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Assessing Families and Couples: From Symptom to System

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CHAPTER 1: Introduction: A Four-Step Model for Assessing Families and Couples

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CHAPTER

1

Introduction: A Four-Step Model for Assessing Families and Couples

A Short Review of the Evolution of Family Therapy

The pioneers of family therapy taught us to see beyond individual personalities to the patterns that make them a family—an organization of interconnected lives governed by strict but unspoken rules.

Since the time of Bateson, Bowen, and Ackerman, however, the field has evolved from its original emphasis on family interactions to focus on the narrative construction of experience—in short, from interpersonal relationships to individual cognition. This progression is puzzling when you consider that the great innovation of family systems theory was the discovery that people’s lives are inextricably intertwined and that the behavior of family members is, to a great extent, a function of the way they interact with one another.

The various therapies based on this premise were directed at changing the organization of the family. We thought then that when the family organization was transformed, the life of every family member would be altered accordingly. Family therapy flourished not only because of its effectiveness, but also because it helped us rediscover the fundamental interconnectedness of the human condition: What family systems theory taught us was that the family is more than a collection of individuals; it is a system, an organized whole whose parts function in a way that transcends their separate characteristics.

We learned to see the unity of the system by blurring our focus on personalities in order to see the whole. Unfortunately, in the process of stepping back to see the system, family therapists sometimes lost sight of the individual human beings that make up a family. Although it isn’t possible to understand people without taking their social context into account, notably the family, it was misleading to limit our focus to the surface of interactions—to social behavior divorced from inner experience.

Family therapy’s bridge to the twenty-first century was social constructionism—the idea that our experience is a function of the way we articulate events—that is, the stories with which we describe our experience. This shift from behavior to cognition opened a new world of possibilities.

The narrative approach that now dominates family therapy is a perfect expression of the postmodern revolution. When all knowledge is regarded as constructed rather than discovered, it's fitting that the leading approach to family therapy is concerned with the ways people create meaning rather than the way they behave. Unfortunately, in the process of rediscovering individuals and their inner experience, postmodern approaches have tended to lose sight of families and their relationships.

One reason the field gravitated from family interaction to individual cognition was that we got away from the study of families in order to concentrate on techniques for changing them. Inspired by Bateson's scientific commitment to observation and study, the first family therapists spent a good deal of time watching and listening. They were willing to observe and learn about families because they were in terra incognita. Unfortunately, as they became more concerned with therapeutic techniques than with understanding families, family therapists got away from this receptive openness. Change, the dynamics of change, the expansion of voices and meaning, became the focus, while the psychological organization, the interconnection of the people who created the meaning and the conversations, were taken for granted, if not ignored altogether.

Another, less benign, reason for the contemporary neglect of families is that there has always been an invidious anti-family undercurrent in family therapy. Therapists first encountered the family as an adversary. The advent of family therapy may have been a scientific advance, but it also had moral and political undertones. Previously, madness was ignored, ostracized, or locked up. Now it was located in the family where responsibility, or blame, could be shared. Family therapists rescued schizophrenics from psychiatric invalidation by demonstrating that their crazy behavior made sense as a desperate solution to a disturbed family situation. It wasn't the patient but the family that was deranged.

In their efforts to make individual family members autonomous agents in their own right, practicing therapists ran smack up against powerful family opposition to growth. The individual might want to get better, but, it was said, the family may need someone to play the "sick" role. Patients became "identified patients"—family scapegoats sacrificed to maintain the family's precarious equilibrium. Family therapists saw themselves as avenging angels bent on rescuing innocent victims by slaying family dragons. The attack on the family found its most strident voice in the 1960s. According to R. D. Laing,¹ the natural child was a prisoner of repressive forces of family and culture. Although Laing's portrayal of the family as villain was dramatized to extremes—"the concentration camp of modern society"—it was consistent with the way many people looked at families.

The Bateson group's observations were meant to be scientific, yet their language for describing family systems was combative, often suggesting not just resistance but willful opposition to change. The concept of the *double bind* led to a view of therapy as the liberation of the individual from the pathological rules of the family. The idea that families were oppositional put therapists in an adversarial stance. Because families were seen as mindless systems, at once rigid (holding fast to their own ways) and slippery (hard to pin down), interviewing them

became a struggle. Even family therapists who got past the idea that patients were innocent victims of malevolent kinfolk often felt themselves in opposition to families who stubbornly resisted efforts to change them. This oppositional quality of families was captured in Bowen's concept of the *undifferentiated family ego mass*,² which threatened to drown the individuality of the self. Even Minuchin's work with *enmeshed families*,³ designed to liberate the triangulated child, as well as the Milan school's concept of *dirty games*⁴ often took on the appearance of an adversarial struggle.

