THE
PAPERS
OF
PHILIP J. GUERIN, JR., M.D.

Edited by Leo F. Fay

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THE GUERIN PAPERS

As of this writing, Phil Guerin is still doing what he's done for the past 50 years: taking care of patients. His identity as a physician-psychiatrist is second only to that of husband and father. A master therapist since he was a psychiatric resident, in recent years he has evolved his own version of combining family systems psychotherapy with the latest advances in psychiatric medicine.

Guerin was influenced by some of the greatest pioneers of the family therapy movement, and he himself became one of its best theoreticians, spokesmen, and teachers. He taught and influenced thousands of mental health professionals by lectures, demonstrations of therapy sessions both live and on tape, and by three books and numerous papers. He founded the Center for Family Learning, which trained many professionals in his theory and methods. The Center's publications and family systems education for the lay public spread the word far beyond the Northeast.

Many of Guerin's ideas about coaching individuals, the therapy of couples, and treating the families of symptomatic children have become a standard of care in the field of psychotherapy. His historical writings about the field are among the most frequently cited papers in the family therapy literature. These writings, papers, and selections from his books are reproduced below for anyone who wants to read them.

PART I: THE HISTORY AND DEVELOPMENT OF FAMILY THERAPY

Guerin has long been interested in the history of the family therapy movement, and has always believed that, for the movement to grow and prosper, its practitioners need to build on what has come before, and to share their ideas with the people who come after them. It is only by doing this, rather than ignoring everyone else and insisting that the "my" approach is the final answer, that family systems theory will become part of the psychiatric armamentarium over the long haul.

These beliefs are incorporated in the following eight papers. Family therapy made its early appearance in professional journals in the 1950's. By the 1970's and into the 80's, it had become a, if not the, major new element in psychiatry, psychology, and social work. In the mid-1970s, the American Orthopsychiatric Association asked Phil Guerin to assemble and edit a volume that would illustrate the development of the family therapy movement from its origins to that time. For the first chapter of this volume, Family Therapy: Theory and Practice *(Gardner*

Press, 1976), Guerin wrote a history of the ideas and the key figures in the development of family therapy since the 1950s.

Guerin's essay is a definitive description of the first 25 years of the effort to widen the lens of psychiatric theory from a focus on the individual to a focus on the context, especially that of the family, as the explanation for neurotic and even psychotic symptoms. Guerin's history is also a demonstration that the very principles the movement was discovering about how families operate also govern how systems like the family therapy movement operate. "Family Therapy: The First Twenty-Five Years," is the first piece reproduced below.

Family Therapy: The First Twenty-Five Years

Philip J. Guerin, Jr., M.D.

This chapter is written in the spirit of the freedom of information. Most of the information is one or another person's particular version of factual events, and as such should not be construed to represent the absolute truth, but rather many different people's version of the truth. The reports of historical happenings included here, in addition to being personal versions, also represent the way human relationship systems operate, and are not a function of malice and/or paranoia on the part of any one individual or group of individuals.

The years from 1950 to 1975 may be said to constitute the first quarter-century of the field of family therapy, and it is within this chronological framework that I propose to explore the history of the movement. My main purpose is to clarify the developmental history of the field so as to enable future students of family therapy to organize and distinguish between old and new ideas. I will focus on three major areas: the context determinants that went into the formation of the family movement; the professional network of people and their interconnections with one another throughout the United States; and the theoretical classification of the family field.

Historical Development

The family movement had its beginnings in the late 1940s and early 1950s in different, somewhat isolated areas throughout the country. At that time the nation was going through the aftermaths of World War II, the Korean conflict, and the bomb; one of the noticeable reactions was an increased amount of family togetherness, a backlash to the separations of World War II. Psychiatry had become an attractive specialty; and psychoanalysis, having become firmly established as an ideology, was moving from the sanctuary of its institutes back into the medical schools.

As soon as any ideology becomes established, professional outsiders – "change merchants" – in the field become impatient with its limitations and set out to establish new frontiers and new ways of thinking. The major thrust of the development of the family perspective was due to frustration on two counts, namely, from the attempts being made to apply conventional

psychiatric principles to work with schizophrenic families, and from the attempts to deal with behavior difficulties and delinquency in children. All of the important work in the family movement was being done under the rubric of research. Murray Bowen emphasized this in an article about developments in the field for the *American Handbook of Psychiatry*.

> A psychoanalytic principle may have accounted for the family movement remaining underground for some years. There were rules to safeguard the personal privacy of the patient/therapist relationship and to prevent contamination of the transference by contact with the patient's relatives. Some hospitals had a therapist to deal with the carefully protected intrapsychic process, another psychiatrist to handle the reality matters and administrative procedures, and the social worker to talk to relatives. In those years this principle was a cornerstone of good psychotherapy. Finally it became acceptable to see families together in the context of research.

Family research with schizophrenia was the primary focus of a majority of the pioneers in the family movement: Bateson, Jackson, Weakland, and Haley in California; Bowen in Topeka and Washington; Lidz in Baltimore and then in New Haven; Whitaker and Malone in Atlanta; Scheflen and Birdwhistle in Philadelphia.

Nathan Ackerman, perhaps the most widely known pioneer in the family field, came to the family movement by a different route. A card-carrying psychoanalyst, he was also a child psychiatrist; and as early as 1937, at the age of 28, he published a paper on "The Family As a Social and Emotional Unit." Donald Bloch, now director of the Ackerman Family Institute in New York, has described Ackerman's paper thus:

> The 1937 paper appeared in the *Bulletin* of the Kansas Mental Hygiene Society; indeed it was the lead article. Its title was "The Family As a Social and Emotional Unit." It was written while Ackerman was a staff member at the Southard School, the children's division of the Menninger Clinic. The paper is short, barely 5 pages long; to read it now illuminates the spirit of the man, his awareness of human interrelatedness, his compassion, and above all, his intuitive feeling for the ambiguous quality of intimate networks. The first paragraph has a grand architectural quality:
>
> "None of us live our lives utterly alone. Those who try are doomed to a miserable existence. It can fairly be said that some aspects of life experience are more individual than social, and others more social than individual. Nevertheless, principally we live with others, and in early years almost exclusively with members of our own family."

Ackerman saw his work and the work of his colleagues in the Child Guidance movement as the "real" beginning of the family movement. In a 1967 paper, "The Emergence of Family Diagnosis and Treatment, a Personal View," he said:

> The family approach arose in the study of non-psychotic disorders in children as related to the family environment. The relative prominence of recent reports on schizophrenia and family has somewhat obscured this fact.

The necessity of remaining under the protective umbrella of research also affected the child wing of the family movement, as demonstrated by the Wiltwyck Project. In the early 1960s, Minuchin, working at Wiltwyck School, began with others a research project to study the families of two

delinquent boys, both of whom had been in trouble with the law. Richard Rabkin, a New York psychiatrist and author of such controversial papers as "Is the Unconscious Necessary?" says that the Wiltwyck project was possible because of the "hopeless nature" of the patient population – that is, since there was no effective way to work with these boys, research along the family lines was possible.

Between 1950 and 1975 the family movement went through a series of fascinating developments. From 1950 to 1954, it was more or less underground. By that I mean that research was being done that was based on a view of the family as the unit of emotional dysfunction, but the work was isolated and disconnected. No one mentioned this research in the professional literature or at national meetings. During these years, however, Bateson was forming his communications project in California, and Bowen was well into his work on mother/child "symbiosis," schizophrenia, and the family at the Menninger Clinic.

In 1950 William Menninger prodded GAP to form a committee on family, and John Speigel was assigned the task of surveying those who were working on family. He focused on finding out what it was like to work with the family rather than with an individual. He immediately saw it was necessary to define the matter in terms of family process rather than intrapsychic experience; he therefore proceeded to define a *family*, and to note the contextual forces operating on it. His report, therefore, does not list those who were working with families, or where and how they were doing it. In fact, he failed to pick up the research in California and Topeka, and he discovered only sociologists working with families. Actually, Speigel, aided by Florence Kluckhorn, tried to make the concept of working with family process comprehensible to traditional psychiatry.

Meanwhile, the work of John Rosen, a psychiatrist, with schizophrenic patients in Bucks County, Pennsylvania, had begun to influence several of the family therapy pioneers. Rosen originated direct confrontational analysis of schizophrenics and in 1948 had visited the Menninger Clinic for a period of about a month to demonstrate his method using selected case material and a one-way screen. As Bowen puts it, "By the time Rosen left, all 100 psychiatric residents were into trying some version of Rosen's direct analysis." Bowen himself tried it for a couple of years, but by 1950 had moved into formulating and refining his ideas about mother/child symbiosis and its role in schizophrenia. Bateson's group, organized in 1952 in California, was also interested in Rosen's work and came to Philadelphia to observe it. Also, Whitaker, Warkenton, and Malone, working on a somewhat similar model in Atlanta, were also tuned into Rosen's work, as was Al Scheflen in Philadelphia.

Chestnut Lodge in Rockville, Maryland – the home of Frieda Fromm-Reichman, Otto Will, and Harold Searles – was outside the family movement, although its philosophy, strongly influenced by Sullivan, permitted the focus of therapy to shift away from purely intrapsychic toward interpersonal examination. Don Jackson and Don Bloch were both residents at Chestnut Lodge from 1950 to 1953. Jackson left to return to California, where he soon joined the Bateson project. Jackson and Bowen were later introduced by Tetzlaff, who had been a medical school classmate of Jackson's.

In 1957 and 1958, the family movement surfaced nationally. In 1956, Speigel had first heard of Bowen's work, by then already well underway at NIMH, as well as Lidz’s work, begun in Baltimore and then moved to Yale-New Haven. Speigel organized a panel on Family Research

for the March, 1957, Ortho program. This was the first national meeting at which these family schizophrenia research ideas were presented. In addition to Speigel, that panel included Bowen, Lidz, and David Mendel of Houston – then working on family groups with Seymour Fischer, and later to become widely known for Multiple Impact Family Therapy. Fifty people attended, Bowen recalls.

Three months later at the APA Meeting, also in Chicago, Spurgeon English, then chairman of Psychiatry at Temple, organized a panel on Family. Nat Ackerman was secretary to that panel; Jackson participated in addition to Bowen and Lidz. This meeting led to Jackson's book *The Etiology of Schizophrenia*. The 1957 APA Meeting provided another network connection. Bob Dysinger, a coworker of Bowen's in the NIMH project, invited a classmate of his from the University of Illinois to the panel on Family: Charles Kramer, since then the founder and Director of the Chicago Family Institute.

Jackson published *The Etiology of Schizophrenia* in 1959. In that same year Bowen published "Intensive Family Therapy," a paper on the NIMH project, in which he talked about the concept of triangulation, which at that time he was calling the interdependent triad. By 1968 Nat Ackerman founded the Family Institute in New York City to provide himself a place for organizing and teaching his work. In 1962 he joined Jackson to produce the field's first journal, *Family Process*.

From 1964 to 1968, large numbers of central publications and the first audiovisual productions appeared. Birdwhistle and Scheflen produced the Hillcrest Series, four 16mm sound color movies showing Ackerman, Bowen, Jackson, and Whitaker, each interviewing the same family. The Philadelphia Family Institute was formed in 1964 by a group of approximately twelve family clinicians and researchers. Nagy and Framo together edited *Intensive Family Therapy*, bringing together in one volume much of the work being done around the country with schizophrenic families. In 1966, Bowen published the first major theoretical paper on family systems, "The Use of Family Theory in Clinical Practice." Watzlawick and Jackson published "Pragmatics of Human Communication," and Virginia Satir published *Conjoint Family Therapy*.

Toward the end of this period, a number of geographical moves took place. Whitaker left Atlanta to be full professor at the University of Wisconsin; Satir left MRI and went to Esalen; Haley left MRI, and went to Philadelphia to join Minuchin, who had left New York and brought Montalvo and Rossman with him to Philadelphia. Al Scheflen left EPPI and Temple to come to New York to begin his human communications research project under the administrative umbrella of Israel Zwerling at Bronx State, Einstein. A few years earlier Zwerling had set up the Family Studies Section at Bronx State. In January 1969, the family of family therapists experienced the loss of one of its most significant pioneers with Don Jackson's death.

In the late 60s and early 70s Minuchin's work with anorexia was published. Haley's writing and reputation began to grow. The Georgetown University Symposium on Family expanded from a reunion for alumni of the residency program to a meeting attended by over a thousand people each year. The Family Studies Section at Bronx State became known as a teaching and training center throughout the country. In 1970, using the liaison between Einstein and Fordham that I had established in 1969, I produced the first of the three annual Fordham/Einstein Symposiums on Family Therapy. These served to stimulate an ever-increasing number of family therapy

meetings throughout the country. In 1972 the publication of *The Book of Family Therapy* further established Bronx State Family Studies Section at home and throughout the country.

Also during the late 1960s and early 1970s, an anti-theory trend was developing, along with an intensified ideological war between analysis and systems people. The battles centered on issues like the sanctity of the transference, and the necessity of the concept of the unconscious. This warfare cut across the field and reached deeply into the center of the family movement. However, with the death of Nat Ackerman in 1971, the family movement lost its most creative and zealous psychoanalytic proponent, and after it, the center of the field moved swiftly toward systems.

California

In 1952, Gregory Bateson received a grant to study human communication. The study was housed at a VA hospital where Bateson was the ethnologist, and it was not a clinical project. The first two people Bateson hired to work with him on this grant were Jay Haley and John Weakland. In 1954, Don Jackson, a supervising psychiatrist in residency programs at the same VA Hospital, came into the project as a psychiatric consultant and clinical supervisor. Out of their work came the most important paper on the double bind, "Toward a Theory of Schizophrenia." In his book, *Steps to an Ecology of the Mind*, Bateson divides the credit for the concept of the double bind as follows:

> To Jay Haley is due credit for recognizing that the symptoms of schizophrenia are suggestive of an inability to discriminate the Logical Types, and this was amplified by Bateson, who added the notice that the symptoms and etiology could be formally described in terms of a double bind hypothesis. The hypothesis was communicated to D. D. Jackson and found to fit closely with his ideas of family homeostasis. Since then Dr. Jackson has worked closely with the project. The study of the formal analogies between hypnosis and schizophrenia has been the work of John H. Weakland and Jay Haley.

Bateson's work is central to the development of systems thinking in relation to human behavior. Perhaps the biggest single demonstration of this is his paper, "The Cybernetics of Self," a theory of alcoholism. Thus Bateson, the anthropologist, and Jackson, the clinician, moved to develop systems concepts, with the assistance and collaboration of Haley and Weakland.

In 1959, as some of the energy was waning from the Bateson Project, and as family therapy was becoming nationally known, Jackson formed the Mental Research Institute. The Bateson Project didn't officially end until 1962, but during these three years of coexistence there was no formal link between the project and MRI. Ideas and staff were interchanged, but there was no formal connection. At the end of the Bateson Project, Haley joined Jackson at MRI.

Also in 1959, Virginia Satir moved from Chicago to California. While in Chicago, Satir had worked and taught at the Chicago Psychiatric Institute. In 1958, her interest in family brought her to visit the Bowen Project at NIMH. The next spring, having moved to California, she met Bowen at the Ortho meeting and he in turn suggested she seek out Jackson. Satir joined Jackson at MRI, and quickly found herself at the center of the family therapy movement. She brought the ideas at MRI and elsewhere around the country together in her 1967 publication, *Conjoint Therapy*. Satir’s ability to synthesize ideas, combined with her creative development of teaching

techniques and general personal charisma, gave her a central position in the field. Satir and Haley left MRI around the same time, in the mid-1960s; Virginia went into the fast-developing growth movement, and became the first director of Esalen.

Haley, on the other hand, went to Philadelphia to further develop his ideas about the family as a system. He has become known for being especially antigrowth, emphasizing all its negative connotations. Early in his years at Philadelphia, he collaborated with Minuchin on the development of structural family treatment; more recently, he has turned his energies to strategic therapy, and to furthering the work begun by Milton Erickson.

The loss of Jackson, Haley, and Satir in a short period of time was a severe blow to MRI. It faded from national view in the years immediately following Jackson's death, and only recently, under the leadership of Watzlawick, Weakland, and Fisch, has it again surfaced. This threesome has successfully taken some of the ideas of Bateson, Jackson, and Haley, added them to the mathematical productions of Paul Watzlawick, and produced an excellent monograph called *Change*. *Change* is a treatise on the concept of clinical change and its relationship to human systems and brief strategic family therapy.

