, Ackerman's model of the family was like the psychoanalytic model of individuals writ large; instead of conscious and unconscious issues, Ackerman talked about how families confront some issues while avoiding others, particularly those involving sex and aggression. He saw his job as a therapist as bringing family secrets out into the open.

To encourage families to relax their emotional restraint, Ackerman himself was unrestrained. He sided first with one member of a family and then with another. He didn't think it was necessary—or possible—to always be neutral; instead, he believed that balance was achieved in the long run by moving back and forth, giving support now

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MEET THE THERAPIST

NATHAN ACKERMAN

Nathan Ackerman's ability to understand families enabled him to look beyond behavioral interactions and into the hearts and minds of each family member. He used his forceful personality to uncover a family's defenses and allow their feelings, hopes, and desires to surface. Ackerman's psychoanalytic training is evident in his contributions and theoretical approach to family therapy. Ackerman proposed that underneath the apparent unity of families there existed a layer of intrapsychic conflict that divided family members into factions.

Together with Don Jackson, Ackerman founded the first family therapy journal, *Family Process*, which is still the leading journal of ideas in the field.

to one, later to another family member. At times, he was unabashedly blunt. If he thought someone was lying, he said so. To critics who suggested this directness might generate too much anxiety, Ackerman replied that people get more reassurance from honesty than from false politeness.

Carl Whitaker

Even among the iconoclastic founders of family therapy, Carl Whitaker stood out as the most irreverent. His view of psychologically troubled people was that they were frozen into devitalized routines (Whitaker & Malone, 1953). Whitaker turned up the heat. His "Psychotherapy of the Absurd" (Whitaker, 1975) was a blend of warm support and emotional goading, designed to loosen people up and help them get in touch with their experience in a deeper, more personal way.

Given his inventive approach to therapy, it isn't surprising that Whitaker became one of the first to experiment with family treatment. In 1943 he and John Warkentin, working in Oakridge, Tennessee, began including spouses and eventually children in treatment. Whitaker also pioneered the use of cotherapy in the belief that a supportive partner helped free therapists to react without fear of countertransference.

Whitaker never seemed to have an obvious strategy, nor did he use predictable techniques, preferring, as he said, to let his unconscious run the therapy (Whitaker, 1976). Although his work seemed totally spontaneous, even outrageous at times, it had a consistent theme. All of his interventions promoted flexibility. He didn't so much push families to change in a particular direction as he challenged them to open up—to become more fully themselves and more fully together.

In 1946, Whitaker became chairman of the department of psychiatry at Emory University, where he continued to experiment with family treatment with a special interest in schizophrenics and their families. During this period, Whitaker organized a series of forums that led to the first major convention of the family therapy movement. Beginning in 1946, Whitaker and his colleagues began twice-yearly conferences during which they observed and discussed each other's work with families. The group found these sessions enormously helpful, and mutual observation, using one-way vision screens, became one of the hallmarks of family therapy.

Whitaker resigned from Emory in 1955 and entered private practice, where he and his partners at the Atlanta Psychiatric Clinic developed an *experiential* form of psychotherapy, using a number of highly provocative techniques in the treatment of families, individuals, groups, and couples (Whitaker, 1958).

During the late 1970s, Whitaker seemed to mellow and added a greater understanding of family dynamics to his shoot-from-the-hip interventions. In the process, the former wild man of family therapy became one of its elder statesmen. Whitaker's death in April 1995 left the field with a piece of its heart missing.

Ivan Boszormenyi-Nagy

Ivan Boszormenyi-Nagy, who came to family therapy from psychoanalysis, was one of the seminal thinkers in the movement. In 1957, he founded the Eastern Pennsylvania Psychiatric Institute in Philadelphia, where he attracted a host of highly talented colleagues. Among these were James Framo, one of the few psychologists in the early family therapy movement, and Geraldine Spark, a social worker who worked with Boszormenyi-Nagy as cotherapist and coauthor of *Invisible Loyalties* (Boszormenyi-Nagy & Spark, 1973).

Boszormenyi-Nagy went from being an analyst, prizing confidentiality, to a family therapist dedicated to openness. His most important contribution was to add ethical accountability to the usual therapeutic goals and techniques. According to Boszormenyi-Nagy, neither pleasure nor expediency is a sufficient guide to human behavior. Instead, he believed that family members should base their relationships on trust and loyalty and that they must balance the ledger of entitlement and indebtedness. He died in 2008.