When today's family therapists call for a collaborative approach to families, what they have in mind is getting away from the perceived aggressiveness of earlier approaches. The pioneers first encountered the family as an adversary—"homoeostatic," "resistant"—in part because they approached it with built-in prejudice. Bent on rescuing "family scapegoats," they saw mothers as enemies to be overcome and fathers as peripheral figures to be ignored. When Harlene Anderson and Harry Goolishian⁵ advocated a collaborative approach, what they renounced was the authoritarian model, in which the clinician plays the all-knowing expert to whom the patient looks for answers. In rejecting the cybernetic model—families stuck in dysfunctional feedback loops—postmodern therapists repudiated the idea that families have something wrong with them. Unfortunately, they also turned their backs on the three defining discoveries of family therapy: (1) recognizing that psychological symptoms are often related to family conflict; (2) thinking about human problems as interactional; and (3) treating the family as a unit.

Early versions of family therapy *did* sometimes cast families in a bad light and blame them for their problems. The narrative movement helped shift the field toward partnership with families. In the process of rejecting the patronizing consciousness of that earlier age, however, narrative therapists also rejected systems thinking, emphasizing its mechanistic elements, while ignoring its more humanistic implications.

An Equally Short Review of the Evolution of Structural Family Therapy

What made *Families and Family Therapy*⁶ so well received thirty years ago was that it offered a simple yet comprehensive model for understanding not just the dynamics of interchange between two people (*double bind*, *pursuer-distancer*, and so on) but the organization of the entire family. One of the reasons family therapy can be so difficult is that families often appear as collections of individuals who affect each other in ways that are powerful but not easily understood. Structural family therapy offered a framework that brought order and meaning to those transactions, though in the process it may have erred by ignoring individual dynamics—that is, rejecting the influence of personal history in the construction of family experience and unattended meaning in favor of process. Also, as is true of the field in general, structural family therapy has, over the years, also followed a trajectory from trying to understand families to strategizing how to change them.

In the first book about our work, *Families of the Slums*⁷, the focus was on family organization: the description of subsystems; alliances and coalitions; boundaries differentiating function; and the way in which family members behaved differently in different subsystems as issues of belonging and its miscarriage were played out in the enmeshed or disengaged organization. Therapy was based on an understanding of family organization. The goal of the therapeutic exploration was the discovery of the organization of the family that facilitated certain types of experience and behavior—in particular, which types of family relationships encouraged acting-out behavior in adolescents. Thus accurate assessment was the precondition for intervention.

In *Psychosomatic Families*⁸ the question was what types of family relationships encouraged somatization. Only after we understood the dynamics did we develop techniques to challenge pathological rigidities and encourage new ways of relating and functioning. Once again, assessment was the first priority.

In *Families of the Slums* we posited a *disengaged* type of family organization in which parents either didn't pay attention to their children's behavior or responded with authoritarian control. Action jumped from neglect to violence. The parents' responses depended more on their own mood than on their children's behavior. The lack of predictability of parental responses handicapped children in understanding rules and developing inner control. Control remained the province of the parents and was capricious. I don't know if today we would adhere to all the assumptions we accepted in the 1960s when we wrote *Families of the Slums*, but it is clear that the emphasis of our exploration was on understanding problems before attempting to change them.

In *Psychosomatic Families* we tried to describe the organization of families that produced somatic symptomatology. We posited that these families were *enmeshed*, conflict-avoidant, over-protective, and that parental conflict was detoured via the triangulation of the identified patient. Further research by subsequent investigators questioned some of our descriptions and suggested others. But the power of our interventions was based on our assessment of the entrenched family dynamics and our awareness, in the cases of families with anorexic children, for instance, of the urgency of starvation. The lunch session we developed to challenge the pattern of starvation was guided by our understanding of the family organization and directed toward eliciting conflict between parents and identified patients and toward challenging parental detouring of spouse conflict via the identified patient.

As in our work with acting-out children, the work with anorexics started by observing family functioning, formulating hypotheses about family organization, and then developing techniques to introduce novelty in the relationship among family members. The emphasis on understanding the family was overshadowed later by developing interventions and exploring the therapist's style, the family context, and the organization of agencies that provided services. The field of family therapy was moving in the direction of abandoning the observation of families and focusing on techniques (*circular questioning, hypothesizing, invariant prescription*), issues of therapist authority, and authorship, and lately on the power of stories to give meaning to behavior.

The Therapist's Style 50 Years Later

A therapist's style changes with his or her development as a person and a professional, and in accordance with the times. Being an octogenarian allows me to look at the past, where I see not a seamless trajectory but a journey with pauses; and where I start again, sometimes, after stopping to recognize that I have been traveling with certainty a road that was misleading. It is a path characterized by shedding and starting anew.