Topeka – Washington, DC

The history of Washington, DC and the family movement is the history of Murray Bowen, NIMH, and Georgetown University School of Medicine, Department of Psychiatry. Bowen's work with families had actually begun in Topeka. In 1951 he requested the use of a cottage on the grounds of Menninger for use in the study of schizophrenics and their families. He began asking the mothers of his schizophrenic patients to come to Topeka and stay for one or two months at a time, to move into the cottage and take over at least partial care of their schizophrenic offspring. In 1952 and 1953 he began to include some fathers in the research, but the main focus was around mother/child symbiosis.

In 1954 Bowen left Menninger to come to NIMH. There he set up the landmark project of hospitalizing whole families of schizophrenics for observation and research. This project was seen by Bowen and others, particularly Jackson, as the Camelot of family research, out of which would come a revolutionary way of conceptualizing human emotional dysfunction that would turn psychiatry toward a totally new direction.

Well underway by 1956, this project aroused considerable national and international interest. By mid-1956, however, the project was already experiencing an administrative squeeze. Bowen attributes the fall of this Camelot to the fact that much of what his project was producing was heretical to prevalent ideologies. The presentations and publications of the project work were censored by delay and restrictions on space. Administrators asked questions like, "Are you sure you mean that?" and, "Don't you think you ought to have harder scientific evidence before presenting that data?" Pressure to change direction was applied through administrative edicts that restricted operating space, budgets, and procedures.

Bowen began to search for a place to relocate his project. He decided to go to Georgetown University because of the vision and support offered by George Raines, then chairman of the Department of Psychiatry at Georgetown Medical School. Shortly after Bowen left NIMH for

Georgetown and before his project staff could relocate, George Raines died of cancer. Bowen's project staff never made it to Georgetown.

Lyman Wynne took over the family section from Bowen. He continued there through the 60s and early 70s, when he left to assume the chairmanship at University of Rochester. During this time Wynne's project produced a number of significant papers, as well as talented researcher clinicians like Schapiro, Beels, and Reiss. Its ideology was more traditional than Bowen's, and perhaps most closely resembles the work of Ted Lidz at Yale-New Haven.

Still at Georgetown Bowen received a grant in 1973 to train third, fourth, and fifth year residents full-time in family systems theory and intervention. Bowen, also working at the Medical College of Virginia, established probably the most extensive video project of ongoing therapy in existence. This project has produced a number of excellent video teaching tapes, the most worthy of which is *Steps Toward a Differentiation of Self*.

Atlanta-Madison

From approximately 1943 to 1945, Carl Whitaker was working with John Warkenton in Oak Ridge, Tennessee. They began doing co-therapy, seeing the identified patient and then adding another family member and finally even bringing the children to the sessions. They were doing work with children around the issues of behavior problems and delinquency. Later, in 1945 and '46, they became interested in schizophrenia.

In 1946 Whitaker went to Emory University in Atlanta and became Chairman of the Department of Psychiatry, and Warkenton went with him. They were joined by Thomas Malone, who provided an analytic background. Their studies centered on schizophrenics and their families. In 1948 the trio began to have meetings every six months that would last about four days. During these meetings, they made use of one-way screening rooms with the individual patients on one side and the three of them on the other. They took turns going in and working with the patient; in addition to observing individual patients, they observed groups of patients and families, and each other's work. In 1953, at the 10th meeting of this group, they moved the site to Sea Island, Georgia, and invited Rosen, Scheflen, Bateson, and Jackson to join them. Thus a large number of therapists worked alternately on the same family or individual, and each learned something from the others.

In 1955 Whitaker left Emory University, and his whole group, including Warkenton and Malone, went into private practice in Atlanta. Then, in 1965, Whitaker was appointed full professor at the University of Wisconsin doing only family therapy. Warkenton and Malone are still in Atlanta in group private practice. Whitaker's work had shifted to a study of normal families, which in turn led him to his present concentration on the role of the extended family in the therapeutic process. He began by inviting maternal and paternal grandparents to the sessions, and now he includes many other family members; sometimes as many as 35 or 40 people meet for a weekend therapy session.

At such marathons, Carl serves mainly as a reactor who allows things to happen among family members while he refrains from orchestrating it and gears his comments to what he observes. He taunts the family about their failures and weaknesses, and attempts to open up the left sides of their brains – that is, he encourages them to expose the unresolved, crazy things that are usually

covered over with the organized structures of the dominant cerebral hemisphere activity. He exposes his own left-sided craziness to the family to make them feel it's safe to delve into theirs. Some see him as having a one-sided brain, but others who watch more closely see the artistic control with which he orchestrates his "craziness."

After Whitaker had left Atlanta for Wisconsin, Frank Pittman came from Colorado to Emory to be Director of the Crisis Clinic. While in Colorado he had been a central investigator of a project that successfully prevented psychiatric hospitalization by using crisis intervention with families. Within a year after its completion everyone central to the project had left Colorado. The entrenched system had triumphed again. Pittman also ran into trouble with his crisis work at Emory, and in a short time he too found himself in private practice in Atlanta, where he has remained to the present.

Philadelphia

Philadelphia has been central to the development of family since the mid-50s. At that time Spurgeon English as Chairman of Psychiatry at Temple was encouraging the work of Rosen, Scheflen, and Birdwhistle. With the advent of EPPI more things began to happen. Scheflen, in political trouble at Temple because of his research purism, moved to EPPI in 1960 and joined Birdwhistle to study the structure and process of psychotherapy. Ivan Nagy came to EPPI in 1958 to set up research on family and schizophrenia. Nagy's staff included Jim Framo, Dave Rubenstein, and Geraldine Lincoln Spark. In the early 1960s, Ross Speck was a psychiatric resident at EPPI; he and John Sonne and Al Friedman from the Philadelphia Psychiatric Center began a project to study the treatment of families in the home. The Philadelphia Family Institute was formed in 1964, with most of the people in the area as founders. From 1965 to ‘68 the direction of the family movement changed as Ross Speck, together with Carolyn Attneave, got into network intervention as a method of ministering to the accumulated ills of the family. Carolyn Attneave’s Indian tribal heritage especially prepared her for this type of work. Also during this period, Jay Haley and Salvador Minuchin came to Philadelphia, and Al Scheflen left to go to New York.

In the late 1960s, Philadelphia Child Guidance formed its boundaries. Jim Framo made an attempt under the auspices of Jefferson Medical School to form a family treatment unit in a community mental health center. He too ran into massive systems reactivity to his work, and in the end he and his Bowen-trained associate, Rick Crocco, left in despair to pursue other ventures. Nagy has continued his work and recently with Geraldine Spark published *Invisible Loyalties*, a view of reciprocity in intergenerational family therapy. Ross Speck has moved from networks to studying the alternative lifestyles of our present culture. The Philadelphia Child Guidance Clinic has successfully introduced family therapy into work with lower socioeconomic families. Minuchin, true to the tradition of the Wiltwyck Project, took on a clinical project with the urban poor in Philadelphia. The Philadelphia Child Guidance Clinic team under Minuchin’s and Haley's leadership was able to take some of the basic family system concepts of Bateson, Bowen, Erickson, and Jackson, add to them Haley's strategic brilliance and Minuchin’s considerable clinical artistry, simplify them, concretize them, and demonstrate their effectiveness in a clinical setting with families and in teaching family therapists. A number of excellent videotapes of the work of this group have been produced.

In the University of Pennsylvania Pediatric and Child Psychiatry Departments the beginnings of success with psychosomatic families and structural family interventions have already been published. Minuchin, using his clinical operation, was able to bring together a highly motivated creative staff. Those who have evolved a special place in the structure of Philadelphia Child Guidance Clinic are Braulio Montalvo as a conceptualizer and commentator on Minuchin's clinical artistry; Harry Aponte, a New York born Puerto Rican social worker just named to succeed Minuchin as Director of Philadelphia Child Guidance Clinic, who has become an expert on intervening with lower socioeconomic families; and Ron Leibman, a child psychiatrist who skillfully advances the Minuchin methods in the psychosomatic arena.

Of added import for work in Philadelphia was the removal of Israel Zwerling from Bronx State, Einstein, to Chairman of Psychiatry at Hanneman.

New York

In New York, Nathan Ackerman was the dominant figure in family psychiatry. Since the depression years of the 1930s, when he had become interested in the effect of chronic economic hardship on families, Ackerman had been interested in families. He was perhaps most moved by his experience in visiting an impoverished mining community in western Pennsylvania. A 1937 paper documents his observations of the unemployed miners.

> I went to see, firsthand, the mental health effects on the families of unemployed miners. This experience was a shocker; I was startlingly awakened to the limitless, unexplored territory in the relations of family life and health. I studied twenty-five families in which the father, the sole breadwinner in the mining community, had been without work for between two and five years. The miners, long habituated to unemployment, idled away their empty hours on the street corner, or in the neighborhood saloon. They felt defeated and degraded. They clung to one another to give and take comfort and pass away the endless days of inactivity. Humiliated by their failure as providers, they stayed away from home; they felt shamed before their wives. The wives and mothers, harassed by insecurity and want from day to day, irritably rejected their husbands; they punished them by refusing sexual relations. The man who could no longer bring home his pay envelope was no longer the head of the family. He lost his position of respect and authority in the family; the woman drove him into the streets. Often, she turned for comfort to her first son. Mother and son then usurped the leadership position within the family. Among these unemployed miners, there were guilty depressions, hypochondriacal fears, psychosomatic crises, sexual disorders, and crippled self-esteem. Not infrequently, these men were publicly condemned as deserters. The configuration for family life was radically altered by the miner's inability to fulfill his habitual role as provider.

By the late '40s and early '50s Ackerman had begun to send his staff on home visits to study the family. During this time his public clinical work centered on individual child therapy, and the psychoanalysis of adults. In his private practice he experimented with his own particular brand of family therapy. One of Ackerman's most prominent analyands was Israel Zwerling, who together with Marilyn Mendelsohn, an analysand of Don Jackson's, put together the Family Studies Section at Albert Einstein College of Medicine. Andy Ferber was named Director in 1964.

Ackerman was a consultant to the Family Studies Section on a one day a week basis from 1964 to ‘67. In 1967 the Section began bringing in people with different ideologies. To Zwerling and Ferber's lasting credit, they managed to assemble the most diverse group of family therapists ever to work under the same roof – not only that, for over five years they maintained an environment that fostered this diversification.

By 1965 Nate Ackerman had founded the Family Institute, moved it to New York, and hired Julie Leib as Executive Director. One of Ackerman's proudest accomplishments at the Family Institute was the establishment of a low to moderate cost clinic for the practice of family therapy, thereby not restricting it to middle and upper class families. He introduced a sliding scale there because he still remembered the psychic pain he'd seen in the miners’ families during the Depression.

Nathan Ackerman lived and died a staunch psychoanalyst; nonetheless this orthodoxy did not save his heretical ideas about families from the establishment system’s automatic response. Two events emphasize this point. While he was on the faculty of Columbia Presbyterian Psychiatric Institute, his Family Therapy Conferences were scheduled to conflict with other conferences that were mandatory for residents. And in the fall of 1971, at the GAP meeting following his death, and even though he was instrumental in the founding of GAP, his name was left out of the traditional opening memorial service.

After Ackerman's death, the Family Institute was renamed the Ackerman Family Institute. The Directorship was assumed by Don Bloch who had previously been working with Otto Will as Director of Research at Austen Riggs in Stockbridge, Massachusetts.

In 1970 I assumed the position and responsibility of Director of Training at Family Studies Section, Bronx State, Einstein. I did so predicated on Ferber and Beels, together with Al Scheflen, taking on the project of developing a new systems residency program at Bronx State. The demand for training from outside the Einstein Medical School network was increasing. In order to meet this need and provide funds for videotape projects, I set up an extramural training program in family therapy at Bronx State. Soon there were 150 in-house and extramural trainees, professionals and paraprofessionals, a year. Betty Carter and Monica Orfanidis joined the extramural program; Peggy Papp also became interested in Tom Fogarty's and my work, and she joined the section as a part-time faculty member.

In 1972, with the residency project underway, Andy Ferber was reluctantly ready to move back into the Family Studies Section. For a number of political and administrative reasons, it was decided that I would take the extramural training program up to Westchester, and set up a center which would both house the extramural training program and offer a program of continuing education for families in the community about how family systems operate. We hoped that this program would be effective in the prevention of emotional dysfunction, and also aid in developing a clinical service to provide a different kind of elective experience for Bronx State residents. Then Israel Zwerling left Bronx State and Einstein to assume the Department of Psychiatry chairmanship at Hanneman. As part of the turmoil to be expected in any system after the loss of a leader as powerful as Zwerling, Ferber, certainly one of Zwerling's favorite sons, left Bronx State and moved to Westchester and Harlem Valley Psychiatric Center, where he is Director of Training. In 1973, along with Betty Carter, Tom Fogarty, and Peggy Papp, I founded the Center for Family Learning in New Rochelle, New York.

In addition to these major centers several other places have been important to the development of family therapy.

In Chicago – where the 1957 American Orthopsychiatric Association Meeting launched family therapy nationally, and where Virginia Satir began her work – there are two foci of family therapy. One is the Chicago Family Institute, formed by Chuck and Jan Kramer; it has ongoing training and clinical programs, and has just recently affiliated with Northwestern University School of Medicine. Across town is the Institute for Juvenile Research, where Irv Borstein, with frequent visits from Carl Whitaker, has put together a clinical training program. Len Unterberger, a psychologist, was one of the central people in Borstein's program, but has since moved on to other things.

In Boston, several family therapy centers have developed independently of each other. Since the early days of family therapy, Norman Paul has been held in high esteem. He has appeared on national television to promote the cause of family therapy throughout the country; his work on operational mourning is widely recognized. He has, however, also experienced pressure from the academic system to change his views on family therapy. A few years ago he resigned from academic psychiatry to join the neurology faculty at Boston University.

Fred Duhl bypassed some of the system difficulty by setting up the Boston Family Institute. In addition to his wife Bunny, his mainstays early on were David Cantor and Sandy Watanabe. BFI has its own clinical and training programs in family and has recently added an elaborate video production division to its organization.

Sandy Watanabe left Boston to go to the Chicago Family Institute. Kantor, author of *Inside the Family* and one of the originators of family sculpting, recently formed the Cambridge Family Institute with Carter Umbarger, a Minuchin-trained family therapist. John Pearce left the Ackerman Family Institute in the late 60s to go to Boston, where he was active with Marvin Schneider, a psychologist, in forming and nurturing the Boston Society for Family Research and Therapy. That organization, still active in the Boston area, is presently under the leadership of Bob Aylmer, Eve Welts, and Jim Krainen.

And finally, this overview must mention Houston, and the multiple impact family work there.

Theoretical Classification

As any new field of study develops, a certain degree of chaos and disorganization is unavoidable. It is difficult to define the similarities and differences in pioneering work, and any attempts to arrive at an overview fall prey to predictable responses. Some therapists perceive all ideas and techniques as basically the same; others define their own work as totally different from everyone else's.

Still others attempt to organize the chaos by classifying it. There are to date three attempts at classification: the GAP report, *The Treatment of Families in Conflict*; the Beels and Ferber classification published in Family Process as "Family Therapy, a View"; and my own classification, presented in a paper at the Georgetown University Symposium on Family Therapy in 1970. The Beels and Ferber classification and mine were later combined into a video training tape called *The Field of Family Therapy*.

In 1970 the Family Committee of GAP published a monograph on family therapy titled *Treatment of Families in Conflict.* At the time of publication the committee's chairman was Norman Paul, and the membership included, among others, Nagy, Bowen, Mendell, Speigel, Wynne, and Zwerling. One chapter, "Premises About Family Therapy," classified family therapists from A to Z.

> Position A will locate those one-to-one therapists who occasionally see families but retain a primary focus upon the individual system, and position Z those who use exclusively a family system orientation. One should keep in mind that both positions involve the practice of treating whole families and that, between these two positions, most therapists combine these interests in differing proportions. No attempt is made to put specific people at points on the scale.

Al Scheflen had a significant influence on the Beels and Ferber classification; he shared with them a decade of interest in studying the structure and process of psychotherapy by direct observation. Adopting direct observation as their basic method, Beels and Ferber also assumed that a therapist's theory was just a rationalization for his or her clinical behavior. One negative aspect of this assumption was that it fostered an anti-theory position, and overemphasized the therapist's personal style. The positive aspect was that in the long run it taught theory zealots like me to understand that theory is an abstraction of a natural process, and as such each theory represents merely one among many possible abstractions.

Beels and Ferber did direct on-site viewing of therapy sessions, and studied films and videotapes of therapists at work. They then organized their observations around the concept that therapists could be classified according to their therapy session behavior as either conductors or reactors.

Conductors are therapists with aggressive, public, charismatic personalities; they have a strong value system, and they carry their beliefs into their work with families. Nat Ackerman, who broke all family rules with warmth and humor; Virginia Satir, who teaches people how to live; Sal Minuchin, who moves in fast to break established patterns of family dysfunction; and Murray Bowen, who orchestrates the family's progress by his never-ending quest for research – all are conductors.