Salvador Minuchin

When Minuchin first burst onto the scene, it was the drama of his clinical interviews that people found captivating.

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This compelling man with an elegant Latin accent would seduce, provoke, bully, or bewilder families into changing—as the situation required. But even Minuchin's legendary flair didn't have the same galvanizing impact as the practical simplicity of his structural model.

Minuchin began his career as a family therapist in the early 1960s when he discovered two patterns common to troubled families: Some are *enmeshed*—chaotic and tightly interconnected; others are *disengaged*—isolated and seemingly unrelated. Both types lack clear lines of authority. Enmeshed parents are too entangled with their children to exercise leadership; disengaged parents are too distant to provide effective support.

Family problems are tenacious and resistant to change because they're embedded in powerful but unseen structures. Take, for example, a mother futilely remonstrating with a willful child. The mother can scold, punish, or reward, but as long as she's enmeshed (overly involved) with the child, her efforts will lack force because she lacks authority. Moreover, because the behavior of one family member is always related to that of others, the mother will have trouble stepping back as long as her husband remains uninvolved.

Once a social system such as a family becomes structured, attempts to change the rules constitute what family therapists call **first-order change**—change within a system that itself remains invariant. For the mother in the previous example to start practicing stricter discipline would be an example of first-order change. The enmeshed mother is caught in an illusion of alternatives. She can be strict or lenient; the result is the same because she remains trapped in a triangle. What's needed is **second-order change**—a change of the system itself.

Minuchin worked out his ideas while struggling with the problems of juvenile delinquency at the Wiltwyck School for Boys in New York. Family therapy with urban slum families was a new development, and publication of his discoveries (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967) led to his being invited to become the director of the Philadelphia Child Guidance Clinic in 1965. Minuchin brought Braulio Montalvo and Bernice Rosman with him, and they were joined in 1967 by Jay Haley. Together they transformed a traditional child guidance clinic into one of the great centers of the family therapy movement.

In 1981, Minuchin moved to New York and established what is now known as the Minuchin Center for the Family, where he pursued his dedication to teaching family therapists from all over the world. He also continued to turn out a steady stream of the most influential books in the field. His 1974 *Families and Family Therapy* is deservedly the most popular book in the history of family therapy, and his 1993 *Family Healing* contains some of the most moving descriptions of family therapy ever written. Minuchin died in 2017.

Other Early Centers of Family Therapy

In New York, Israel Zwerling and Marilyn Mendelsohn organized the Family Studies Section at Albert Einstein College of Medicine. Andrew Ferber was named director in 1964, and later Philip Guerin, a protégé of Murray Bowen, joined the section. Nathan Ackerman served as a consultant, and the group assembled an impressive array of family therapists with diverse orientations. These included Chris Beels, Betty Carter, Monica McGoldrick, Peggy Papp, and Thomas Fogarty. Philip Guerin became director of training in 1970, and shortly thereafter, in 1973, he founded the Center for Family Learning in Westchester, where he and Thomas Fogarty developed one of the finest family therapy training programs in the nation.

In Galveston, Texas, Robert MacGregor and his colleagues developed *multiple impact therapy* (MacGregor, 1967). It was a case of necessity being the mother of invention. MacGregor's clinic served a population scattered widely over southeastern Texas, and many of his clients had to travel hundreds of miles. Therefore, to have maximum impact in a short time, MacGregor assembled a team of professionals who worked intensively with the families for two full days. Although few family therapists have used such marathon sessions, the team approach continues to be one of the hallmarks of the field.

In Boston, the two most significant early contributions to family therapy were both in the experiential wing of the movement. Norman Paul developed an *operational mourning* approach designed to resolve impacted grief, and Fred and Bunny Duhl set up the Boston Family Institute, where they developed *integrative family therapy*.

In Chicago, the Family Institute of Chicago and the Institute for Juvenile Research were important centers of the early scene in family therapy. At the Family Institute, Charles and Jan Kramer developed a clinical training program that was later affiliated with Northwestern University Medical School. The Institute for Juvenile Research also mounted a training program under the leadership of Irv Borstein, with the consultation of Carl Whitaker.

The work of Nathan Epstein and his colleagues, first formulated in the department of psychiatry at McMaster University in Hamilton, Ontario, was a problem-centered approach (Epstein, Bishop, & Baldarin, 1981). The McMaster model goes step by step—elucidating the problem, gathering data, considering alternative resolutions,

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and assessing the learning process—to help families understand their interactions and build on their newly acquired coping skills. Epstein later relocated to Brown University in Providence, Rhode Island.