Mara Selvini-Palazzoli,⁹ an extraordinary pioneer, had the courage to publicize her mistakes and her new beginnings. Each beginning carried a certainty that was necessary, apparently, to provide the energy for traveling new roads. But then, to the dismay of her students and followers, there was another beginning with the same certainty. Paradoxes were replaced with circular questioning; family games were superseded by invariable prescriptions; while her colleagues Boscolo and Cecchin¹⁰ replaced their approach with a postmodern focus on the construction of meaning.

Likewise, through more than 50 years as a therapist, I have continually refined my style of intervening, while more or less keeping a base of continuity in my thinking. Let me acknowledge, first, that I am an inveterate borrower. I read the work of my colleagues, usually with opinions, seldom with indifference. And I copy. I copied from Virginia Satir and Nathan Ackerman; from Bateson and Haley; from Whitaker, Bowen, Watzlawick, Peggy Papp, and Cloe Madanes. And then from the postmodernists, the Milan group, Harlene Anderson and Harry Goolishian, Michael White and David Epston, Steve deShazer, and many others.

I never felt that any of us had exclusive rights to our ideas. If a therapist's ideas are good, it is his or her gift to the field, and there for the picking. I knew, nonetheless, that when I copied from Carl Whitaker—asking a spouse when he or she “divorced” his or her partner and married the children or golf—I was not impersonating Carl: I was incorporating him, with a Spanish accent and subtleties that were mine, not his.

Life experience tunes the therapy style: Jorge Luis Borges taught me the value of mystery and uncertainty; my mother, the significance of order in life; my father, the distortions of justice, being Jewish, the importance of ethnicity, being an immigrant, the angst of not belonging. Almost forgotten experiences can be rekindled by an encounter with a new family. Once you accept that a therapist is a partial and biased instrument, you recognize the importance of self-knowledge, and you can borrow freely from life. It is part of the use of self that family therapists are trained to focus on.

Of course I also copied myself. I continuously worked through my repertoire of responses. I selected a phrase or a concept that seemed effective in certain situations with some kinds of families and I repeated it in similar circumstances. I tried shading, humor, and emotional tonalities. Those rehearsals occurred spontaneously, and then, to my surprise, emerged as techniques. Finally, they became part of my repertoire, until, like the sword of a Samurai which becomes part of his arm, I wasn't aware that I was using them. A reader of my books may find it entertaining to track how frequently I repeat myself, though always as if I'm spontaneously innovating.

Through decades of practicing therapy, I have moved from being an active challenger—confronting, directing, and controlling—to a softer style, in which I use humor, acceptance, support, suggestion, and seduction on behalf of the same goals I have reached for with the sharper style. I’ve evolved from being directive to being more collaborative, without abandoning my role as an expert; from seeing families and people embedded in their social context to observing family systems and individual psyches, without losing awareness of their mutual influence on each other; and from focusing exclusively on the present to exploring the influence of the past, though always with the goal of facilitating change in the present. These changes have made my style both more complex and differentiated.

Through this evolution, some actions and some phrases have become my trademark. I will share them with you now, hoping that you will borrow from them when it’s appropriate.

Nonverbal Interventions

I use space as an indicator of emotional proximity. For instance, as you will see later, I asked Sara, the young “parentified daughter” I saw in Spain, to move her chair away from her family, as a way of suggesting independence. I do that frequently. I asked the mother in the Austrian family to do the same thing, and at times I ask a disengaged family member to come closer to somebody else. It’s a simple intervention, easy for both adults and children to grasp. And because asking people to move their chairs offers a suggestion without words, family members fill it with their own meaning.

When working with young children, I often ask them to stand up next to their parents, and sometimes I ask parents to pick the child up in their arms. If I’m working with so-called “impossible” young children, I ask them to punch my open palm until they get tired, insisting that they should try really hard. These are graphic ways to remind people that children are not heavyweights; they’re not strong and, compared to their parents, they don’t really have power.

At times, I shake hands with family members to indicate approval of something they’ve said or done; and when I’m working with a rural family, I’m likely to seal a contract for change with a handshake, drawing on my experience of what was binding in the small town where I grew up.

The Use of Metaphor

Metaphors make it possible to challenge family members without making them feel defensive. It’s easier, for example, for a father to hear that he should be gentler with his daughter because “his voice is strong, while hers is soft” than to be told that his domineering manner intimidates her. A well-chosen metaphor can cut through a family’s polite fictions. In families where the children are caught in the conflict between their parents, asking “Who is the sheriff in this family?” make some things very clear, very fast. Following up with, “And is your partner a deputy sheriff or the attorney for the defense?” helps complete the picture.

I try to couch my directives for change in a two-part challenge that I call “a stroke and a kick.” For instance: “You are very clever, but you’re not wise.” Or: “Since you’re so loving and protective, how is it that you don’t see the harm in what you’re saying (or what you’re doing)?” Or: “It’s strange how very concerned families tend to be blind sometimes.” And so on.