Reactors are described as less public personalities who get into families by playing different roles at different times. Reactors are divided in to two further groups: analysts and systems purists. Among the analyst reactors are Whitaker, who invades the family and takes over roles with the co-therapist functioning as his lifeline; Nagy and Framo, who identify and relabel phasic interactive patterns of the family; and Wynne and Searles who openly register their own feelings of anger, confusion, and futility to the family. Haley and Jackson are classified as systems purist reactors – critical observers making heavy use of paradox to manipulate the power structure of the family. Beels and Ferber conclude by reminding us that both groups exercise control in their own particular way. The conductors implement their control in obvious direct ways, reactors in indirect paradoxical ways. As for where Beels and Ferber fit into their own classification, I see them both as reactors: Ferber in the style inherited from Carl Whitaker, Beels in the style of a reasonable professor who clarifies, negotiates, and interprets the family's group process.

Today Beels and Ferber's study is useful in helping family therapists in training get a sense of how their basic style of operating with the family fits with that of others. Beginning family

therapists inevitably go through stages in which they mimic the styles of the masters. Only if this remains a fixed phenomenon does it become an obstruction to the development of the therapist as a clinician. It is my belief that a well-defined open-ended theory does allow a family therapist to involve his or her personal style of operating with the family.

For example, as a family supervisor I was watching one of our trainees work with the family. This is a talented and creative lady, outgoing, forceful, totally irreverent, and never at a loss for thoughts or words. She has a significant degree of clinical experience and competence. Of late she has been getting into family systems theory more and more. She sat at the point of a triangular seating arrangement leaning back in contemplative fashion, asking very carefully worded, measured questions, cooling affect on her part and on the part of the couple, and carefully directing the flow of conversation through her. As I watched, I asked myself, "Does theory set limits on style and confine it to a certain repertoire of behavior? Shouldn't theory, if it's valid, free a therapist or agent of change to have multiple and widely variant stylistic ways of movement with a family?"

There should be many stylistic ways to approach the same clinical situation. Perhaps one therapist with a flamboyant, unmeasured, provocative, and affectively-charged style might lean toward the father of the family, place his hand on his arm, and say, "Where are you going, man? You gun shy? All your wife has to do is get upset and you head for the hills. How come you're so surprised your son stands in better than you do? Well, I guess she isn't doing any better dealing with your distant reasonableness. Maybe you two deserve each other." Another therapist, who is quiet and reserved, might ask a series of measured and balanced questions in the same situation: "How much of your being away from home a lot is tied into the pull of those outside things, and how much is it connected to your getting out from under trouble in your relationship with your wife? When she gets upset and you get bugged, how would you go about managing to stay around?"

If either therapist can avoid blaming, labeling a victim or a villain, becoming judgmental of the family, and adding his or her emotional reactivity to the stew, he will be fulfilling his responsibility to the family as an agent of change and his responsibility to himself to be himself. A valid theory should not confine the therapist’s repertoire of behavior; otherwise only those people with a particular style of behavior would be able to use a particular theory, and that theory is then doomed to become a rationalization for a way of doing things.

Styles as such should not be disconnected from theory; but neither should theory dictate the personal style of the therapist. If a theory is valid, it will free its practitioners to use various styles that are natural to them.

Partly because of this belief of mine and partly in reaction to the anti-theory trend in the field, I set out to classify family therapists according to their theoretical persuasion. I divided family therapists into two basic groups, psychoanalytic and systems. The analytic category is subdivided into individual, group, experiential, and Ackerman-approach categories.

Some analytic therapists see families only when it is necessary to deal with situations in which a member or members of the family of their individual patient were undoing the progress that was taking place in the individual therapy. As a result of these family interviews, often other members of the family would be referred for individual therapy with other therapists. Others

however, focus intensely on the family as a series of interlocking dyads, and in their work define process along the lines of interlocking intrapsychic processes. They try to salvage the concept and clinical tool of transference, alternately focusing on the aspects of transference observable between individual family members and therapists, and/or between family members themselves, particularly marital pairs. This method is especially effective with highly motivated neurotic level families; however, in times of extreme stress, therapists who do this often withdraw from a family model and revert to individual therapy for one or more family members.

Today more and more traditional therapists are beginning to see families. Many psychoanalysts with a wealth of clinical experience and a large investment in individual thinking are becoming interested in the systems approach to the family, and trying to deal with the ideological differences in these two approaches. Others are first seeing families and then adapting their own ideologies and techniques to fit the shift in the clinical context. There is also significant interest in the adaptation of general systems theory to work with families.

Probably most of what goes on throughout the country that is called *family therapy* is practiced on a group model. Bell was one of the original clinicians to embark on family group family therapy; Lyman Wynne and Chris Beels are other well-known family therapists using primarily a group theoretical stance. Basically they define the family as a natural group as opposed to an artificially formed T-group. The family members are encouraged to interact with one another. The therapist assumes an observer position, and moves into direct or clarify process or to make process or dynamic interpretations.

In the past few years this group has also shown an increasing interest in general system concepts and in the structures of transactional analysis as they apply to working with families clinically. Alger has combined group, general systems, and confrontational use of video playback in his version of family and multiple family therapy.

By 1968 there was a strong experiential thrust in the field. The experiential therapist defines his operating clinical territory as the time and space of the therapy session. The therapist sets several rules as to what will or will not happen in the session. Some of these rules are explicit, others are communicated on a meta level. One of the forbiddens is reporting on the goings-on between the sessions. The therapist attempts by use of his or her feeling-level barometer to monitor the family for feeling-level issues. Picking up an issue the therapist then moves to engage the family in an "experiential happening." The idea is that if the family could experience themselves in the therapist’s presence in a different way on a feeling-level, change for the better – that is, a more open feeling-oriented family – would occur. The most widely known proponents of this position once were Whitaker and Andy Ferber; but Whitaker has since shifted his focus from attempting to stage an experience for the family to attempting to set up an emotional experience for himself. His premise is that rather than trying to force the family to have an experience, if he as the therapist has an experience in craziness, the family will automatically benefit from their experience of him.

I expected when I first moved from Washington to New York that Ackerman family therapy would be the prevalent form. Experience didn't bear this out. Ackerman in person and on film showed himself to be a crafty experienced clinician, at ease in the clinical situation involving the whole family. The theoretical threads running throughout his work were dependency, sex, and aggression. Ackerman remained closely tied to his position as a psychoanalyst, and it interfered

with the development of a clearly delineated family theory in his work, as a result of which he had difficulty involving a reproducible method of clinical family intervention.

Norman Ackerman, Nathan’s cousin and also an accomplished and experienced psychoanalyst and family therapist, is strikingly similar in his clinical operations. In recent years Norman has moved more and more toward systems as the theoretical base for working with families. Two other senior clinicians in the family movement also strongly influenced by Ackerman are Israel Zwerling and Salvador Minuchin. A videotape of a Zwerling family interview shows this influence, as Zwerling skillfully moves the family to a clear definition of the problem. Zwerling also has remained strongly wedded to psychoanalytic theory; at the same time he functions as perhaps the most important and effective administrative protector of developing family systems concepts. Minuchin shows the influence of Ackerman in his clinical artistry; he also reflects the theoretical influence in recent years of Jay Haley. Minuchin has somehow combined these influences and added his own considerable clinical experience and skill. Since 1970 Minuchin has clearly moved from an analytic theoretical base to a system-base. In fact, he may well end up by bridging the ideologies in such a way that it will allow therapists to move more comfortably back and forth between them.

In 1970, the systems view was clearly a minority point of view. There were two major foci of its development in the field – the work of the California communications theorists, derived from Bateson, and the work of Murray Bowen.

Bateson's communications project, which was further developed by Jackson, Haley, and Satir, used a communications and structural model to define family process dysfunction. What has grown out of the original work is twofold: strategic therapy, and family structural therapy. Strategic brief systems therapy combines a communications systems approach, the use of paradox, and the strategic wizardry of Milton Erickson. Together these provide a framework for bringing about change in the system. The focus is directly on the presenting symptoms; the reality of the problem is defined as narrowly as possible, and strategies of intervention are planned.

A basic premise is that reality is defined as we choose to define it. In people's attempts to deal with life, their solutions most often become the problem. The hope is that intervention will bring about an alteration and redefinition of "reality" in the form of a more functional solution. This method appears to differ from that of Minuchin in that in addition to communication, symptom focus, and paradox, Minuchin takes into consideration the characteristics of families, boundaries, and structural concepts such as triangulation. Minuchin's work is thus broader than the strategic therapists', but considerably narrower in scope than Bowen's.

The family systems theory developed primarily by Bowen originally centered on concepts closely tied to psychoanalysis and schizophrenia. Since the 1950s, however, Bowen has consistently moved to develop an extensive, all-encompassing system-based theory of emotional dysfunction. His working field is a three- to four-generational view of the family, in which he pays special attention to the triangulation, marital fusion, and reciprocity.

Each systems-based ideology differs in the scope of its focus, philosophy of what is possible in life via therapy, and definition of education. The strategic and structural approaches are both pragmatic and context determined in their philosophy; their focus is symptom-oriented and their

belief is in the implicit education of experience. Their outlook is more pessimistic than Bowen's. The Bowenian model is cautiously idealistic and optimistic about the inherent human potential for growth and change. It is strongly based on a philosophy of free will. Education at its best is seen as a combination of the implicit knowledge of experiences, solidified and reproduced by cognitive appreciation of its form. The differences in philosophy and outlook are probably due to a combination of the personal characteristics of the people involved, the characteristics of the majority of their patient populations, and the context limitations of each.

In the years since I first published this classification, the systems approach has moved from the periphery to the center of the field. Different people mean different things by the word *systems*, however. As I see it today, there are basically four kinds of systems orientations present: general systems; structural family therapy; strategic family therapy; and Bowenian family systems theory and therapy.

The best psychoanalytic thinkers, like Otto Kernberg, frequently speak of general systems applications to the larger social context both in order to understand human behavior and to mobilize forces to alter the context. On an interventional level, however, they move back to cause-and-effect individual theory and the corresponding techniques. Other general systems thinkers such as Scheflen are heavily into the study of context determinants, sociology, and anthropology. Since this type of general system abstraction has not as yet been translated into clinically relevant terms, these people assume a position of interventional nihilism.

Another possible way to classify family therapists cuts across the theoretical positions. Some use family interventions in all or most of their clinical work, but when faced with emotional dysfunction at home seek an individual therapist for that person. Others seek intervention on a family level for their personal system as well.

The men and women who have been largely responsible for creating, thinking through, and sustaining interest in the field of family therapy over its first quarter-century developed their own base lines and fought a guerrilla war. Those who follow in the second twenty-five years may not fully appreciate the context in which they operated. A useful paradigm for understanding the development of family movement as a conceptual revolution might be the struggle of Sigmund Freud as he tried to convince the established medical community of his own time that his ideas were not the ramblings of a madman.

The future of the family therapy movement will be determined by many things. Two major influences will be the course of research, and clinical work. Another influence will be the future relationship between family therapy and the field of psychotherapy at large. Will it be able to move more into the mainstream without becoming absorbed and dissipated? It is inevitable that the restless minds of a new generation will seek new approaches to understanding human emotional functioning. If family therapy does become conventional and orthodox, it will, like other human systems, draw up its own lines of resistance to change. Time will tell; and it will be fun to watch and participate.

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In the early 1990s, the American Psychological Association invited Guerin to contribute a chapter in a volume being edited by Donald K. Freedheim, to be called The History of Psychotherapy: Century of Change. Guerin's contribution was to be on the development of family systems therapy over the previous 40 years. Guerin agreed, on condition that he could ask the psychologist David R. Chabot to collaborate on the project. The result, "Development of Family Systems Therapy," is an updated version of his first history and a new view of the following fifteen years. It is the next piece reproduced below.

There is considerable overlap between these two essays. There is also, however, a great deal of material that is unique to each of them. They have two themes in common: they are both fascinating descriptions of the personalities involved in the beginning and development of the family systems movement; both of them are also detailed and lucid interpretations of the theories – different and yet interconnected – developed by these men and women. Guerin had an inside view of almost all the major figures, and was an avid student of theory. Both pieces will repay a careful reading.

The Development of Family Systems Theory in Family Therapy

Philip J. Guerin, Jr., M.D. and David R. Chabot, Ph.D.

The family has long been recognized as an important factor in the physical, spiritual, and emotional well-being of its individual members. Research and clinical work with emotional dysfunction in families dates back at least as far as Freud. Thinking about the family in relation to the emotional well-being of its individual members appears to have gone through a series of evolving, yet somewhat repetitive cycles. In the years when emotional problems were viewed as a byproduct of neurological and/or moral failings within the individual, the family was seen as the victim of its dysfunctional member. As psychological theories moved toward explanations based on deficiencies in nurturing, families came to be viewed as the malignant victimizers. Today an interesting dichotomy exists. On the one hand, advances in biological psychiatry and neuropsychology have focused on the family as a genetic source of schizophrenia and depression, while simultaneously being victimized by the stress of living with the disorder in a family member. On the other hand, self-help movements such as the Adult Children of Alcoholics in essence have framed every conceivable malady as a byproduct of the victimizing experience of having a parent with a dysfunction such as alcoholism.

From a clinical perspective, the family has long been included in dynamic formulations and treatment planning. Freud's published cases exhibited an interest in and appreciation of family factors. The phobic problems of Little Hans were treated by Freud's coaching of the father, a method not too discrepant from what a modern-day family therapist might use. Alfred Adler's investment in the Child Guidance Movement, with its emphasis on the importance of family in the diagnosis and treatment of emotional problems in children, is another example of focus on the importance of the family. Nathan Ackerman, one of the founding fathers of the modern

family therapy movement, demonstrated in 1937 his interest in the emotional power within the family when he studied the impact of the "Great Depression" on coal miners' families. Minuchin in 1987 called attention to the work of child psychiatrist Fred Allen, who interviewed families as part of the clinical evaluations of children at the Philadelphia Child Guidance Clinic as early as 1924.

In the early 1950s, small groups of professionals in the mental health field, working separately and in disparate places, began a movement to make the "family unit" a primary focus of research and clinical intervention. Over the 40 year period from 1950 to 1990 family psychotherapy has evolved from these beginnings in the research studies of families with a schizophrenic member, and in the child psychiatrist's attempt to incorporate family members into the treatment of troubled children and adolescents, to a full-fledged division of the mental health field.

There are many histories of family therapy already in existence. Among those most useful to the student and practitioner are Guerin (1976), Kaslow (1980), Goldenberg and Goldenberg (1983) and Nichols (1984). Each of these surveys charts those people in their times and places, whose interactions played a significant part in the development of the family therapy movement. This chapter in contrast attempts to focus more on the development of the theory of family psychotherapy and on the oral history of the family therapy movement.

In a 1974 paper on comparative approaches to family therapy, Guerin proposed the first theory-based classification of family therapy. He distinguished between those practitioners who based their clinical methodology on traditional psychoanalytic theory and those who attempted to formulate a systems-based conceptual framework. If this classification were reorganized using the metaphor of the family tree, there would be two major theoretical sources -- trunks -- from which most of what we know as family psychotherapy derived its concepts. The communication-context trunk was represented in the early 50s by the Bateson project. Psychoanalysis, the other major source, has multiple and diverse branches, ranging from technique-oriented minimal use of the family in support of individual therapy, through group therapy, and on to multi-generational systems therapy. There is a further division within the psychoanalytic trunk among those who became interested in the family via studies of schizophrenia, those whose interest stemmed from working with the families of less severely disturbed children and adolescents, and those who went on to use humanistic psychology as their primary framework. To clarify the development of the concepts and clinical methodology of family psychotherapy, the authors have chosen to track the developmental history of four key groups of theorists:

1. The communications trunk began with the Bateson Project, continued through the works of Jackson and Haley and extended to the brief therapy project of Watzlawick, Weakland, and Fisch. The Ackerman Brief Therapy Project and the work of the Milan Associates also branched from this trunk.

2. The psychoanalytic multigenerational systems trunk included the work of Bowen, who developed his theory at the Menninger Clinic, at the National Institute of Mental Health, and at Georgetown University, and the contributions of his major professional descendants. This section of the chapter will also include a view of the work of Wynne, who succeeded Bowen at NIMH, Nagy and Framo, two other prominent multigenerationalists. All of these clinicians began by studying schizophrenics and moved on to work with a less dysfunctional population.

3. The experiential systems trunk included the work of Whitaker, and Satir, both of whom worked independently of one another but shared common humanistic frameworks overlaying primarily psychoanalytic beginnings.