Important developments in family therapy also occurred outside the United States. Robin Skynner (1976) introduced psychodynamic family therapy at the Institute of Family Therapy in London. British psychiatrist John Howells (1971) developed a system of family diagnosis as a necessary step for planning therapeutic intervention. West German Helm Stierlin (1972) integrated psychodynamic and systemic ideas for treating troubled adolescents. In Rome, Maurizio Andolfi worked with families early in the 1970s and founded, in 1974, the Italian Society for Family Therapy; Mara Selvini Palazzoli and her colleagues founded the Institute for Family Studies in Milan in 1967.

Figure 1.2 summarizes the major events in family therapy. Now that you've seen how family therapy emerged in several different places at once, we hope you haven't lost sight of one thing: There is a tremendous advantage to seeing how people's behavior makes sense in the context of their families. Meeting with a family for the first time is like turning on a light in a dark room.

THE GOLDEN AGE OF FAMILY THERAPY

In their first decade, family therapists had all the bravado of new kids on the block. "Look at this!" Haley and Jackson and Bowen seemed to say when they discovered how the whole family was implicated in the symptoms of individual patients. While they were struggling for legitimacy, family clinicians emphasized their common beliefs and downplayed their differences. Troubles, they agreed, came in families. But if the watchword of the 1960s was "Look at this"—emphasizing the leap of understanding made possible by seeing whole families together—the rallying cry of the 1970s was "Look what I can do!" as the new kids flexed their muscles and carved out their own turf.

The period from 1970 to 1985 saw the flowering of the classic schools of family therapy when the pioneers established training centers and worked out the

1946	Bowen at Menninger Clinic, Whitaker at Emory, Bateson at Harvard
1948	Whitaker begins family conferences on schizophrenia
1949	Bowlby "The Study and Reduction of Group Tensions in the Family"
1950	Bateson begins work at Palo Alto, VA
1952	Bateson receives grant to study communication in Palo Alto
	Lyman Wynne at NIMH
1956	Bateson, Jackson, Haley, & Weakland "Toward a Theory of Schizophrenia"
1957	Boszormenyi-Nagy opens a family therapy clinic in Philadelphia
1960	Family Institute founded by Nathan Ackerman (renamed the Ackerman Institute in 1971)
	Minuchin begins doing family therapy at Wiltwyck
1965	Minuchin becomes director of Philadelphia Child Guidance Clinic
1967	Henry Dicks *Marital Tensions*
1973	Phil Guerin opens Center for Family Learning in Westchester, NY
1976	Jay Haley opens Family Therapy Institute in Washington, DC
1989	Nancy Boyd-Franklin *Black Families in Therapy*
1992	Monica McGoldrick opens Family Institute of New Jersey
2003	Greenan & Tunnell *Couple Therapy with Gay Men*
2006	Minuchin, Nichols, & Lee *Assessing Families and Couples*
2010	Sprenkle, Davis, & Lebow *Common Factors in Couple and Family Therapy*

FIGURE 1.2 Major Events in the History of Family Therapy

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implications of their models. The leading approach in the 1960s was the *communications model* developed in Palo Alto. The book of the decade was Watzlawick, Beavin, and Jackson's *Pragmatics of Human Communication*, the text that introduced the systemic version of family therapy. The model of the 1980s was *strategic therapy*, and the books of the decade described its three most vital approaches: *Change*, by Watzlawick, Weakland, and Fisch;[1] *Problem-Solving Therapy*, by Jay Haley; and *Paradox and Counterparadox*, by Mara Selvini Palazzoli and her Milan associates. The 1970s belonged to Salvador Minuchin. His *Families and Family Therapy* and the simple yet compelling model of *structural family therapy* it described dominated the decade.

Structural theory seemed to offer just what family therapists were looking for: a simple way of describing family organization and a set of easy-to-follow steps to treatment. In hindsight, we might ask whether the impressive power of Minuchin's approach was a product of the method or the man. (The answer is, probably a little of both.) In the 1970s, however, the widely shared belief that structural family therapy could be learned easily drew people from all over the world to what was for a decade the epicenter of the family therapy movement: the Philadelphia Child Guidance Clinic.

The strategic therapy that flourished in the 1980s was centered in three unique and creative groups: the Palo Alto Mental Research Institute's brief therapy group, including John Weakland, Paul Watzlawick, and Richard Fisch; Jay Haley and Cloe Madanes, codirectors of the Family Therapy Institute of Washington, DC; and Mara Selvini Palazzoli and her colleagues in Milan. But the leading influence in the decade of strategic therapy was exerted by Milton Erickson, albeit from beyond the grave.