As you will see, in more than one case in this book I say, “Love is a golden cage. . . . People don’t realize it’s a cage because it’s golden . . . but it is a cage . . . you can’t fly away.” This kind of intervention has replaced my earlier challenges to enmeshment, which were sometimes heard as an accusation and a demand for change.

About the circular effect of children and parents on each other, I say: “Parents are jailers who are prisoners—and children are prisoners who are jailers.” “Children throw bait and parents bite like fish caught by their children. . . . There is a cycle of fisherman and fish, and you fluctuate from one to the other.”

About people who overextend their availability and are overburdened, like the mother in the Martinez family, I may say, “There is a Hindu goddess (or Mexican or Greek or Christian) who has eight arms. You have only two, but you think you have eight. . . . You don’t know how to ask for help. . . . You don’t delegate.”

The enmeshed parent-and-disengaged-partner dynamic can be brought into focus by asking, “When did you divorce your partner and marry the children?” A variation on this metaphor when there are no children might include something like, “When did you divorce your partner and marry your career (or the tennis racquet)?”

Effective challenges describe what people are doing and its consequences. However, in order for clients to hear what is being pointed out they must not feel scolded. Thus, for example, we often say “That’s interesting . . .” before pointing something out, in order to make it an object of curiosity rather than an occasion for defensiveness.

Moreover, although it’s tempting to tell people what they *should* do, doing so greatly reduces the likelihood of them learning to see what they *are* doing and its consequences.

If I’m working with a couple, I’m apt to say, “You can’t change yourself, but you can change your partner. What are the changes you want him (or her) to go through so your life will be easier?” Then I offer a “magic wand” (in the form of a pencil or something similar) and ask one of them to look at their mate as a sculptor looks at a piece of marble, thinking and talking about the changes that would be necessary. I may comment that in the Yin-Yang you can change the other by changing the context of the whole.

These interventions invite family members to look at themselves as part of a tale told by a mischievous storyteller. Please use and modify them as needed; no prescription is necessary.

At this point, a reader may ask: With all the borrowing from other therapists’ techniques, the evolution of style, and the influence of life experiences that call previous certainties into question, where is the core of structural family therapy and where is “enactment,” which has been a distinctive technique in the tool box of structural therapists? Let me answer the last question first. Enactment developed

out of our distrust of the stories families tell the therapist and of the distortions inherent in the way the therapist listens and responds.

We assumed that family members tell rehearsed stories and that novelty might better come out of conversations and transactions among them, which the therapist can track and keep going. At some point in this process emotional responses interfere with coherence; family members and therapists find themselves in new territories where they can explore new behavior and new meanings.

It seems to us that this technique could be embraced by therapists who are concerned with the collaborative construction of meaning. The truth is that in structural family therapy, enactment has moved up; it is less a technique than a pervasive attitude.

About the core of structural family therapy, I can say that although I changed my style of interviewing, I remained loyal to theoretical concepts I developed in the 1960s: that families are social organisms structured in subsystems separated by boundaries; that the subsystems define the functions of their members; that family members organize themselves into alliances, affiliations, and coalitions; that families develop and go through transitional periods as they change; and so on.

Focusing on the family as the context for understanding the way in which its members develop and modify their conception of self and others and observing the power of the family to influence the experience and the behavior of its members remain at the core of systemic family therapy.

As the field of family therapy has changed over time and corrected its early scotomas, structural family therapy has also developed a new, wider lens that encompasses the individual as a psychological unit, and includes exploration of the past as a way of understanding the present. The four steps described in this book are my way of growing with the field, representing the broader vistas that have come with time, thought, and experience.

A Map for Assessing Families and Giving Directions to Therapy

The map we've developed for assessing families may seem simple, but it is the product of sifting through 50 years of concepts and techniques in family therapy.

In the last decade, I have been giving two-day workshops for large groups in the United States and abroad. In these workshops I have followed a regular format that seemed to work well for the families, the audiences, and myself.

I arrive some days before the workshop and interview two families. I edit tapes that I present the first day and the second day see both families live in a studio that projects the sessions to the audience. In general we (the family and I) manage to present a coherent narrative that seems to take into account the cultural context of the family. I have followed this format in 26 countries, from New Zealand to Japan, Spain to Germany, and Mexico to Argentina, working with a translator in most instances.

I have questioned the nature of the fit between myself and these families from so many diverse cultures. This mutual understanding shouldn't be possible,

because I frequently find myself missing the verbal nuances that are so important in therapy and I have worked in countries where I was totally ignorant of cultural mores. I came to the conclusion that there are two ways of explaining this phenomenon. One would be that I am a master hypnotist, able to convince families in different cultures that my way of looking at their experience is superior to theirs; the other more likely explanation is that all of us, myself included, are subject to common ways of looking at and understanding family relationships, and that I offer to families an organizing framework that seems to explain their plight, and they then use this model and innovate on it, bringing in their own individual ways.