4. The structural family therapy theorists began their work in the Child Guidance movement. It included the significant contributions of Nathan Ackerman, a child psychiatrist, and continues to the present in the work of Salvador Minuchin, another child psychiatrist.

5. Behavioral family therapy, which is viewed by the authors as outside family systems theory, is commented on briefly.

Communication Theorists

Bateson

The Bateson Project began in California in the early 1950s. Its goal was to demonstrate how the communication patterns in families with a schizophrenic member made logical sense if one understood the rules of the relationship context or culture in which the symptoms were produced. The project was staffed by a diverse and multitalented group of professionals.

Gregory Bateson, an anthropologist and student of animal behavior, evolution, ecology, and cybernetics, brought a knowledge and understanding of context, culture, and the structure and function of communications to the work. He was far more interested in the science of communication and theory building than in therapy. Bateson derived his model for studying communication from the theory of logical types (Whitehead and Russell, 1910). He began his work in psychiatry through a collaboration on the social matrix of psychiatry with Jurgen Ruesch at the Langley Porter Institute in California.

In 1952 Bateson received a grant from the Rockefeller Foundation to study the nature of communications. The following year he was joined by Jay Haley, who had just received his MA in Communications from Stanford. Also joining the project at that time was John Weakland, a chemical engineer interested in cultural anthropology. In 1954 Bateson was awarded a grant from the Macy Foundation to study patterns of communication in schizophrenics. It was at this point that Don Jackson, a psychiatrist, joined the project as clinical consultant and supervisor of psychotherapy. Jackson had been supervised as a psychiatric resident by Harry Stack Sullivan and brought with him an understanding of the interpersonal dimension of psychopathology. This group of Bateson, Haley, Weakland, and Jackson then undertook the study of communication in families with a schizophrenic member. In the early phases of their work together, staff members interviewed individual hospitalized patients at the Palo Alto Veterans Hospital. From these interviews and the staff collaboration that followed, the concept of the "double-bind" began to emerge. It was based on several preliminary ideas having to do with notions of family homeostasis and multiple, often contradictory, levels of communication and relationships. In certain relationship situations an overt, explicit meaning of a communication is contradicted by the implicit or "meta-" message. Hoffman cites an excellent example of such a bind when one person in a relationship expresses to the other the command "dominate me." Clearly the person addressed can only dominate by obeying the command, thereby complying, which is the opposite of domination. Hoffman points out that the only way one can respond to such a request is to

point out the impossibility, make a joke, or leave the field. However, families often block all attempts to make the implicit explicit, or attempts to clarify contradictory messages even in a joking way, and often, especially in the case of children, it is not possible to leave. When these conditions exist, a potentially malignant context has been established that can foster significant symptomatic behavior.

The six basic characteristics of the double bind were summarized by Nichols in 1984 as follows:

1. Two or more persons are involved in an important relationship.

2. The relationship is a repeated experience.

3. Primary negative injunction is given, such as "do not do this or I will punish you."

4. A second injunction is given that conflicts with the first, but at a more abstract level. This injunction is also enforced by a perceived threat. This second injunction is often nonverbal and frequently involves one parent negating the injunction of the other.

5. A third-level negative injunction exists that prohibits escape from the field while also demanding a response.

6. Once the victim is conditioned to perceive the world in terms of a double bind, the necessity for every condition to be present disappears and almost any part is enough to precipitate panic or rage.

The concept of the double bind, like many ideas before and since, did little to alter the course of schizophrenia. However it did mark the beginning formulation of a series of interconnected ideas that form the basis for what is known today as strategic family therapy.

Jackson's continued refinement of the double bind concept manifested itself in his work on creating a therapeutic double bind. The therapeutic double bind is an intervention wherein the therapist attempts to double bind the patient or family. Whereas the concept of the double bind is defined as containing six characteristics, the notion of the therapeutic double bind is more loosely constructed. As described in 1961 by Jackson, this technique prescribes the symptom. The rationale as documented by Haley in 1961 is based on an attempt to turn the natural oppositional forces within the family system onto the pathological process under investigation, hoping thereby to neutralize the pathological forces and to eliminate the symptoms.

Nichols in 1984 uses an example of Haley's early use of the therapeutic double bind to explain the idea. In this example Haley recommends hearing voices to a schizophrenic patient. If the patient responds by hearing voices he is being compliant with the therapist. If he fails to hear voices he must give up the claim to being crazy. In reality then the therapeutic double bind was the earliest beginning of what has come to be known as paradoxical injunction.

In *The Pragmatics of Human Communication*, Jackson and his co-authors provide an enriched version of this treatment strategy used with individuals and couples. Hoffman in 1981 chooses two examples of Jackson's work in this regard. In one example a woman with intractable headaches is told that her headaches cannot be cured but that the therapist will direct his attentions towards helping her live with her disability. In another case a couple with a chief

complaint of constant arguing and bickering are informed by the therapist that their bickering is a sign of emotional involvement and therefore this apparent continuous conflict only proves how much they love each other. From these two examples, we again see the genesis of the techniques of paradoxical intervention and reframing as practiced in the strategic model of family therapy today.

Jackson founded the Mental Research Institute in 1959 and invited Virginia Satir to join him. Although MRI and the Bateson group occupied the same building for three years, there was no formal link between them. MRI had a clinical treatment bent, while the Bateson Project continued its interest in theory. Although the Bateson Project failed to produce a cohesive comprehensive theory, it did produce a series of interconnected ideas and develop a diverse and talented group of clinicians and researchers, many of whom continue to contribute to the field.

At the time of Jackson's premature death in 1968, he had already published two outstanding books: *The Pragmatics of Human Communication* with Watzlewick and Beavin in 1967 and *The Mirages of Marriage* with William Lederer in 1968. His writing, his contribution to the Bateson Project, and his establishment of MRI have made a lasting impact on family psychotherapy. As the psychiatrist in the Bateson group, Jackson perhaps felt the most pressure to convert the ideas and observations of the project into clinical methods useful in working with families. His early death in a field dominated by personalities has to some degree obscured his contributions.

Jackson shared the belief with Bateson that behavior and communication are synonymous. Like Bowen, he borrowed some of his ideas from biology. Jackson's concept of family homeostasis described how families, like other organic systems, resist change, and when challenged, strive to maintain the status quo even at considerable emotional cost to one of their members. He was among the first to observe the organizing function that a child's behavioral symptoms provide for camouflaging covert parental conflict.

Thus far we have considered, in a much abbreviated way, some of the ideas of Bateson, the anthropologist, and Jackson, the psychiatrist. Their influence on generations of descendants was strong but often not fully acknowledged or documented. Of the persons who played a part in the Bateson Project, those most directly influential on the clinical behavior of succeeding generations of family therapists have been Haley and Satir. The remainder of this section deals with the contributions of Haley and John Weakland who, with his collaborator Richard Fisch, developed one of the first family-based systems of brief therapy. The work of the Ackerman Brief Therapy Group of Hoffman, Papp, and Silverstein and the work of the Milan Associates will also be considered. Satir will be considered in the section dealing with the experiential group.

Jay Haley

Haley emerged from his work on the Bateson Project with a twofold conviction that clinical symptoms were a byproduct of context, and that a power struggle for control was the process behind the behavior patterns in a relationship. A logical consequence of this thinking is the view that a symptom in a person is a strategy for control within a relationship. The covert nature of the process, its being out of everyone's awareness, and the function it serves for the symptomatic individual and for the family homeostasis, make direct confrontation of the symptom and/or making the process explicit a fruitless endeavor. Therefore, counter-strategies that bypass or

confuse the homeostatic mechanism, creating chaos, and allowing for spontaneous reorganization represent the required clinical methodology. From the beginning of his work, Haley paid close attention to hierarchical structure as it relates to power distribution and advocated therapeutic strategies to defeat entrenched patterns of dysfunctional behavior.

Haley's work with Minuchin and Montalvo helped fashion structural family therapy, a method dealt with in detail later in the chapter. Early video training tapes from the structural family therapy project of the Philadelphia Child Guidance Clinic demonstrate clearly Haley's penchant for creating strategies intended to bypass the naturally occurring power struggle between the family and the therapist. Haley believes in exerting influence from an "outsider" position. For example, he formulates intervention plans and supervises their clinical implementation by trainees, but doesn't do clinical work himself. In the 1970s, Haley left Philadelphia and established his own Family Institute in Washington, DC. From then on his focus shifted away from structural family therapy concepts to the pursuit of a more refined understanding of hierarchy, power, and strategic intervention.

It was at this time he surfaced his affiliation with Milton Erickson, a psychiatrist with a partiality for the creative use of hypnotic techniques that in some vaguely understood way seemed to move his patients (mostly individuals) from dysfunction to function. Erickson too "encouraged resistance" as a technique to bypass direct confrontation with symptoms. Haley's derived methods of strategic problem-oriented therapy based on Erickson's methods were presented in his 1976 publication, *Problem-Solving Therapy*. This method came along at a time when long-term psychotherapy was beginning to be viewed by some as inefficient and even abusive to the patient's finances, as well as self-serving for the therapist. By the 1980s, strategic family therapy clearly began to dominate the field of family therapy.

Two predominant characteristics of Haley's methods are his firm belief in the uselessness of direct educational techniques, and his corollary commitment never to explain himself but rather to operate covertly upon the processes of power within a relationship. This second concept is perhaps most easily demonstrated with Haley's approach to the concept of triangulation. Often family therapists will try to deal with triangulation by educating families about how they are caught in the process. Haley rarely ever mentions the concept, but in his training tapes and publications frequently operates in a strategic fashion that relies strongly on the concept. For example, in his training tape "The Boy with the Dog Phobia" he uses the task of the father's buying a dog to confront the father’s and son’s anxiety about dogs, while simultaneously closing the distance between them. An important side effect of this combined structural and strategic intervention that illustrates the notion of triangulation is a surfacing of the mother's depression and of the covert conflict between the parents.

Since the founding of the Washington Family Institute, Haley's major collaborator has been his wife, Chloe Madanes, who has become a respected clinician and author in her own right. Haley and Madanes have fashioned a clinical method for working strategically with severe marital dysfunction that has been documented in Haley’s 1984 book *Ordeal Therapy.* In this method a strategic ordeal is fashioned that provides, on the one hand, a ritual of penance and absolution, and on the other, a bond formed between two people who experience an ordeal together. A classic illustration of this method describes the formation of a strategic ordeal for a couple with a long-term sadomasochistic physically abusive relationship. They were instructed to shave their heads completely, take the hair and bury it in a particular place several hours from their home.

As a follow-up they were instructed to make repeated visits on a regularly scheduled basis to the burial ground. This strategic ritual represented not only a shared ordeal but a symbolic burying of their old dysfunctional patterns of relating, thus freeing them to activate the potential of numerous, unused, more functional patterns in the relationship.

Haley has been critical of traditional psychiatric methods and family therapy methods that fail to take into consideration his basic premises about the importance of power and control. In our opinion, there is nothing incompatible in the structural-strategic approach of Haley and the multigenerational system approaches of Bowen and his descendants. One of the places this becomes evident is in a consideration of the systemic therapy of the Milan group.

Milan Associates

The Milan Associates consisted in its early years of four principals: Selvini-Palazoli, Boscolo, Cecchin, and Prada. Maria Selvini-Palazoli, a psychoanalytically trained psychiatrist, began in the late ‘60s to treat anorexic children and their families. She moved on to work with schizophrenic families from a systems perspective. The Milan Associates model is an interesting method with fibers from the work of the Bateson project, the strategic therapists, Minuchin, Jackson, and Bowen all woven together into a highly creative fabric. Their method stresses the importance of defining the family's rules – an approach similar to that of Jackson in his early work. In addition it pays specific attention to Haley's emphasis on power and control.

The frequency of the sessions – once a month – is often described as making this method "long brief" therapy. This same frequency has been used by Bowen in his work with individuals, families, and multiple family groups since the early ‘60s. Bowen, whose methods will be dealt with in detail later in the chapter, has long believed less frequent sessions were more beneficial to the process of change than once a week meetings, which, he felt, foster dependency between therapist and family and impeded change. Another similarity between the Milan method and Bowen's work has to do with what the Milan group calls "circular questioning." This technique is described as framing every question so as to address differences in perceptions about events and relationships. Any study of Bowen's clinical interviews on videotape demonstrates a very similar technique that Bowen and his descendants have termed the "process question.”

Both the Milan model and the work of Bowen emphasize "therapist neutrality," although each approaches the problem from the opposite position. In the Milan model the therapist tries to remain allied with all family members, and thereby attempts to avoid getting caught up in family alliances and coalitions. If opposites are the same, then being allied with all family members is the same as being allied with none of them, which is Bowen's therapeutic stance.

The Milan group also includes techniques of paradox and counterparadox closely related to the work of Bateson, Jackson, and Weakland on the therapeutic double-bind. In this country the Milan group’s methods were built upon, and modified by, Papp, Silverstein and Hoffman who worked at the Ackerman Institute and fashioned an American version of the Milan method.

Watzlewick, Weakland, and Fisch

Weakland, one of the original principals in the Bateson Project, collaborated with Jackson on a 1961 article which centered on theory, technique, and outcome results of conjoint family therapy used with schizophrenic families. In 1967 Paul Watzlewick wrote a book with Jackson and

Beavin entitled *The Pragmatics of Human Communications*. In it they sought to develop a "calculus" of human communications, that is, a series of principles about communication and meta-communication. They defined disturbed behavior as a communicative reaction to a particular family relationship situation rather than evidence of a disease of the individual mind.

Following Jackson's death in 1968, Watzlewick and Weakland were joined by psychiatrist Richard Fisch, to form the Brief Therapy Project at the Mental Research Institute. The core of their work became an attempt to define clearly the clinical problem as presented, and then carefully link this problem to the repetitive sequences of behavior observable in the relationships surrounding the problem. It was their assumption, derived from the concept of family homeostasis, that these repetitive cycles of relationship behavior, while intended as a solution, end up reinforcing the problem.

For example, in an adolescent-focused family, the problem might be defined as the son's underachieving in school for 10 years. The mother is involved in an intense effort to structure her son's activities and improve his study habits. The more she pressures, the less he does. The strategic therapist, after investigating the "problem" in great detail, suggests the following approach: The mother is told that her interest in and caring for her son are admirable, and the only reason it isn't working is that she hasn't done it with quite enough intensity and should increase her efforts. The therapist explains that the reason this is needed is that her son, although a fine young man, is nonetheless somewhat immature for his age, and therefore, at present, unable to assume responsibility for his school performance.

The mother and the son both develop an oppositional response to the intervention. The mother stops pressuring her son, reasoning that she already has too much responsibility and doesn't have any more time, and that he has to grow up someday. The son is incensed that the therapist has labeled him immature and proceeds to prove him wrong by accepting responsibility for structuring his time better and being less passive about his school performance. With this result the strategic therapist has completed the work of therapy.

In their book these three investigators emphasized both the pathological and potentially therapeutic aspects of paradox in human communications and the value of the therapeutic double-bind. They demonstrated no interest in triangles or transmission of anxiety, in the son's developmental issues, or in the fact that the mother's father is seriously ill. These factors are not included in the problem definition or in the treatment plan unless presented as a problem by the family to the therapist.

In 1974 Watzlewick, Weakland, and Fisch collaborated on a text entitled *Change: Principles of Problem Formation and Problem Resolution*. The book was concerned with "how problems arise, are perpetuated in some instances, and resolved in others." It was an outgrowth of the work of these three men in MRI's Brief Therapy Center. Problem formation, problem resolution, first-order change, second-order change, and reframing are among the important issues addressed. A summary of the principles of first-order and second-order change reveals the importance of this book.

1. First-order change is what occurs within a given system while the system itself remains unchanged. It is a logical, common sense solution to a problem. If Johnny is failing in school, mother must supervise his school work more closely.

2. Second-order change is applied when first-order change, the logical common sense solution, is clearly demonstrated to be at the center of an escalating problem. In other words, use second-order change when first-order change is making the problem worse. (The mother's hovering in the previous clinical example is the escalating problem.)

3. Second-order change based on reframing and paradox flies in the face of logic and common sense and is usually perceived as weird and unexpected. (The second-order change in the above example is the defining of mother's escalating behavior as desirable and is required in greater amounts to produce the desired result.)

4. The use of second-order change lifts the situation out of the trap created by the self-reflexive, common sense solution and places it in a different frame. (The entrapping, repetitive cycle of mother's pressure and son's responsive passivity is replaced by a new sequence of behaviors which eliminates the symptoms.)