Erickson's genius was much admired and much imitated. Family therapists came to idolize Erickson the way we as children idolized Captain Marvel. We'd come home from Saturday matinees all pumped up, get out our toy swords, put on our magic capes—and presto! *We* were superheroes. We were just kids and so we didn't bother translating our heroes' mythic powers into our own terms. Unfortunately, many of those starstruck by Erickson's legendary therapeutic tales did the same thing. Instead of grasping the principles on which they were predicated, many therapists just tried to imitate his "uncommon techniques." To be any kind of competent therapist, you must keep your psychological distance from the supreme artists—the Salvador Minuchins, the Milton Ericksons, the Michael Whites. Otherwise, you end up aping the magic of their styles rather than understanding the substance of their ideas.

[1]Although actually published in 1974, this book and its sequel, *The Tactics of Change*, were most widely read and taught in the 1980s.

CASE STUDY: DEVELOPING YOUR OWN APPROACH TO THERAPY

One of us (S.D.) was a nervous wreck when he started seeing clients. How was he going to know what to say? Maybe the answer was to study the experts, to learn to do what they did. So each week he set out to apply what he'd seen to his own clients. Unfortunately, the more he tried to apply what he'd seen the master therapists doing, the worse his sessions seemed to go.

One of his mentors was a therapist who always seemed to know exactly what to say. For two semesters, he tried to discover the secrets of her success. "What's your favorite theory?" "Which are your most effective interventions?" and "What books should I read?" When he asked what she would do with a particular family, she said "I have no idea. I'd listen to them and see where it went." There had to be more to it than that.

In fact, there was more to it than that. In the next months he learned a lot about how families function, how they get stuck, and how to help them get unstuck. But he also learned to be himself in therapy. The great therapists he'd admired knew what they were doing, but they were also being themselves.

Reflect and Apply

1. Is therapy more of an art or a science?
2. What are the risks of trying to imitate other therapists?
3. How does a therapist's personality and theoretical knowledge interact in effective therapy?
4. How can you learn from observing others without submerging your own style and personality?

Part of what made Jay Haley's strategic directives so attractive was that they were a wonderful way to gain control over people—for their own good—without the usual frustration of trying to convince them to do the right thing. (Most people already know what's good for them. The hard part is getting them to *do* it.) So, for example, in the case of a person who is bulimic, a strategic directive might be for the patient's family to set out a mess of fried chicken,

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french fries, cookies, and ice cream. Then, with the family watching, the patient would mash up all the food with her hands, symbolizing what goes on in her stomach. After the food was reduced to a soggy mess, she would stuff it into the toilet. Then when the toilet clogged, she would have to ask the family member she resented most to unclog it. This task would symbolize not only what the person with bulimia does to herself but also what she puts the family through (Madanes, 1981).

What the strategic camp added to Erickson's creative problem solving was a simple framework for understanding how families got stuck in their problems. According to the Mental Research Institute (MRI) model, problems develop and persist from mismanagement of ordinary life difficulties. The original difficulty becomes a problem when mishandling leads people to get stuck in more-of-the-same solutions. It was a perverse twist on the old adage, "If at first you don't succeed, try, try again."

The Milan group built on the ideas pioneered at MRI, especially the use of the therapeutic double bind, or what they referred to as *counterparadox*. Here's an example from *Paradox and Counterparadox* (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978). The authors describe a counterparadoxical approach to a six-year-old boy and his family. At the end of the session, young Bruno was praised for acting crazy to protect his father. By occupying his mother's time with fights and tantrums, the boy generously allowed his father more time for work and relaxation. Bruno was encouraged to continue doing what he was already doing, lest this comfortable arrangement be disrupted.

The appeal of the strategic approach was pragmatism. Making use of the cybernetic metaphor, strategic therapists zeroed in on how family systems were regulated by negative feedback. They achieved results simply by disrupting the interactions that maintained symptoms. What eventually turned therapists off to these approaches was their gamesmanship. Their interventions were transparently manipulative. The result was like watching a clumsy magician—you could see him stacking the deck.

Meanwhile, as structural and strategic approaches rose and fell in popularity, four other models of family therapy flourished quietly. Though they never took center stage, *experiential*, *psychoanalytic*, *behavioral*, and *Bowenian* models grew and prospered. Although these schools never achieved the cachet of family therapy's latest fads, each of them produced solid clinical approaches, which will be examined at length in subsequent chapters.