A Four-Step Model of Family Assessment

In working with families, the art of assessment is to discover what stands in the way of a family reaching its goals, and joining with them in a vision of how to get from where they are to where they want to be. We approach this task in four steps: (1) opening up the presenting complaint; (2) highlighting problem-maintaining interactions; (3) a structurally focused exploration of the past; and (4) an exploration of alternative ways of relating.

Step One: Opening Up the Presenting Complaint

The first step is to challenge the family certainty that the primary problem is located in the internal machinery of the individual patient. This is the step that transforms therapy into family therapy. The usual techniques include:

- focusing on areas of competence of the identified patient;
- giving a different meaning to the problem that the family has decided upon (reframing);
- exploring the ways in which the symptom presents itself and paying attention to details;
- looking at the problem from different perspectives until the symptom loses its toxicity;
- exploring the context in which the symptom appears;
- exploring other family members' difficulties, similar to or different from those of the identified patient;
- encouraging the identified patient to describe the symptom and the meaning he or she attributes to it, to describe other aspects of himself or herself, to describe the family, in other words, to give him or her respectful space while the other family members become the audience.

Step Two: Highlighting Problem-Maintaining Interactions

The second step is exploring what family members may be doing to perpetuate the problem. The trick is to help clients see how their actions may be maintaining the problem without provoking resistance.

This step is basic to every intervention in system thinking. In effect, the complementary nature of mutual influence of family members is common knowledge and, therefore, it is never a genuine surprise for family members, who have already asked themselves, aloud or silently, "What have we done?" "What should we do differently?" before crystallizing their initial formulation: "It is within him or her." Paul Watzlawick described this process in his paradox: "The problem is the way the family tries to solve it." Almost always the therapist will find a part, the healing part, of family members ready to ally themselves with the process of helping. As a matter of fact, this second step relies on the assumption that family members will change their pattern of relating if they see themselves as able to help the identified patient.

The techniques in this step vary with therapists but are described in all the books on family therapy, and the reader will encounter them again and again sprinkled throughout the cases in this book.

Step Three: A Structurally Focused Exploration of the Past

The third step is a brief, focused exploration of the past of the adult members of the family in order to help them understand how they came to their present restricted view of themselves and others. This step is new for us, though it has always been part of the psychodynamic approach to therapy. We think that the rejection of past experiences in the basic formation of self was an ideological response of family therapy in their polemic with psychodynamic thinkers and that the field is now mature enough to correct its early partisanship.

Being an octogenarian now, I am aware of the debris of my childhood floating around and influencing my present responses. I know that this is true of you, the readers of this book. The question then resides in the way we intervene in this step. How can we use this exploration of the past in ways that facilitate expansion of the pattern of relating in the present?

We see this step as a continuation of the explorations of the styles of relating that the therapist and family members uncovered in the previous step. Therefore, it is pointed toward specific areas that have been uncovered as creating difficulties. The therapist may start with the question to a family member: "I had seen in the last session that you will not challenge your partner even in situations where it is clear he (or she) is wrong and you disagree with him (or her). What experiences in your childhood organize you to avoid disagreement?" Or, "How did your parents select for you this particular pair of lenses?" Or, "This pair of lenses your parents helped you to select seems to narrow your capacity to engage your partner; can you talk about how it is you chose it in your childhood?" Or, "We saw before that you seem to act as if you have eight arms when in fact you know that your two arms are tired and would like not to be so overworked. How did you select in your childhood this particular orientation toward your relationship with others? Can you talk about this?" One could think about this form of inquiry as originating not only in psychodynamic thinking, but also in the narrative tradition of finding new meaning in old stories.

In the third step the children remain as an audience to their parents' stories. In the fourth step they join their parents as active participants. The fourth step is what makes an assessment not just accurate but useful.

Step Four: An Exploration of Alternative Ways of Relating

After developing an initial picture of what's keeping a family stuck, and how they got that way, the family members and the therapist talk about who needs to change what—and who is willing or unwilling. Without this step, which turns the process of assessment from an operation performed on families into an operation performed with them, therapy often becomes a process of pushing people where they see no reason to go. No wonder they resist.

Although much has been written in the field about therapy techniques, we have not explored sufficiently the process of the therapeutic dance, the movements necessary to produce change. Therapy techniques are only tools used to achieve a specific task. Often, therapists carry a toolbox with all the right tools but lack a map. While it is necessary for a therapist to be equipped with some tools to enter into the family system, the tools become counterproductive if there is no conceptual direction behind their application.

In the new millennium, the need is not for more and better techniques—we already have an ample supply of those. Instead, our aim is to provide a framework broad enough to organize the multitude of ways of conceptualizing and intervening in family problems. In the ten cases we present later, we will try to focus on techniques as part of the process to achieve novelty.

Our four-step model is designed to be useful to therapists of various persuasions as they maneuver through the opening stages of family therapy (See Table 1-1).