Over the first 40 years of the family therapy movement, what began as Bateson's interest in culture, communication, and the mysteries of schizophrenia has become a clinical methodology for dealing with a wide spectrum of psychological disturbances within the individual and in relationships. The clinical methodology rests on a loosely connected set of concepts about the nature and patterns of communication (for example, the double bind); about family homeostasis as the natural tendency for the perpetuation of dysfunction in relationship systems; and about triangles as structural expressions of the relationship patterns which maintain a dysfunctional equilibrium. These concepts are then linked under two global assumptions that determine the form of the specific clinical methodology to be applied to a particular situation. The first assumption is that individuals and/or relationships in dysfunction are emotionally caught in a reactive process in such a way that they are unable to free themselves. Increasing efforts to break free only increase friction, frustration, and anxiety; eventually symptoms appear. The second assumption is that in each individual and in each relationship system there is a naturally occurring oppositional reaction, that is, resistance, to attempts at change.

The clinical methodology that arises from these concepts and assumptions is at once simple and complex. The therapist must devise a strategy that neutralizes or bypasses the naturally occurring "resistance" mechanisms. If this task is accomplished a corrective program may be introduced that has a better chance of being successful. The system will thereby lower friction and tension and alleviate symptoms. Once symptoms have been relieved, the system and its individual members are free to resume their individual and collective developmental pathways.

Interventions traditionally developed in this method are more of an art form than other more linear models. The "therapy as an art form" aspect of this model is reminiscent of the healing methods of the Shaman, a particularly interesting twist when viewed in the light of Bateson's beginnings as an anthropologist.

The Psychoanalytic Multi-Generational Theorists

The next group of theorists to be considered is implicitly defined by several common features in their work. Each of them maintained a multigenerational focus, that is, their definition of the family unit included a minimum of three generations. In addition they all begin to study family relationships through an interest in schizophrenia, and started their work with psychoanalytic

theory as their conceptual base. The group can be divided into four sub-categories: object relations and multigenerational themes (Nagy and Framo), a group focus (Bell and Wynne), the Bowen group, and the experientialists (Whitaker and Satir). This section will deal with each of them in turn, emphasizing most the work of Bowen and his descendants.

Object Relations

As mentioned earlier, Freudian theory has long been influential in understanding the impact of family relationships on the psychological functioning of its individual members. In the early days of family therapy, attempts to formulate a separate theory for "family" were resisted by the core of the psychoanalytic community. Family therapy was viewed as a technique similar to group work, which had successfully adapted traditional Freudian theory to its clinical methods. Clinical work with families, from the perspective of the analytic community, was indicated in two situations. One was to deal with family members about ways they were potentially defeating the transferential therapy of an individual. The other was to deal with the opening up of communications around tension-filled issues within the family. Initially there was considerable skepticism about seeing families because of its possible effects upon the transference, but eventually a group of therapists still committed to psychoanalytic theory began to experiment with such methods. Those in the analytic community who maintained both the allegiance to analytic theory and an interest in clinical interventions with families moved toward the model of object relations theory as their primary conceptual base.

The theoretical underpinnings of the object relations approach to family therapy rests on the work of Klein and Fairbairn. Klein’s concept of good breast/bad breast refers to infantile ambivalence about the mother derived from the developmental experiences of nurturance and separation. Fairbairn developed the idea of the existence of internalized relationship structures. Contained within these proposed structures were partial objects, that is, a portion of the ego and the affect associated with the relationship. The external object was perceived as either all good or all bad or both in alternating cycles, which Fairbairn referred to as splitting. It was his belief that when the splitting process was not resolved, the individual's ability to objectify relationships was impaired. This concept of "splitting" has been developed further in the notion of projective identification.

Projective identification is defined as a process whereby an individual first projects onto another person certain denied behaviors or characteristics of his or her own personality. Then in the relationship interaction, the person behaves in ways that either provoke such behaviors from the other, or reacts as if the other possesses these characteristics, which thereby reinforces the projective perception. A simple example from a marital relationship would be when a wife with an internalized judgmental and negative image of herself projects the perception of a harsh, critical, unloving person onto her husband and then behaves in ways that predictably bring forth critical and withholding behaviors on his part.

Family therapists, working with these concepts as a theoretical base, can track this type of interactional process within the session and interpret the object relation forces that are driving the conflict. These methods closely resemble those used early on in psychoanalytically-based family therapy, wherein the existence of naturally occurring "transferences" in the family were hypothesized and interpreted clinically to explain relationship conflict and dysfunction

Nagy and Framo

Ivan Nagy, a psychiatrist, and James Framo, a psychologist, edited a volume together in 1957 entitled *The Intensive Family Therapy of Schizophrenia*, which brought together papers from most of the leading family researchers at that time. Framo went on to adopt Fairbairn's object relations theory as the basis for his work. In his practice this position led to his inviting significant extended family members into the sessions, especially when dealing with marital conflict. Framo also expended considerable effort in his attempts at integrating his work with that of others whose theoretical stance derived primarily from psychoanalytic theory.

Nagy also maintained his primarily psychoanalytic orientation while moving away from the study of schizophrenia to study the issue of "loyalty" in families, in particular as it influences coalitions and alliances over multiple generations. This work is described in his book *Invisible Loyalties*, written with his colleague Geraldine Sparks in 1973. In this text Nagy offers the concept of the "family ledger," an invisible ledger of multigenerational accounts of obligations, debts, and events perceived as relationship atrocities. These firmly entrenched emotional wounds require retribution of some kind over the generations. In 1981 Hoffman proposed forgiveness as the key to this method of therapy. She also draws attention to the aspects of Nagy's method that resembled the reframing techniques of strategic therapy. Hoffman reasons that if the problem's genesis is reframed in terms of old wounds and loyalties, family members have a face-saving mechanism that allows them to give up their present-day conflict.

Group Focus

The family as a naturally occurring group was a logical unit of focus for those who had developed and refined methods of working with artificially formed therapeutic groups. One of the earliest pioneers in the family therapy movement, Bell maintained his theoretical group orientation in his work with families. Lyman Wynne, director of the Family Division at NIMH for many years, is another prominent family therapist who uses a group model.

Bell

Bell began his clinical work with families in the early 50s. His conceptual framework is based on the work of Bion and the Tavistock Group. His efforts to adapt group therapy principles and techniques to the family unit resulted in his formulation of seven stages in the work of Family Group Therapy.

These seven stages demonstrate clearly Bell's investment in traditional analytic and group theory. They include the "initiation," a feeling-out process between family and therapist in which the goals are defined and the therapeutic contract set. The initiation phase is followed by a period of "testing" in which the rules of the contract formed in the preceding stage are tested, and when necessary, are rewritten to fit more closely the reality of the clinical situation. The third stage is termed the "struggle for power." In this phase individuals and sub-group coalitions maneuver for power and influence within the process of the group. The next two phases consist of "settling on a common task" and working toward "completion of a common task." The working through of the first five stages culminates in the sixth stage termed "achieving completion." In this stage, having dealt with the power struggles and coalitions, the group is ready to include all members in the task of developing a climate of mutual support as individual and relationship issues are

discussed and worked out. This having been accomplished, the family group is ready to separate from the therapist and resume its "natural" developmental life. This seventh and final stage is logically termed "separation." Bell strongly believes in the importance of maintaining effective boundaries between the therapist and the family group.

Wynne

Lyman Wynne, who succeeded Bowen as director of the Family Division at NIMH in 1959, also came to the study of schizophrenia and the family with a psychoanalytic background. In addition, his approach to the family was primarily that of an analytically-based group model developed at Tavistock. In his research on schizophrenic families, he developed two interlocking concepts that were mostly descriptive of the family as a group. These two concepts were "pseudo-mutuality" and the "rubber fence" phenomenon. Pseudo-mutuality was a term used to describe a surface appearance of agreement and attachment among family members. In reality the family members were tightly locked into dysfunctional roles that did not permit individuation from the family or truly close relationships within it. Externally, however, particularly in public, the family was unpredictably impenetrable because of its seeming automatic ability to expand and contract in a reflexive fashion. An "outside" person, such as the therapist, seeking to engage family members would feel an ease of entry into the family only to be bounced out as if by a rubber fence if certain unwritten rules were violated. These concepts describe phenomena present in varying degrees in families throughout the spectrum of dysfunction, but particularly in families with a schizophrenic member. These concepts, developed in a research program, have yet to be integrated into a more diverse and elaborate clinical model of family therapy.

Bowen

Bowenian Family Systems therapy is a theoretical-clinical model which evolved directly from psychoanalytic principles and practice. It is the most comprehensive model of family systems theory, insofar as it consists of a defined number of concepts with a corresponding clinical methodology closely linked with the theory. Murray Bowen, its originator and major contributor, began with an interest in studying the problem of schizophrenia, and brought to the study of the family extensive training in psychoanalysis, including 13 years of personal training analysis.

In the early years of the family therapy movement, many of the pioneers trod lightly in the area of theory. Bowen was the exception to this rule, both in his emphasis on the primary importance of theory and in his belief that his observations and ideas could form the beginning of a new theory of human emotional functioning. He hoped his theory would be viewed as evolving from Freudian theory, but as clearly and distinctly different from it in its systems orientation.

Bowen believed that the task of the theorist was to find the smallest numbers of congruent concepts that could fit together and serve as a working blueprint for understanding that part of the human experience under observation. He repeatedly warned of the pitfalls of lowest common denominator eclecticism. Bowen dates the beginning of this theory to his clinical work with schizophrenia at the Menninger Clinic from 1946 to 1954. During this time he studied mothers and their schizophrenic offspring as they lived together in small cottages on the Menninger campus. From this clinical research he was hoping to gain a better understanding of mother-child symbiosis. Observations from these studies led to the formation of his concept of differentiation. From the Menninger Clinic, Bowen moved to the National Institute of Mental Health where he

formed a project to hospitalize and study whole families with a schizophrenic member. It was this project that expanded the concept of mother-child symbiosis to include fathers and inevitably lead to the Bowen concept of triangulation, described later in this section.

In 1959 Bowen left NIMH and went to Georgetown Medical School, where he would remain a professor of psychiatry until his death in the fall of 1990. In his 31 years at Georgetown, Bowen worked to refine his theory by applying it to less dysfunctional populations and by developing a clinical methodology that he could pass on to the psychiatric residents in training at Georgetown. In developing his method of family psychotherapy, the need became clear for a corresponding method that would assist the psychotherapist in the development of his or her own personal autonomy. To this end Bowen began to research and experiment with the emotional process within his own personal family system. The developing concepts of his theory were presented in two key papers: "The Use of Family Theory in Clinical Practice" (1966) and "Theory in the Practice of Psychotherapy" (1976). The documentation of his "research" on his own family of origin was first presented at a national family therapy conference in 1967 and published in 1972 as a paper entitled "On the Differentiation of Self."

In these articles, Bowen designates eight concepts as central to his theory: differentiation of self; triangles; nuclear family emotional system; family projection process; the emotional cutoff; multigenerational transmission process; sibling position; and societal regression.

The concepts of differentiation and triangulation form the core of Bowen's theoretical contribution.

Differentiation

Bowen's concept of differentiation consists of two component parts: emotional fusion within the dyad, and differentiation of the individual. In his observations on mother-child symbiosis Bowen recorded alternating cycles of closeness and distance within the mother-child dyad. He hypothesized that sequential cycles of separation anxiety and incorporation anxiety were the primary emotional forces driving these seemingly automatic and reactive relationship patterns. The very interdependent nature of the relationship between mother and child limited the potential for autonomous functioning in both of them. Their behaviors were determined by their anxious attachment to each other rather than by their own internal choices. By virtue of this fact they may be said to be emotionally fused to one another. On a structural level this fusion denotes a blurring of appropriate personal boundaries.

On a process level there is a contagious anxiety that and traps both members of the dyad, determining their behavior in relation to one another as well as their individual levels of emotional functioning. Anxiety in either the mother or child produces an automatic reflexive response in the other. These automatic emotional responses and behaviors described the fusion (that is, lower) level of Bowen's proposed spectrum of emotional functioning.

The opposite profile is of a high functioning individual capable of emotional connection without being determined by the anxiety in an important other person or in a relationship. This differentiated self is capable of behaving in response to his or her own instinct and judgment guided by principles and opinions even in the presence of considerable anxiety. This profile of

autonomy represents differentiation, which is the opposite of fusion and sits at the higher end of Bowen's spectrum of emotional functioning.

Bowen developed a scale of differentiation which ranged from extreme fusion to the opposite: high differentiation within the person. Higher scores indicated an increasing ability to withstand high levels of anxiety while continuing to be autonomous in life choices, including relationship behavior.

Bowen believed that in dysfunctional families each individual was caught in a reactive emotional process that determines his behavior. He further believed that if one individual could, by conscious effort, lower his anxiety and reactivity to the surrounding emotional forces, that person could get free of this dysfunctional process. Once even partially free, other potential pathways of behavior would become clear to the individual. These new pathways would be more determined by principles of function than by feelings or by the reactive search for emotional comfort and refuge. If one person in the family could do this, others in the family would be afforded the chance to follow, and the functioning level of the entire relationship system would improve.

Bowen's idea that if one individual in a family could get free of the entrapment of the reactive emotional process, so that a potential chain reaction of lowering anxiety could occur throughout the relationship system, this would lead to certain therapeutic consequences. The main one is that a therapist who can remain emotionally free of a family's reactive emotional process can begin the aforementioned desirable chain reaction. How, then, does one train therapists to be capable of such a procedure? In response to this question Bowen developed his method for training therapists to differentiate a self in their own families of origin. He began by doing it himself in his own family, publishing the results, and then challenging those he trained to follow suit. In his paper "Toward the Differentiation of Self in One's Family of Origin", he spelled out his method in detail. Included in this method were four important steps.

1. *Know the facts about your family relationship system.* Bowen encouraged his trainees to construct comprehensive family diagrams in order to document the structural relationships among members of their families and to gather facts about the timing of important events such as deaths, births, etc., which he termed nodal events. He also taught the importance of including in the family diagram evidence of physical and emotional dysfunction, relationship conflicts, and emotional cutoffs, which he viewed as indicators of a family's level of emotional functioning.

2. *Become a better observer of your family and learn to control your own emotional reactivity to these people.* Bowen charged therapists-in-training with this central task to be accomplished on planned visits with team members of their family of origin.

3. *Detriangle self from emotional situations.* This part of the method entails developing an ability to stay non-reactive during periods of intense anxiety within one's own family system. To foster this process of "detriangling," Bowen encouraged those in training to visit their families of origin at times of predictably high tension, such as serious illness and/or threatened death of a key family member. During these visits the goal was to make contact with family members around an anxiety-written issue, to remain less emotionally reactive to other family members, and to refrain from choosing sides when competing influences and differences of opinions led to relationship conflict.

4. *Develop person-to-person relationships with as many family members as possible*. This double-barreled axiom was aimed at fostering detriangulation and encouraging the reestablishment of relationship connections where cutoffs or potential cutoffs had previously existed.

From this consideration of the concept of differentiation and its application to the training of therapists, the complexity of the idea becomes obvious. One of the major difficulties in operationalizing the concept is that by definition, differentiation represents an inborn psychological state inherited at birth from the emotional struggles of previous generations and only changeable to some small measure during an individual's lifetime.

Triangles

Bowen began his working model of the relationship triangle during the NIMH project after including fathers in the study. The interdependence observed in the mother-child dyad also appeared to be present in the relationships involving father. Initially Bowen expressed the idea of an interdependent triad and compared it to a three-legged stool where the removal of one leg destroyed the essence of the stool. Beginning with his observation of the reactive emotional instability of the fusion-laden dyad, Bowen proposed that the transmission of the anxiety in the dyad in order to involve the most vulnerable other in the relationship system formed a potentially stabilizing but dysfunctional structure called a triangle. Considered by many to be the originator of the concept of triangulation, Bowen placed heavy emphasis on the relationship process part of triangulation and little or none on its structural aspects. He focused instead on the potentially ever-changing configurations of relationship triangles. These automatic shifts were driven by the reactive emotional process within the relationship system.

Bowen's method of therapy closely followed his conceptual framework. As a therapist he placed himself in contact with both members of a conflictual dyad and worked to remain emotionally neutral while spelling out the emotional process within the conflictual relationship by the use of a series of "process questions," such as "What about your wife's criticism upsets you the most?" Theoretically this was meant to induce a corrective emotional experience for the family members in conflict, allowing them to lower their anxiety and seek more functional pathways of relating to each other.

It should be noted that there is a distinction to be made between triangles as a relationship *structure*, and triangulation as a relationship *process*. A triangle is an abstract way of thinking about structure in human relationships, and triangulation is the reactive emotional process that goes on within that triangle. In any relationship system, there is any number of potential triangles, and the emotional process of triangulation within the triangle can be either dormant or active in varying degrees at any moment in time.