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Essential Highlights

- For many years, therapists avoided patients' relatives in order to safeguard the privacy of the therapeutic relationship. Freudians excluded the real family to uncover the unconscious, introjected family; Rogerians kept relatives away to provide unconditional positive regard; and hospital psychiatrists discouraged family visits because they might disrupt the benign milieu of the hospital.
- Several discoveries in the 1950s led to a new view—namely, that the family was a living system, an organic whole. Although practicing clinicians in hospitals and child guidance clinics paved the way for family therapy, the most important breakthroughs were achieved by workers who were scientists first, healers second. In Palo Alto, Gregory Bateson, Jay Haley, and Don Jackson discovered that people with schizophrenia weren't crazy in some meaningless way; their behavior was understandable in the context of their families. Murray Bowen's observation of how mothers and their offspring with schizophrenia go through cycles of closeness and distance was the forerunner of the *pursuer–distancer* dynamic.
- These observations launched the family therapy movement, but the excitement they generated blurred the distinction between what researchers observed and what they concluded. What they observed was that the behavior of people with schizophrenia *fit* with their families; what they concluded was that the family must be the *cause* of schizophrenia. A second conclusion was even more influential. Family dynamics—double binds, pseudomutuality, undifferentiated family ego mass—began to be seen as products of a system rather than as features of persons who share certain qualities because they live together. Thus was born a new creature, the *family system*.
- Who was the first to practice family therapy? As in every field, there were visionaries who anticipated the development of family therapy. Freud, for example,

treated "Little Hans" by working with his father as early as 1908. Such experiments, however, weren't sufficient to challenge the authority of individual therapy until the climate of the times was receptive. In the early 1950s, family therapy was begun independently in four different places: by John Bell at Clark University, Murray Bowen at NIMH, Nathan Ackerman in New York, and Don Jackson and Jay Haley in Palo Alto.

- These pioneers had distinctly different backgrounds and, not surprisingly, the approaches they developed were also quite different. In addition to those just mentioned, others who made significant contributions to the founding of family therapy were Lyman Wynne, Virginia Satir, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin.
- What we've called family therapy's golden age—the flowering of the schools in the 1970s and 1980s—was the high-water mark of our self-confidence. Armed with Haley's or Minuchin's latest text, therapists set off with a sense of mission. What drew them to activist approaches was certainty and charisma. What soured them was hubris. To some, structural family therapy—at least as they had seen it demonstrated at workshops—began to seem like bullying. Others saw the cleverness of the strategic approach as manipulative. Families were described as stubborn; they couldn't be reasoned with. Therapists got tired of that way of thinking.
- In the early years, family therapists were animated by confidence and conviction. Today, in the wake of managed care and biological psychiatry, we're less sure of ourselves. What has emerged is "a more participatory, more culturally and gender sensitive, and a more collaborative set of methods that builds on a set of common factors with a stronger evidence base" (Lebow, 2014, p. 368).
- All the complexity of the family therapy field should not obscure its basic premise: The family is the context of human problems. Like all human groups, the family has emergent properties—the whole is greater than the sum of its parts.
- No matter how many and varied the explanations of these emergent properties are, they all fall into two categories: *structure* and *process*. The structure of families includes *triangles*, *subsystems*, and *boundaries*. Among the processes that describe family interaction—*emotional reactivity*, *dysfunctional communication*, and so on—the central concept is *circularity*. Rather than worrying about who started what, family therapists treat human problems as a series of moves and countermoves, in repeating cycles.

Sample pages

Review Questions

1. Briefly describe the clinical forerunners of family therapy.
2. What did researchers on family dynamics and schizophrenia learn that led the way to family therapy?
3. Who were the founders of family therapy, and what were each one's major ideas?
4. How has the field of family therapy changed from its golden age until today?

Reflection Questions

1. What are some practical applications contemporary therapists could draw from the work of John Bell, the Palo Alto Group, Murray Bowen, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin?
2. What are some applications for everyday life that you could draw from the theories and techniques of John Bell, the Palo Alto Group, Murray Bowen, Carl Whitaker, Ivan Boszormenyi-Nagy, and Salvador Minuchin?
3. What are some pros and cons of segregating hospitalized mental patients from their families?
4. What are some of the "basic assumptions" operating in groups of which you have been a part?
5. What role did you play in your family growing up? What potential roles went unnoticed or unfulfilled?