The steps in this chart are oversimplified. In navigating these steps, it is necessary to have some understanding of how families are organized, but not to impose one's own pet concepts on them. The aim of assessment must be to discover with families a new and useful way of understanding their dilemmas and to explore their resources to heal themselves.

TABLE 1-1 The Four-Step Model

| Step 1 | Step 2 | Step 3 | Step 4 |
|---|---|--|---|
| Decentralize presenting problem and symptom bearer. | Explore family pattern that maintains presenting problem. | Explore what key family members bring from the past that still influences the present. | Redefine the problem and open up options. |

TABLE 1-2 Expansion of the Four-Step Process

| Understanding Family Organization | Techniques |
|-----------------------------------|-----------------|
| Structure | Joining |
| Boundaries | Enactment |
| Alliances | Listening |
| Coalitions | Mapping |
| Triangulation | Reframing |
| Family Life Cycle | Intensity |
| | Competence |
| | Boundary Making |
| | Unbalancing |

When we tried to assess the usefulness of our instrument with beginning therapists who were graduate students in a family therapy course, the students understood the concept inherent in the first step and knew that they needed to decentralize the identified patient and the problem and move toward interpersonal relationships. But they didn't know how to do it. They realized that they needed to find a language to invite family members to explore this territory. To fill this gap, we taught family organization and how family members are a part of the family system. The map then lost its simplicity because aspects of how to join a family, how to understand family members' stories in the context of family systems, how to maintain curiosity and support family members while challenging family rigidity, how to hear content and see behavior—in sum, how to do therapy—were missing.

One Last Moment of Reflection

Before embarking on a case-by-case application of our model, it might be well to consider a few questions about the whole idea of evaluating families.

Is family therapy the best way to alleviate the pain of an individual family member? Can family therapy have unanticipated consequences for the identified patient, or for other members of the family? Can beneficial changes in a family be considered inappropriate in their social context? In other words, can change be seen as morally, politically, or ideologically wrong?

Gregory Bateson asked similar questions and was leery about the idea of trying to change people. As an anthropologist he was disinclined to make judgments. Therapists, he thought, were taxonomists: They create diagnostic labels and then believe that this is reality.¹¹ Bateson worried about the cultural bias of therapists' assumptions and about the pressures they put on people to accommodate to their version of the way things should be. Such concerns have been amplified in recent years by the postmodernist critique, which challenges the very notion that truth can ever be known. What passes for truth, say the postmodernists, is only one way of telling a story.

In the age of postmodern skepticism, family therapists find themselves at a crossroad. Can they, like a character in a Jorge Luis Borges story, walk two roads at the same time? Can they accept a family's story as valid and still think a new story might be more useful? And if so, must they choose between seeing troubled families as stuck in self-defeating patterns of behavior *or* self-defeating cognitions?

Today we find ourselves in a paradox similar to the one physicists found themselves when they asked if light was transmitted as particles or waves. Their response was: Yes; it depends on the nature of the observation. But instead of realizing that there may be more than one way of describing people, family therapists tend to divide into theoretical camps: the narrative school, following postmodernism, embrace storytelling. It's the stories people tell themselves that organize their experience and shape their behavior. Therapy, then, should be about helping families reexamine their presuppositions. System therapists, on the other hand, see troubled families acting in self-defeating ways. Actions and beliefs may reinforce each other, but change is often best brought about from the outside in. Our position is that although families may get stuck in destructive patterns of interaction, it is their perspectives that both constrain and facilitate the way they think and behave—and that, to be effective, we must meet family members both as actors and as authors of their own stories.

Action and cognition do not exist apart from each other. Family members need to explain who they are by creating stories. The stories may sustain or modify the way they relate, facilitating new organizations that necessitate new stories, and so on. It depends on the nature of the experiment and of the experimentation which road you emphasize. But one is always walking both roads.

A Word About the Therapist

It seems easier to begin by defining what a therapist isn't: A therapist isn't fair or just, or a politically correct practitioner; not an ethicist, not a logistician, not all-knowing. The therapist is a practitioner of change. But change is always resisted: by the familiarity of well-traveled pathways, by a family's conviction about the way things are, by the competitive tension between the "selves in relation" that make up a family, and by the demands for change that family members make on each other.

Therefore a therapist is a changer with limited options who will be effective only if he or she can disrupt the family norms that maintain their assumptions. To do this the therapist will need to enter into a relationship with family members that offers hope that alternative ways of being in relationship will bring benefits: diminution of pain, increase of satisfaction, and knowledge.

All of this means that a therapist is a constrained changer. It's the family members who determine the limits and possibilities of alternative ways of relating. Change, therefore, is a collaborative enterprise, in which to be effective a therapist needs to accommodate to family members, join with them, and expand both his use of himself in the relationship with them and their use of themselves in relation to each other. The image of the all-knowing, all-powerful therapist who imposes his assumptions on trusting and gullible family members cannot coexist with the previous description of the therapeutic process. Of course we've all known therapists who

assume an authoritarian posture in therapy, but most of them ultimately fail, and the experience is painful for them and frequently damaging for family members.