The clinical description of a triangle is the way the three-way relationship looks at a given moment, or the pattern to which it regularly returns after temporary realignments. For example, at the time a couple presents for treatment, the triangle with their son may have become relatively fixed so that the mother and the son are overly close and the father is in the distant, outsider position. This alignment may occasionally shift, so that there are times when either the mother or the son is in the outside position and the father has some closeness with his son or his wife, but then it shifts back to its usual structure. Triangulation is the emotional process that goes

on among the three people who make up the triangle. For example in the triangle just described, the father might desire a connection with his son and resent his wife's monopoly of the boy's affections; the mother may be angry at the father's distance from her and compensate by substituting closeness with her son. The child in turn may resent his father's inattention and criticism and may move toward his mother, but at the same time be anxious about his overly close relationship with her. As the emotional process of triangulation moves around the triangle, it can produce changes in its structure. For example, the father may try to reduce his loneliness by moving toward his son or his wife, or the son may try to avoid confusion with his mother by distancing toward his peers, causing his parents to draw together in their concern for him.

Thus, triangles can shift their structure at any time for a variety of reasons, and the process of triangulation has the potential for motion at any time. As changes do occur, demands are placed on individuals and on the system to realign in a way that ensures the emotional comfort of the most powerful person and preserves the stability of the system. As Bowen pointed out in 1978, the most uncomfortable person in the triangle may try to lower his or her anxiety or emotional tension by moving to a person or thing. If that effort is successful, another person becomes the uncomfortable one and will work to become more comfortable. Bowen's concept of the relationship triangle most clearly differentiated his family systems theory from other theories of human emotional functioning.

Bowen's Descendants

During his 31 years at Georgetown, Bowen worked on the refinement of his theory and its clinical application with non-psychotic families. During this time he was instrumental in the training of many psychiatrists. Among the most prominent and influential of these are Philip Guerin and Thomas Fogarty. Both were trained by Bowen during the 60s, left Georgetown and joined the Einstein Families Studies Section in New York where Zwerling and Ferber were assembling a faculty that was representative of the diversity of thinking and practice in the field of family therapy. While in Einstein they trained Betty Carter, Monica McGoldrick, Ed Gordon, Eileen Pendagast, and Katherine Guerin, all of whom, along with Peggy Papp, joined Guerin and Fogarty in 1973 to form the Center for Family Learning in New Rochelle, New York, the other major research and training facility for Bowenian theory and methods.

The work of Guerin and Fogarty, Carter, McGoldrick, and Michael Kerr has been the most extensive and influential in the field at large. Similar to the descendants of the Bateson Group, the interconnections of these individuals is of interest in studying the development of Bowenian theory. Fogarty, Guerin, and Kerr were all psychiatric residents in the Georgetown program. Kerr remained at Georgetown as Bowen's closest associate, and his theoretical contributions have been reflective of that close collaboration. Fogarty, although influenced by Bowen, was less wedded to the multi-generational model and most of his contributions to the theory have been confined to the nuclear family and the individual. Guerin adhered more closely to Bowen's emphasis on the importance of family of origin work than Fogarty, but was also influenced by Fogarty and the Einstein faculty, particularly Andrew Ferber and Albert Scheflen. Guerin's most important contributions to family theory are clarifications and elaborations of the concepts of both Bowen and Fogarty as well as the specific application of the theory to the building of clinical models for the treatment of marital conflict and child and adolescent centered families. Carter and McGoldrick were trained by Guerin during his tenure as director of training at Einstein. As third-generation descendants, Carter and McGoldrick have contributed to family

theory in the areas of the family life cycle, as well as around the issues of ethnicity and feminism.

Fogarty and Guerin

Fogarty, like Bowen, began his work with a focus on the individual. Unlike Bowen he paid more attention to the development of structural concepts and their clinical usefulness in therapy. Fogarty's concept of the individual is a highly structural one, which he termed the four-dimensional self, including the lateral dimension, the vertical dimension, the depth dimension, and the dimension of time. The lateral dimension represents the interactive part of the individual, where the movement toward and/or away from others is formed and operationalized. It is within this dimension that Fogarty developed his most widely known contribution, which is the notion of repetitive patterns of pursuit and distance with the corresponding concept of the emotional pursuer and the emotional distance or in the marital relationship.

Closely connected to the lateral dimension was the depth dimension wherein, Fogarty hypothesized, were stored the residue of an individual's emotions accumulated over time as a byproduct of relationship experiences. He proposed a link of significant influence between this depth dimension and the lateral dimension of the individual. Of additional importance in this depth dimension is Fogarty's later focus on the importance of the existential state of emptiness to the process of developing an autonomous self. This intense feeling-level experience is the ultimate experience of the depth dimension.

The vertical dimension contained the occupational and professional potential and actualization of the productivity of an individual. The time dimension had to do with the individual's experience of time, the way in times of stress he or she tended to develop anxiety about the future or ruminate on the failures and misfortunes of the past. In addition the time dimension contained a person's basic rhythm and was linked to the lateral dimension’s pursuer and distancer. For example, an emotional pursuer’s rhythm was observed to be erratic, varying between high speeds and dead stop, while the emotional distancer was observed to have a much more constant or steady rhythm.

Fogarty's goal in working with the structural model of the individual was to produce a functional emotional balance. The individual should be "centered," that is, in touch with and regulating the appropriate balance among each of the four dimensions of self in his life. For example, he or she should not be preoccupied with productivity and under-responsible in personal relationships. Drawing on this concept, Fogarty was the first to describe the relationship dance of emotional pursuit and distance in the marital relationship. This concept, more than any other of Fogarty's, has been incorporated into the work of most practicing family therapists.

Fogarty also contributed extensively to the development of the concept of triangulation. Again, unlike Bowen, Fogarty focused on the structural aspect of triangulation, especially as it related to treatment planning. He was perhaps the first to focus on the structural aspects of child-centered triangles with his strategies of altering these structures by moving overinvolved mothers away from, and distant fathers in toward, the symptomatic child. Minuchin, in his structural family therapy, brought together the same type of structural alteration of triangles and combined it with creative strategic movement around the organizing symptom of the child, such as having lunch served in a therapy session with the family in which one of the children has an eating disorder.

Guerin's theoretical contributions also began with the individual. While director of training at Einstein, he formed the first formal training groups for therapists who wished to study themselves and their families of origin. In this work he focused on the development of the concept of an individual's adaptive level of functioning in order to operationalize the more fixed, innate aspects of differentiation. In doing this he drew a distinction between the automatic emotional responses of the individual that emanate from their innate level of differentiation, and those more functional responses that can be fashioned over time by conscious effort on the part of the individual within the context of their relationships. The changes brought about by these conscious efforts can be measured by improved functioning in the face of significant stress, especially in the categories of productivity, more functional relationship connectedness, and personal well-being. Over long periods of time these conscious-effort changes may become automatic, thereby marking an increase in differentiation. In this way the concept of adaptive level of functioning is consistent with Bowen's concept of differentiation.

Guerin has also contributed an elaboration and further development of Fogarty's emotional pursuer and distancer concept into a paradigm termed the “Interactional Sequence." This sequence of behavior is central to the clinical methods entailed in his model of marital therapy. In that model, as well as in his model for child- and adolescent-centered families, Guerin has proposed a typology of triangles which describes and categorizes the numerous potential triangles in any case of marital discord or child-centered dysfunction. The purpose of the typology is to foster more accurate and teachable (reproducible) methods of intervention.

Carter and McGoldrick's contributions to Bowen in theory have included an expansion of the concept of the genogram and important nodal events into a more developmental perspective. They proposed a family life cycle as a backdrop for understanding development of stress and its role in the production of relationship conflict and symptoms in an individual. In addition, McGoldrick, working with Pearce and Giordano, added the consideration of culture and ethnicity to the view of the "family relationship system." Carter, working with Papp, Silverstein, and Walters, focused on the importance of women's issues in the study of and clinical intervention with families.

In conclusion, it is of interest that Bowen's model consists of the multigenerational family unit as the context in which to study individuals in their relationship conflicts under the siege of intense anxiety. Fogarty and Guerin each focus on the individual, the dyad, and triangles. Kerr focuses on anxiety, and Carter and McGoldrick on the impact of the contextual aspects of developmental stress, ethnicity, and feminism in the family system

The Experientialists

Experiential family therapy is characterized by its emphasis on intuition, feelings, unconscious processes, and atheoretical stance. The two major figures in this branch of the family therapy movement are Carl Whitaker and Virginia Satir. Both of them draw upon quite different epistemologies for their therapies, but they share a common set of experiential assumptions and techniques in their clinical work.

Whitaker

Whitaker's approach to family therapy is pragmatic and a-theoretical (to the point of being anti-theoretical). He considers theory to be useful only for the beginning therapist. He believes that the real role of theory for the novice therapist is to control his or her anxiety about managing the clinical situation. Whitaker prefers to use the support of a co-therapist and a helpful supervisor to deal with the stresses rather than relying on theory.

The basic goal of therapy for Whitaker is to facilitate individual autonomy and a sense of belonging within the family. The emphasis is on the emotional experience, not conceptual understanding. Above all, the process of therapy is a very personal experience for the therapist. Existential encounter is believed to be the most important aspect of the psychotherapeutic process for both the therapist and the family. In his own clinical interviews Whitaker's highest stated priority is to "get something out of it for myself." What he does clinically, on a fairly consistent basis, is to seize on a perception of the family's "craziness" and attempt to escalate this state of affairs to the level of the absurd. Hoffman in 1981 offered a classic example of this method in her report of an interview in which Whitaker turns to a young man had recently made a suicide gesture and says to him, "Next time you try that, you should go first class, take someone with you, like your therapist." Whitaker explains this maneuver as an attempt at augmenting the pathology of the family until the symptoms disappear. Although Whitaker's contributions to the family therapy movement have been considerable, his contribution to a theory of family psychotherapy has been minimal.

Virginia Satir

Virginia Satir, like Whitaker, represents a clinical method that is highly personalized, experiential, and immensely popular. Satir began her work with families in Chicago, and in 1959 came to California to join Don Jackson at MRI. There she organized what may be the first formal training program in family therapy. Although she left MRI to work at Esalen, where she further developed her humanistic experiential approach, much of her conceptual framework is based on the ideas of the Bateson Project, especially in the formulations of Jackson concerning the rules that govern relationships and the forces of family homeostasis. Satir speaks of the family as a "balanced" system and, in her assessment, seeks to determine the price individual family members pay to maintain this balance. She views symptoms as blockages to growth which help to maintain the family status quo. She is more important as a skilled clinician and teacher then as an original theorist. However her impact on the practices of family therapists was far from minor. Indeed, she may be the most influential of all the people mentioned in this chapter. Despite the fact that Satir did not primarily concern herself with theory, there are several basic theoretical premises that are contained in her work. First, there is a strong emphasis on individual growth stemming from positive self-esteem. Second, there is an emphasis on communication patterns among family members. Third, she addresses the rules by which the family members interact with one another and, fourth, she emphasizes the family linkage to society.

These four aspects of family life are all viewed as universal needs and forces operating in all families. In Satir's definition of healthy families, the individual member has positive self-esteem and communication is clear, emotionally honest, and direct. The family rules by which the system maintains itself are conducive to individual growth. Thus, family rules are human, flexible, and appropriate to the situation at hand. Last, the family does not function as a closed emotional system, but rather is open to larger systems in society and hopeful in its outlook. As a counterpoint, Satir believes that troubled families do not foster positive self-worth;

communication patterns are indirect and vague; rules are not flexible but absolute; and the family functions as a closed emotional system in a defensive and negative manner.

Based on these theoretical premises Satir stated her goals in family therapy: "We attempt to make three changes in the family system: first, each member of the family should be able to report congruently, completely, and obviously on what he sees and hears, feels and thinks about himself and others, in the presence of others. Second, each person should be addressed and related to in terms of his uniqueness, so that decisions are made in terms of exploration and negotiation rather than in terms of power. Third, differentness must be openly acknowledged and used for growth." While conceptualizing the family by using the above theoretical premises, Satir's technique of therapy involves heavy use of herself in a direct pragmatic and supportive way. She described herself as a mirror, allowing the family to see how it was functioning, and as a teacher, suggesting ways to grow by offering specifics on how to improve self-esteem and communication patterns.

There is some suggestion that Satir may have overworked the theoretical concepts of self-esteem and communication in her attempts to account for both normal and pathological functioning. Like Whitaker, her highly individual and powerful persona makes reproducibility a problem for descendant generations. On the other hand, the opportunistic view of the potential for growth in families and her dynamic teaching of many other family therapists make her a major personality in the field of family therapy.

The Structural Family Therapy Theorists

As mentioned earlier in this chapter, the work of Allen in 1924, Adler in 1931, and others has demonstrated the influence of families on troubled children. In this section we will consider the contributions of Ackerman and Minuchin to the theory of family psychotherapy, as it stems from their work with dysfunctional children and adolescents.

Ackerman

A man of broad interests, Ackerman was a prolific writer on a variety of topics. Early in his medical career he published on the psychological aspects of hypertension and on the impact of the economic depression of the 1930s on coal miners’ families. A fully trained psychoanalyst, he maintained his commitment to psychoanalytic thought and practice. Ackerman's belief in the primacy of analytic theory resulted in his not developing a conceptual model for the clinical work he did with families. His clinical artistry was tied to his ability to utilize psychodynamic concepts in clinical work with families.

A study of his clinical interviews on film suggests three themes in his work, consistent with his use of analytic theory: nurturance and dependency, control and anger, sexuality and aggression. These themes can be viewed as corresponding to the different stages of psychosocial psychosexual development of the individual: oral, anal, and phallic. Operationalizing the oral theme, Ackerman would challenge family members on their excessive need to be fed, on their "sucking" behavior, and on their desire to be a baby. He would provoke them into expressing their anger and would openly discuss their unconscious oedipal strivings. As a clinician in a family session, he quickly took charge and made contact with each family member after playfully teasing the children, flirting with the women, and challenging the men in a fairly

aggressive style. He was an activist, stirring up emotion by a process he called "tickling the defenses." He believed it was healthy to let emotions out, especially to express anger openly.

Today, Nathan Ackerman's contribution to family psychiatry is experienced by many as remote, in much the same way most people experience the process in their own extended families – interesting but irrelevant to the present.

As remote as Ackerman's contributions may seem to some, it remains relevant to the major issues in family therapy. A disciplined clinical investigator with a broad perspective, he was sensitive to the impact of the social context on families far earlier than most. His study of the families of coal miners during the lingering depression of the late 1930s remains a model for studying the impact of social context on the internal dynamics of the family. It raises questions still pertinent today, such as: What constitutes a functional adaptation versus a maladaptation? What are the premorbid or even pre-event characteristics of those who adapt well versus those families who are thrown into chaos and fragmentation?

A current issue in the field of family therapy to which Ackerman contributed is the need for a typology of families. The advent of DSM III and the federal government's push for evaluation of clinical results are two factors that have reawakened interest in this area. In Ackerman's 1958 book The *Psychodynamics of Family Life,* he presented a preliminary typology of families. The categories included were: disturbance of marital pairs; disturbance of parental peers; disturbance of childhood; disturbance of adolescence; psychosomatic families.

A clinical typology, even one that is symptom focused as this one is, is essential to the development of corresponding clinical methodologies, which can then be evaluated.

In 1981 Hoffman offered an interesting thesis concerning the connection between Ackerman and Minuchin. She sees Ackerman as basically a structuralist in his approach to dysfunctional families. In her analysis of the transcript of one of Ackerman's cases she draws some fascinating parallels between the clinical work of the two men. Indeed, it is interesting to note that Ackerman had been Minuchin's supervisor in the latter's psychiatric training.

Salvador Minuchin

Minuchin, a child psychiatrist and fully trained psychoanalyst, began to do family therapy at the Wiltwyck School for Boys in New York in the late 1950s, in which he included the parents and siblings of the identified patients in family sessions. The staff of the Wiltwyck Project, begun in 1962, included E. H. (Dick) Auerswald, Richard Rabkin, Bernice Rossman, and Braulio Montalvo. It was Auerswald, who, strongly influenced by Bateson's "ecological system" ideas, brought these ideas to the Wiltwyck Project. Rabkin, also a psychiatrist, brought a certain irreverence for traditional theories and methods best documented in his text *Inner and Outer Space* and in an essay entitled "Is the Unconscious Necessary?"

The Wiltwyck Project was an important experience for Minuchin, greatly enriching his developing models of family therapy. The Wiltwyck experience was followed by his tenure as director of the Philadelphia Child Guidance Clinic, to which he brought along Montalvo and Rossman, and also attracted Jay Haley, Lynn Hoffman, Peggy Papp, and Carl Whitaker. When all of the major early contributions to family therapy are considered, Minuchin stands out for his openness to the ideas and work of others. This is perhaps best demonstrated by his 1962 tour of

family therapy centers throughout the country to observe and learn what others were doing with symptomatic families.

Minuchin’s video training tapes show him to be a flamboyant and skilled operator of relationship systems, and at times outrageous, in the tradition of Ackerman and Whitaker. Minuchin differs from Ackerman and Whitaker in his conceptual framework, however, just as they differ from each other. Ackerman remained wedded to psychoanalytic theory, while Whitaker maintained the anti-theoretical position that theory can be a rationalization for certain behaviors and a method for avoiding the emotional experience of the moment. Although analytically trained, Minuchin formed his model based on the family as a relationship system. This model rests heavily on the notion that most symptoms, whether they present as a dysfunction in an individual (such as anorexia), or as a conflict in a relationship, are a byproduct of structural failings within the family organization.

The conceptual model begins with the notion that the family is normally determined by structure, function, boundaries between subsystems, and degrees of functional attachment among individuals. The family, as defined by Minuchin, is the nuclear family or household, as opposed to Bowen's multigenerational unit. Minuchin would include the grandparental generation into his observational lens only when the grandparent was a part of the household. His description of the family system as a whole relates to the degree to which a family structure demonstrates appropriate boundaries. Those families with dysfunctional structures are grouped into two categories. "Enmeshed" is the term used for those families characterized by overly permeable or absent boundaries, and the term "disengaged” is used for families with rigid boundaries between individuals that don't allow enough flexibility of response or sufficient relationship attachment. The "structure" of structural family therapy can be best understood by consideration of the concept of boundaries and triangles or "conflict detouring triads" as triangles have at times been termed within this model.

Minuchin's concept of boundaries calls for clearly demonstrated "membranes" among the various subsystems within the family organization. The family monitor or gatekeeper, so designated by the appropriate function and position of power, decides *what* member or members of the family may pass through these membranes and *when* they may do so. For example, the father might be designated as the gatekeeper of the membrane or boundary surrounding the marital relationship, and the oldest sibling might be viewed as the appropriate gatekeeper for the sibling subsystem. Developmental issues are also part of these boundary decisions. This is most clearly evident in the therapeutic importance given to establishing and maintaining the privacy of an adolescent’s room.

The structural therapist maps out weaknesses in the boundaries of the family organization and plans direct interventions as remedies to this problem. For example, in a child centered family in which the parents expend most of their time and emotional energy on the kids, the structural therapist very early on in the process of therapy might suggest that the parents retire to their room by 9:30 PM three evenings a week, keeping the door closed until at least 11:30 PM, and that once a month they go away by themselves. In a similar way an adolescent might be given permission to close the door of her bedroom for two hours every evening. These interventions make explicit therapist-perceived boundary problems and are formulated in order to allow the relationship and individual process linked to them to surface.

In his classic text, *Families and Family Therapy* of 1974, Minuchin relies heavily on the construct of relationship triangles to track the pathological relationship process in the family and to provide the rationale for various structural interventions. In a 1978 book, *Psychosomatic Families*, which was based on his work with the families of children suffering from either asthma, diabetes, or anorexia, Minuchin proposed a typology of triangles in these families. In this typology he has designated two types of what he calls "conflict detouring triads:" "detouring attacking" or "detouring supportive." In the deterring attacking triads, the parents are joined together in agreement over what is wrong with their child's behavior. Both parents are angry with the child and they take turns in criticizing the behavior. However the fact that each of them has a different idea of how to fix the problem may drive them into conflict with each other. In the detouring supportive structure both parents join together in mutual concern over a child with emotional and/or psychosomatic problems. Rather than attacking their child, they are almost overly concerned and supportive in their efforts to alleviate the situation for him.

It is evident in Minuchin's case reports in the literature and on video training tapes, that there is a consistent application of principles based on a theory of family structure and organization.

These principles include: (1) The importance of the therapist relating to the power distribution within the family system and the hierarchical structure of that system. For example: his first move in a therapy session is often to connect with the father as the gatekeeper to the family system. At times he would even ask explicit permission of the father to talk to the other family members present in the room. (2) An assessment of the generational boundaries and the dysfunctional structure of the intergenerational triangles. This is demonstrated by the way Minuchin fashions his interventions around boundary problems and around alterations in the structure of a central symptomatic triangle.

Minuchin's model was a major breakthrough in the history of family therapy. His video training tapes demonstrated the systemic aspects of clinical problems formerly thought of as residing within the individual. In addition, these same tapes demonstrated relief of the symptoms over time. The impact of Minuchin's model was to turn the heads of the mental health movement toward the developing field of family therapy. One of the most admirable aspects of Minuchin's work has been the ability to make his conceptual ideas and clinical methodologies effective with underprivileged populations.

Comment on Behavioral Family Therapy

Behavioral therapists have a long history of applying their behavioral principles to a variety of problems that occur within the family. However, the major part of this work has occurred outside the mainstream of the family systems therapy movement. Family systems therapists, for the most part, left the established theoretical groups with which they were originally associated to form their own informal, and later formal, organizations. These organizations were committed to the development of new theoretical formulations of family functioning. On the other hand behavioral family therapists tended to maintain their identification with organizations wedded to established behavioral theory. In large measure this was due to their commitment to that theory.

However, there have been some noteworthy efforts by behaviorists to more fully deal with the problems of the family system. Jacobson and Margolin in their marital therapy work have developed a view of reinforcement that is both circular and reciprocal. An example is the

following: A wife asks her husband for more time together, the husband is not so inclined and doesn't respond. The wife begins to become angry and demanding, and the husband says, "There is no way I'm going to spend time with you when you act like such a shrew." This only serves to increase the wife's anger and behavioral tirade. Finally, in exhaustion, the husband gives in, saying, "Okay – if you just stop we will go out somewhere to eat."

In this sequence the wife has been reinforced for throwing the tirade and the husband has been reinforced for giving into the wife's negative behavior by her stopping her tirade after he agrees to go out. In their model each marital partner's behavior is both being affected by and influencing the other's. Thus, this model maintains the centrality of behavior modification by intervening to alter the reinforcement contingencies, while at the same time attempting to deal with the relationship focus by focusing on how both spouses participate in the process of reinforcement.

Gordon and Davidson in their work with behavioral parent training acknowledged the importance of a "broad-based" model of assessment. This broad-based model includes factors in the family system which may potentially interfere with behavioral parent training, such as marital conflict. They even go so far as to state, "In certain situations, successful treatment of these other family difficulties may obviate the need for any further treatment [of the child]." The broad-based model of assessment extends the potential focus of treatment to other areas of the family system. However, the theory used to conceptualize and treat the problems of the child remains embedded in individual behavioral psychology.

Stuart in his behavioral marital therapy makes a point of including some efforts to improve the general communication skills of the couple. The attempt to improve communication skill is over and beyond his attempts to modify specific behaviors in the relationship. Liberman acknowledges the importance of the therapeutic relationship over and above the specific behavioral techniques: "Without the positive therapeutic alliance between the therapist and those he is helping, there can be little or no successful intervention."

Thus, as behavior therapists attempt to deal with the complex problems of families they are not only modifying their procedures, but are attempting to incorporate systems principles. To date, however, a real difference continues to exist between the underlying theory of behavioral family therapy and family systems therapy.

Conclusion

The significant contributions of a number of prominent family therapists have not been included in this chapter. We have attempted to present the work of those investigators who have been most focused on the development of a conceptual framework for family psychotherapy. Forty years into its life-cycle, the family therapy movement has not yet developed a single comprehensive integrated theory. Three major models have been developed and emphasized in this chapter: the strategic, the multigenerational (Bowen), and the structural (Minuchin) approaches. Each of these models has its strengths as well as its weaknesses. The strategic model, although it clearly demonstrates the power of context and the magic of paradox and reframing, fails to offer a consideration of the internal developmental struggles of the individual. Therefore it overvalues context in much the way that a theory of the individual undervalues it.

The multigenerational models of Bowen and his descendants represent the most consistent effort at developing a broad-based theory of family psychotherapy, including their attention to the development of individual autonomy. However, Bowenian models become somewhat murky in attempts to define and describe differentiation and triangulation. In addition, their clinical techniques can become overly ritualized and constricted.

The structural modern model of Minuchin is the clearest and most easily understood among the three models. However it is much more a model for doing therapy than an attempt at developing a comprehensive theory of family psychotherapy. In addition, although it is eminently teachable and reproducible, it is almost entirely a method for working with child focused families. It offers little assistance for working with the problems of relationship conflict between adults and/or working with an individual.

One of the most important questions for the future of the family therapy movement is what will happen as the old guard of pioneers moves on and the new generation steps forward. How much of an attempt will be made to elaborate further some or all of the concepts developed in the first 40 years? If family theory is to continue to develop as the conceptual basis of a comprehensive model for understanding the individual's emotional functioning in a relationship context, several eventualities must occur. There must be a sophistication and refinement of the characteristics of functional versus dysfunctional relationship systems, a systemic model of the individual including a continuum that links his "inner and outer space," and a model for tracking dyadic interaction and triangle formation. The goal of these refined family concepts and models would be the development of an integrated system of interventions which would enhance the ability of the therapist to steer relationship process toward better functioning both for individuals and for the family system as a whole. If this is not forthcoming, family psychotherapy the may become more like group therapy – a clinical modality to be used at specific times in response to specific clinical indications in conjunction with, or in lieu of, additional psychodynamically based individual therapy.

The following brief reminiscence was part of chapter 3 in The Book of Family Therapy, *published in 1972. Each contributor to the book was asked to write a "personal rather than ideological" account of their journey toward family therapy. This is Phil Guerin's.*

We Became Family Therapists

Philip J. Guerin, Jr., M.D.

A personal statement as to one's evolution to the professional position of "family therapist" borders on the impossible. How does one portray an accurate, factual account of the numerous complex factors in any such evolution? The task, as issued by the editors, contained one simple

and concise direction, that there be maximum "camp" and minimal "bull." The implicit difficulty with this lies in the fact that one man's "bull" is another's "camp," and vice versa. Another difficulty in this for me stems from my hereditary position in a long line of "Irish Bull."

The two most important determinants of my present professional position are my contact with Murray Bowen while in my residency training at Georgetown, and my part in the process of my own personal family system.

About three-quarters of the way through my first year of residency, while in the midst of working with my "prize schizophrenic," I first heard some of the ideas of family systems theory. These ideas seem to make some sense when related to the context of my personal and professional experiences. However, the new concept of seeing people's problems as based in a dysfunctional family system rather than a dysfunctional ego state raised much confusion among my synapses and consequently in my verbal utterances.

My analytical supervisors became concerned. As time progressed, and the prognosis worsened, they became alarmed: was I heading down the road to *psychic degradation*?

As I experienced the concern of my supervisors, many of whom I still recall with a fond respect, I often felt like abandoning my heretical ways. Despite these feelings, I plodded on. In a sanctioned part-time evening clinical job I began doing family work with three individual families, and with four others in a multiple family model. I converted my" prize schizophrenic" into a research project called "An Attempt at Family-Social Network Therapy with a Schizophrenic Family." The supervision of this work also included the beginning of my research into the process of my own family system.

Part way into my second year residency at Georgetown, I began having thoughts about shifting to another training facility. I believe my main reason had to do with the fact that I had also been a medical student at Georgetown and thought that perhaps moving to the public school system might be a broadening experience. When offered a position as chief resident at Albert Einstein's College of Medicine of Yeshiva University in New York City, I went from one parochial system to another in the true spirit of ecumenism. I remember that my relieved supervisors thought I might regain my orthodoxy at Einstein.

My year as chief resident at Einstein was difficult. Once again I found myself surrounded by a group of superior caliber psychoanalysts. In addition, I had to teach the psychoanalytic model to the junior residents. I also didn't have much free time, and had to squeeze in a family case here and there. During this time my functioning as a family therapist declined and I had difficulty keeping my thinking clearly on either a psychoanalytic or family systems track. During this time I even considered once again the idea of embarking on a personal analysis. Somehow "resistance" prevailed. Once I was a few months past my year as chief resident, the ability to think clearly about family systems returned and I was on my way. During this difficult time, I think continuing to work on my own personal family system and seeing the theoretical concepts at work there, having a continuing relationship with Murray Bowen, as well as developing relationships with Tom Fogarty and Andy Ferber, sustained my commitment to the family movement.

Having seen some of the theoretical concepts of family systems theory at work in my clinical experience, it seemed reasonable to study myself in the context of my own personal family system using these concepts as basic assumptions. Prior to taking on this research project, I had tended to see myself and others in my family from a characterological point of view. Defense mechanisms, oral, anal, and genital fixation levels, were formulated in my mind as I observed the part of their behavior bothersome to me. As I began this research project on self, the beginning of a new way of viewing life evolved. A personal vignette may serve to clarify.

My wife and I, since our days as camp counselors together, have always enjoyed each other's company, and shared a certain number of common interests as well as a desire to laugh with life even in some of its most somber moments. Throughout our relationship I had desired a greater closeness, an increased mutual sharing of thoughts and feelings. Kathy's usual program of behavior is to create space between her and others, allowing others to move toward or pursue her. In a quiet, ladylike gentleness there is little open volunteering of thoughts or feelings. In face of stress or anxiety, she tends to frankly distance from others and further wall off her personal space of thoughts and feelings. The quiet gentleness can appear to turn into a confused helplessness. So it is not too surprising that as her mate I should be a space-filler, or mover toward people, an outpourer of personal thoughts and feelings. In times of stress and anxiety benevolent interest becomes over-concern, other-control, and the taking over of responsibility for the space maker. The closeness that I viewed myself as desiring was, in fact, operationally an attempt at other-control – to soothe my own anxiety.

Over a period of time as a more objective awareness of this process developed, I decided to abandon my attempts at changing Kathy and began to try to change myself. In doing this, I experienced the degree of anxiety and emotional pain that goes along with even *attempting* to change a program of behavior or a way of operating. By a series of experimental moves, I learned that if I could reverse the process with Kathy and create emotional space by my distancing from her, she would eventually have to move toward me. However, I found I could only hold the distance long enough if I had a planned series of moves. Also, initially Kathy's moves towards me would be to find out if I were bugged or upset. There still was little openness with her own thoughts and feelings. I eventually added another move to my plan and begin airing my own personal thoughts and feelings without a fixed expectation of a reciprocal move by Kathy. Following my airing I would distance into a household project. Over a period of days, Kathy gradually began the process of sharing her thoughts and feelings with me. Kathy, being a perceptive girl (whom else would a perceptive person like me marry?), caught on quickly and very soon was doing her share of reversing the process. She would move toward and crowd me as a subtle way of letting me know I was off on a splurge of infantile and demanding behavior. The end result, I believe, has been an increase in separation and closeness on both our parts, an increase in each of our levels of emotional functioning and an increase in the functioning level of the nuclear part of our family system. At this point in time, I would view our relationship as a functional one, in which the potential for change on both our parts is possible. I believe that personal growth and maturity are best worked on and attained in the context of the marital relationship.

The emotional process between Kathy and me, described in preceding paragraphs, is at best oversimplified. It fails to speak sufficiently to the intricacy of the process itself and the way in which, over the years, it inevitably moved to involve both our children and our extended

families. The corresponding increase in individuality and closeness in my relationship with my wife has provided part of the nidus for my continuing commitment to family as a way of thinking. The commitment entails an attempt at further developing a theory of family systems, as well as a continuing commitment to working on myself in this context, in order to become knowable to myself and others in my family. It is to be hoped they also will come to be more knowable to themselves and to me.

At present, I am struggling to keep my professional belief system open and growing. I see family systems theory as a workable way to approach thinking about the problems of the human phenomenon. I see other theories (including psychoanalysis) as also being plausible explanations for human behavior.

Professionally, I now spend a portion of my time sharing with others (called trainees) some of my ideas about family systems. Another portion of my time is spent as a consultant to a large number of families in my private practice. The remainder of my time is committed to continuing working on my own family system, playing with three lovely little girls, mowing the lawn, and various and sundry other activities.

All in all, it's not a bad deal. I mean, in what other professional position could you look forward to the 30-to-40% bracket opportunity for dispensing pure “Irish Bull?”

Guerin presented this paper in honor of Nathaniel Ackerman in 1981 at an Ackerman Family Institute conference.

The Contribution of Nathan Ackerman to the Theory and Art of Family Therapy

Philip J Guerin, Jr., M.D.