Thus, a therapist is an expert who embraces uncertainty, joins families in the adventure of expanding and enriching their ways of relating, and challenges their certainty by helping them see alternative ways of relating.

In the cases you will be reading, we have two therapists, Salvador Minuchin and Wai-Yung Lee, showing their way of expanding families' repertoires. Like all therapists, both have their own style but, in Harry Stack Sullivan's words, they are both "more simply human than otherwise." Therefore they share their repertory with you knowing that their techniques can be borrowed and transformed to fit your own unique approach.

We will present ten cases, each consisting of two interviews following our four-step model. We tried to select families with issues that therapists often encounter, and we came up with five clusters:

1. families with troubled children;
2. stepfamilies;
3. couples' complementarity;
4. psychosomatic families; and
5. the family and social services.

Each cluster will be introduced with comments about the generics in dealing with the subject matter. We aren't completely satisfied with our groupings; they are arbitrary and we could have selected others. Nonetheless, we invite you to join us in our tour of the process of therapy.

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PART ONE

Troubled Children and Their Parents

In the Middle Ages, children didn't exist. They were seen as small adults, and treated accordingly. Family portraits from that time show familiar-looking mothers and fathers dressed in silks and brocades. Standing alongside them, however, you will see strange miniature replicas of those parents dressed just as they are, graphic evidence that children are constructed in the mind's eye of adults. Since that time childhood has been elevated to such exalted status that in today's family the parents revolve around the children like planets circling the sun. A brief look at the history of psychiatric treatment of children will show that our view of childhood's problems has also evolved—in ways that reflect our ongoing ambivalence about the family as well as advances in understanding.

It was Freud who taught us that psychological disorders were the consequence of unsolved problems of childhood. Freud's discoveries indicted the family, first for the seduction of innocence and later as the agent of cultural repression. If children grow up to be a little neurotic—afraid of their own healthy instincts—who else do we blame but their parents? Given that emotional problems were spawned in the family, it seemed natural to assume that the best way to undo the family's influence was to isolate relatives from the patient's treatment, to bar their contaminating influence from the psychiatric operating room.

Alfred Adler was the first of Freud's followers to pursue the implication that treating children might be the most effective way to prevent adult neuroses. To that end Adler persuaded the Viennese school system to establish 32 child guidance centers between the end of World War I and the early 1930s (Mosak, 1995). Adler's (1927) approach was to offer encouragement and support to help alleviate children's feelings of inferiority so they could work out a healthy life style and achieve success through social usefulness. Implicit in Adler's *individual psychology*, however, was the notion that families did more to subvert than to foster children's healthy innate potential. When clinicians think about families it's often as destructive forces in the lives of their patients. What catches our attention are differences and discord. The harmonies of family life—loyalty, tolerance, mutual aid, and assistance—often

slide by unnoticed, part of the taken-for-granted background of life. Adler (1929) delineated three approaches to parenting that robbed children of their courage and resulted in the famous *inferiority complex*. These three approaches were: (1) feeling sorry for the child, (2) pampering or overprotecting the child, and (3) neglecting or abusing the child.

In 1909 the psychiatrist William Healy founded the Juvenile Psychopathic Institute (later the Institute for Juvenile Research) in Chicago, a forerunner among child guidance clinics. In 1917 Healy moved to Boston and established the Judge Baker Guidance Center, devoted to evaluation and treatment of delinquent children. Although child guidance clinics remained few in number until after World War II, they were eventually established in every city in the United States, providing for the assessment and treatment of childhood problems and the complex family and social forces contributing to them. Treatment was carried out by clinical teams who focused much of their attention on the family environment. Gradually, child guidance workers concluded that the real problem wasn't the obvious one, the child's symptoms, but rather tensions in the family that were the source of those symptoms. At first there was a tendency to blame the parents, especially mothers.

The chief cause of childhood psychological problems, according to David Levy (1943), was *maternal overprotectiveness*. Mothers who had themselves been deprived of love became overprotective of their children. Some were domineering, others overindulgent. Children of domineering mothers were submissive but had difficulty making friends; children with indulgent mothers were demanding at home but well-behaved at school. Not long afterwards, Frieda Fromm-Reichmann (1948) coined one of the most damning phrases in the history of psychiatry, the *schizophrenogenic mother*. These domineering and aggressive women, especially when married to passive or indifferent men, were thought to provide the most virulent form of pathological parenting. Although these studies drew attention to the importance of the family, the tendency to blame parents, especially mothers, for problems in the family was an unfortunate example of scapegoating that continues to haunt the field.

Even after the importance of the family was recognized, mothers and children were still treated separately, and discussion between therapists was discouraged on the grounds that it might compromise the individual therapeutic relationships. The usual arrangement was for a psychiatrist to treat the child while a social worker saw the mother. Counseling the mother was secondary to the primary mission of treating the child. Sometimes, as an afterthought, fathers were seen in the evening in groups. In this model, the family was viewed as an extension of the child, rather than the other way around.

Eventually, the emphasis in the child guidance movement changed from seeing parents as cruel and inadequate to the view that problems derived from relationships among patients, parents, and significant others. This shift had profound consequences. No longer was psychopathology located within individuals; no longer were parents villains and children victims. Now their interaction was seen as the problem.

John Bowlby's work at the Tavistock Clinic ushered in the transition to a family approach. Bowlby (1949) was treating a child and making slow progress. Feeling

frustrated, he decided to see the child and his parents together for one session. During the first half of this session, the child and parents took turns complaining about each other. In the second half of the meeting, Bowlby explained to each of them what he thought their contributions to the problem dynamic were. Eventually, by working together, all three members of the family developed sympathy for each other's point of view.

Although Bowlby was intrigued by the possibilities of these conjoint interviews, he remained wedded to the traditional psychotherapy format. Family meetings might be useful for information gathering, but only as an adjunct to the real treatment, individual psychoanalytic therapy.

What Bowlby tried as an experiment, Nathan Ackerman saw to fruition—family therapy as the primary form of treatment in child guidance clinics. As early as 1938, Ackerman went on record as suggesting the value of viewing the family as a unit when dealing with disturbance in any of its members (Ackerman, 1938). Subsequently he recommended studying the family as a means of understanding the child, instead of the other way around (Ackerman & Sobel, 1950). Having seen the need to understand the family in order to diagnose problems, Ackerman then took the next step—family treatment.

Once we began to see children in the context of their families, a new world of possibilities opened up. Bringing in the family is like turning the light on in a dark room: Some things become very clear very fast. Not only do you see how family members may be maintaining the child's problems, but you also see how they can work together to resolve them. That's why it's astonishing that 50 years later, in the twenty-first century, most efforts to treat children still focus on the individual psychopathology of the child. This leads us to reflect on the extraordinary capacity of mental health practitioners to follow their ideological maps, even in the face of evidence that children are inextricably embedded in their families' dynamics.

* * *

When families bring their children for treatment, the temptation is to get caught up in the details of the child's problems, as though it were the therapist's job to solve those problems. As long as you view psychological problems as embedded in individuals, it makes sense to focus on hidden motivations, warped personalities, and dysfunctional neurotransmitters. The kinds of questions you ask are: What is the child doing? What motivates the child to do that? and What happened in the child's past to make him or her behave that way?

But the first, or perhaps most important, question a systemic therapist asks is: What are family members doing that helps maintain the identified patient's symptoms? This question shifts the focus to a transactional perspective. And then, because most troubled interactions are triangular, we ask, How effectively are the parents working together to deal with their child's problems?¹ The point isn't to shift blame from the child to the parents but to consider how effectively, or ineffectively, the family is organized to deal with its problems.

One of the things that makes conflict between parents almost inevitable is that people look at parenting from different perspectives. One may have a shorter fuse.

One may worry more than the other. One sees children as needing protection, while the other sees them as needing to stand on their own two feet.² In happy families such differences enable parents to work out a balanced approach to the children. But, unfortunately, parents often polarize each other, pushing each of them to more extreme positions, and making them undercut each other's efforts. Couples in conflict to begin with are even more likely to be at odds over their children.

A common pattern in couples with marital conflict is one parent overly close with the children and the more distant parent in a critical position, whether openly or not. A wife who is an emotional pursuer, frustrated with her husband's distance, turns to pursuing her children. One child, sensitive to his mother's upset, gets caught in the triangle and starts acting out in some way. The child's problems bring the parents together in concern, or allow them to fight over how to handle the child.

Thus one of the most common structural presentations of a parent-and-child triangle is the mother and child enmeshed, and the father disengaged. A systemic therapist can address this problematic structure by joining with the disengaged parent to draw him or her back into the family circle and then have the couple move together and reestablish the appropriate generational boundary in the family. But, as we shall see in the following two cases, it's important to remember that the map is not the territory. The structural metaphor shouldn't make us forget that families are made of flesh-and-blood human beings, and that therapy only works when it's a collaborative enterprise. Parents are also a couple, and it's a mistake to think that you can simply push two unhappy people together. In order to get to the heart of the matter, a therapist must uncover and address the couple's unhappiness and the conflict between them.

NOTES

1. Not all parents come in pairs, of course. But single parents who have problems with their children often turn out to be in conflict with boyfriends or girlfriends, with ex-spouses, or with the child's teachers.
2. Scratch the surface and you'll discover that many of these assumptions are projections of the parents' own experience, which is what the third step of our assessment model is designed to explore.

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