The story goes that when God found out that Al Scheflen, Margaret Mead, and Gregory Bateson had all arrived within a relatively short period of time, he summoned the director of the Celestial Institute for the study of aggression and sexual passivity in wayward angels to his side. God spoke: "Angel Nathan," he said, "you have given me 10 good years of service. I must tell you that three of your most honored colleagues have arrived and I feel it is time for a meeting to evaluate the progress of the family therapy movement on earth." Angel Nathan smiled, realizing how just a few years before God paid no attention to the arrival of mental health-social science types. He felt gratified that he had influenced God to the degree that he now openly admitted when he was angry, and even enjoyed an occasional fight. According to God's wishes Angel Nathan summoned the spirits of Scheflen, Mead, and Bateson. When this majestic foursome met

with God they enthusiastically discussed and evaluated the present state of the family therapy movement on earth. As the meeting drew to a close God told them he was pleased and would grant each of them one final question about the course of future events on earth. Dr. Mead spoke first: "I'd like to know if the people on earth will ever come to realize that all phenomena are understandable in the light of natural history." God answered: "Not in the span of years equal to your lifetime on earth, Margaret." Dr. Bateson spoke next: "Will the new epistemology ever really take hold?" God answered: "Not in the span of years equal to your lifetime on earth, Gregory. Dr. Scheflen asked: "Will people ever stop being distracted by words and tune into the way they really communicate with one another?" God answered: "Not in the span of years equal to your time on earth, Albert." Angel Nathan spoke last: "Tell me Lord," he said, "will Sal Minuchin ever admit that I taught him everything he knows?" God answered: "Not in the span of years equal to *my* lifetime, Nathan."

As a psychiatric resident at Georgetown in the mid-60s I heard tales of Nathan Ackerman's struggle to establish a base of family psychotherapy within the psychiatric community of New York City. It was reported that his elective family conference for residents at Columbia was scheduled either at the same time as other, mandatory, conferences, or at 4: 30 on Friday afternoon. In spite of roadblocks like this, like a true pioneer, he struggled on. When I came to New York and to Einstein I expected to find literally hordes of Ackerman clones ministering to the needs of New York families. To my surprise I found none. I discussed the problem with one of my professors, Al Scheflen, who suggested that I do an organized study of Ackerman family therapy films. In following through on Dr. Scheflen's suggestion, I discovered many things about Nathan Ackerman. His consummate skill in engaging many different types of personalities into a relationship struggle with him and each other quickly became evident. I also discovered his, at times measured, at times seemingly unbounded, provocativeness, as he attempted to mobilize affect and surface process. Also, in a seemingly random fashion, he uncovered sexuality, dependency, and aggression, and then wove them into the fabric of all his clinical interviews. My conclusions at the end of my study were that Ackerman's lack of operational orthodoxy, his idiosyncratic clinical style, and his loyalty to psychoanalytic theory made him essentially non-reproducible. This, I thought, explained the absence of Ackerman clones in New York.

One afternoon, shortly after I reached these conclusions, I dropped in at a seminar at the Einstein Family Studies Section. A family was being interviewed. The therapist-teacher held his body vis-à-vis the family in a fashion similar to Nathan Ackerman. The tonal quality and inflections of his voice bore marked similarities; his moves with the family were nearly identical. I had found my Ackerman clone. His name was Norman Ackerman, a cousin and former student of Nathan's. The only difficulty was now I didn't know if the process of cloning was educational or biological.

My first substantial contact with Nathan Ackerman came in the fall of 1970 at the Georgetown Family Symposium when he was distinguished visiting professor and I was presenting a paper on "Style, Art, and Theory in Family Therapy." In that paper I had the chutzpah to present my analysis of Ackerman's work, including the part about it being non-reproducible and the discovery of his cousin-clone.

Dr. Ackerman was amused and following the session approached me to inquire of his cousin Norman's well-being. Again with unfailing chutzpah, I teasingly offered to coach him with his extended family. He laughed, and we went on to talk about other things. He asked if I would

allow a "poor old man" one question. "Explain to me if you can," he said, "how a cold fish like Bowen, who is so afraid of his own feelings, attracts such a large cadre of loyal sons?" Ackerman, an astute observer of human relationship process, seemed somehow oblivious to and puzzled by the process in which his own dominant, aggressive, emotionally pursuant temperament often evoked a response of distance from many of his professional children, while Bowen's more distant, aloof, orthodox mysticism seemed to encourage discipleship.

A few months prior to his death in the spring of 1971, Dr. Ackerman summoned me to discuss with him the possibility of my joining the staff of his Institute. That meeting lasted two hours and I left considering it a privilege to have been granted the time. We spoke of many things, mostly my goals and aspirations. I can remember his cautioning me to be disciplined in my work, not allowing the lure of instant prestige or fame to distract me from it. As I reflect back on that meeting tonight I can't help but think that Papa Nathan would be disappointed in me and many of my colleagues who have at times abandoned the discipline of painstaking, time-consuming, clinical investigation to run prematurely into the spotlight with incomplete hypotheses, trumped-up results, and warmed-over, thinly disguised modifications of other people's work.

Today, Nathan Ackerman's contribution to family psychiatry is experienced by many as remote, in much the same way most people experience the process in their own extent families – interesting but irrelevant to what is going on now.

Some of this phenomenon can be explained by the climate of the "now" generation we live in, with its difficulty in seeing much value to the perspective of a time continuum encompassing past, present, and future. In addition to this, there is the naturally occurring developmental process between mentor and student, pioneer and later settler, like the process between parent and child. When the student grows tired of the constraints of the one-down position and perhaps experiences the vulnerability of the mentor, there is a move for independence. At this point in time, in order to facilitate the separation, there is an automatic reflex undervaluing of the contribution made by the mentor. As this process intensifies, the potential for conflict and alienation is considerable. I remember stories of the intense public fight between Andy Ferber and his mentor Nathan Ackerman shortly before Dr. Ackerman's death. In reflecting on those stories I wondered when I would fight with Bowen, and undervalue his contribution to my development. I guessed it would be different with Murray and me than it was with Nathan and Andy. Probably as different as the British are from the Yiddish: the British who leave without saying goodbye, and the Yiddish who say goodbye without leaving.

As remote as Ackerman's contribution may seem, if we attempt to define the major issues in family psychiatry today there is a definite relevance. The June 1981 newsletter of the American Family Therapy Association outlines a number of these major issues. On the front page is a report on the upcoming annual meeting of the AFTA in Seattle later this month. The opening plenary session will honor Gregory Bateson and Al Scheflen and is entitled, "The Idea of an Aesthetic Contextual Unity." It will focus on "the critical idea of aesthetic unity of social contexts."

Ackerman, a disciplined clinical investigator with a broad perspective, was sensitive to the impact of the social context on families far earlier than most. His study of the families of coal miners enduring the lingering depression of the late 1930s remains to the present a model for studying the impact of social context on the internal dynamics of the family. The same model

could be applied to the study of families of the ‘80s as they attempt to adapt to the impact of the women's revolution, the sexual revolution, the parental paralysis that follows reading too many How-To-Parent books. The model raises several issues. What constitutes a functional adaptation versus a maladaptation? What other premorbid or pre-event characteristics of the families that adapt well versus those that are thrown into chaos and fragmentation? These are a few of the many questions relevant to the clinical practice of family therapy that the social context investigators may attempt to answer in the years that lie ahead. There is often a gap between social context investigators and clinical practitioners.

To get in touch with the power of the social context one only needs to visit the Museum of Natural History, affectionately known as the cellar of Maggie’s Place. There the lesson of man's evolving destiny can overpower you and make you feel at once in awe, and irrelevant. Those investigators that became immersed in the natural history method, like Mead and Scheflen, often end up in a position of interventional nihilism, believing men had little or no control over their lives. Clinicians traditionally defended against these feelings of impotence by denying the existence of the social context, thereby running the risk of being insensitive to or invalidating the reality struggles of their patients. Ackerman worked at establishing and maintaining the linkage between the forces of the social context and the internal dynamics of the family. It is a model worth emulating.

Also discussed in the AFTA newsletter is the issue of the need in the field of family therapy for a typology of families. The advent of DSM-III and the federal government's push for evaluation of clinical results are two factors that have we awakened interest in this area.

In Ackerman's 1958 book, *The Psychodynamics of Family Life*, he presents his preliminary typology of families: disturbance of marital pairs; disturbance of parental pairs; disturbance of childhood; disturbance of adolescence; psychosomatic families.

In our work at the Center for Family Learning, using a different conceptual framework, we have modified Ackerman's typology somewhat, and since 1974 had used a typology which includes: marital conflict (four stages); child centered family; adolescent centered family; families with a dysfunctional adult; psychosomatic families; substance abuse families; issue-centered families (for example, death).

The clinical typology, even one that is symptom-focused as these are, is essential to the development of corresponding clinical methodologies. The results of these methodologies can then be evaluated.

In our present state, unless more creative methodologies are developed, we run the risk of abusing and overusing the techniques of structural alteration of triangles, strategic use of paradox, and getting to know your grandmother, to the point of ending up with several chiropractic schools of family therapy. However, if family therapists begin to feel like "one trick ponies" they should not be too critical of themselves without taking into account several factors.

Perhaps as much as 95% of the practice of primary care medicine is symptom-relief focused, and primary prevention as a reality is in its infancy. A thorough review of the general psychiatric literature will reveal that most, if not all, of the psychiatric subspecialties tend toward doing the same thing, their thing, in response to everything. I expect any day now to read that premature

ejaculation has taken its place alongside depression, neurosis, headaches, and panic attacks, as curable with the use of Tofranil. The beauty of family systems is that it provides a context for planning, implementing, and evaluating all of the various forms of intervention.

Evaluation is another major issue that confronts us. The process of evaluation of results, though essential, is a tricky business. Any system of evaluation of family treatment must include a look at symptom relief, symptom substitution, and symptom shift to another member or part of the system. There are still family therapists who, if you bring them a broken carburetor, will change all the tires on the car. This often borders on clinical irresponsibility. However, the same could be said of those family therapists that operate on a family system effectively enough for Sally's phobia to go away, and then don't bother to look for or recognize the developing depression in mother as a side effect of the therapy. Likewise, when the alcoholic husband becomes dry and his wife develops rheumatoid arthritis; when the depressed wife gets better and the marriage goes into extremes. These predictable developments can be viewed as a logical sequence of phases or stages of therapy, and can be effectively responded to in that fashion. Results must also be evaluated over both the short- and long-term.

Another and perhaps one of the most interesting aspects of evaluation is the study of the placebo effect: the phenomenon wherein the relationship between patient and therapist magically brings about a relief of symptoms. Research studies in Rehabilitation Medicine demonstrate that the effect of the placebo on results is most often underestimated rather than overestimated. Family therapy investigations in the structure of magic have focused on the specifics of the contextual-communicational aspects of therapist-patient interaction. A further context analysis of different master therapists in multiple clinical situations might serve to elaborate further the other component parts of this placebo-magic so that it could be reproduced. The library of films of Nathan Ackerman's clinical work would be a valuable asset in such a study. On the other hand, perhaps we should accept that certain parts of human beings and their relationships defy measurement or quantification, and not take the magic out of magic by trying to understand and categorize it. Rather they allow it to take its fullest form of expression in an individual therapist’s clinical artistry. It is in this category, the art of family therapy, that Nathan Ackerman perhaps made his most significant contribution.

In order to understand fully this contribution you must appreciate the constraints of the context in which it took place. Remember that Ackerman dared to sit in the room with more than one family member at a time when this was considered heresy. Even today, decades later, a majority of mental health professionals are more comfortable with one person in the room at a time. In watching Ackerman's films to study his clinical artistry, certain identifiable patterns emerge. At the beginning of each session he quickly moved to establish contact with each person in the room. Questions, comments, banter, teasing, joking, touching were all part of his extensive repertoire. He called it "tickling the family to come alive." He truly made use of his natural self. An awareness of the attributes and limitations of one's own temperament and style of operating are essential to the family therapist becoming a clinical artist. Not everyone can be effective using paradoxes and clever strategies, or asking lists of benign questions, or teasing or being humorous. Knowing what fits with you allows for the most effective appropriate use of self as an instrument of healing in the art of family therapy.

As I have said before, a major portion of Ackerman's art was his ability to engage family members in a relationship struggle with himself and with one another. This is important because

the concept of struggle is central to any relationship. The struggle does not always have to be explicit; an implicit struggle can be a challenge and even rewarding fun. But it is of the utmost importance to keep the struggle playful rather than allowing it to become deadly. If it becomes deadly, which it inevitably will at times, know how to lighten it back up to playful. Ackerman loved the struggle; as clinicians each of us must hone our skills in this art of relationship struggle, keeping in mind three things: a deadly struggle continued too long is destructive; the absence of struggle is often a malignant form of emotional fusion; in a playful struggle lies the potential for true intimacy.

One of the ancient squabbles of family therapists has been the question of being emotionally in the system or outside of the system. In recent times this has given way to the important notion of "operating the system:" interacting with the family in a way that elicits conflictual process, fosters movement towards resolution, and allows individual family members a chance at autonomy with emotional connectedness. Ackerman, Bowen, Whitaker, Satir, and Minuchin are all masters, each in an artistically different manner, at operating a family system.

I have told you of my two-hour meeting with Dr. Ackerman in the early spring of ‘71. A few months after that meeting, Judy Lieb called me one Saturday in June to inform me of Nathan Ackerman's death. After I hung up the phone I cried. Compared to countless others, I had hardly known the man, but it felt like a family member had died.

At his funeral I had the privilege of chauffeuring Drs. Bowen, Wynne, and Minuchin to the cemetery. On the ride I was struck by the way the Minuchin quickly assumed control of the process in the car in a very Ackermanesque, provocative manner. As we set off to the cemetery, he inquired of Drs. Bowen and Wynne what they thought of this funeral racket, and then beaming with the discovery that both Bowen's and Wynne’s fathers were funeral directors. Having gained mastery over his two colleagues, Minuchin leaned forward from the backseat and addressed me. "Pheel," he said, "you are one of Murray's boys, no?" "No sir," I replied, "Murray is one of my boys." "Now I know you are one of Murray's boys." He laughed and went on to further conversation with Drs. Bowen and Wynne. I can remember thinking as I drove along, maybe Ackerman is reproducible after all.

Immortality is an elusive thing. Men seek it in different ways:

1. Through a belief in the hereafter and the immortality of the human soul.

2. Through the acquisition of earthly fame – the method currently in vogue, beautifully expressed in the theme song of the movie of the same name. "I sing the body electric. I celebrate the me yet to come, I toast to my own reunion when I will be one with the sun, and we'll all be stars."

3. Finally, man seeks immortality through his children.

Nathan Ackerman left us, the family of family therapists, a legacy. He launched a movement that has touched and will continue to touch the lives of many in an important and positive way. He launched an institute that bears his name, and is recognized internationally. But perhaps like most of us his true immortality rests with his children and his children's children.

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Bowen – The Man and His Theory

Philip J. Guerin, Jr., M.D.

In any discussion of Murray Bowen, the man, it might be interesting to start with some of the anecdotes surrounding his career. One that comes to mind was an experience I had at Nathan Ackerman's funeral in 1971. To fill in the background to this, I should mention that over the years Ackerman and Bowen had been the "Sinatra and Crosby" of family therapy. Depending on whom you talk to, one of the other of them was the "founding father" of the field of family therapy. And at meetings together, somehow they were frequently bunked in the same room.

Now, Ackerman used to worry that Bowen repressed his feelings too much; that his mental health and well-being were in jeopardy. Ackerman would prod him to express his anger more freely, telling him it was good for the soul and essential to the libido. Bowen would handle this by promising to *try* to express his feelings, by keeping his reading light on all night, and introducing Ackerman to everyone the next day as his "blood-brother Nat." In the years just before Ackerman’s death, their relationship became even more interesting. Ackerman was the honored guest at Bowen's Georgetown Symposium in 1970.

About a month before he died I spent two hours with Ackerman in his office. We talked of many things. He told me of his respect for Bowen and his belief that if someone could just connect Bowen with his feelings he could make an even greater contribution to psychiatry. Ackerman also shared with me his wonderment at how someone as aloof and remote from his feelings as Bowen was could possibly have amassed such a cadre of loyal professional sons. A month later the family of family therapists was shocked and saddened at the premature death of Nathan Ackerman.

At Ackerman's funeral I had the privilege of driving Murray Bowen, Lyman Wynne, and Sal Minuchin to the burial site. During this trip Minuchin took charge and in his usual manner surfaced a previously unknown bond between Bowen and Wynne. Both of their fathers were undertakers. The Minuchin then turned to me and said, "Phil, you are one of Murray's boys." I said, "No, Sal, Murray is one of my boys." Minuchin replied, "Now I *know* you are one of Murray's boys. As we drove on I thought of Ackerman's wonderment at the loyalty of Bowen's boys. I was glad to have known Nat Ackerman. Today his "blood-brother" Murray is having his day in Ackerman town. I wonder what NASA would say!

Several years later my wife and I traveled to Bowen's hometown in Waverly, Tennessee to his father's funeral. I had left New York in the middle of a CFL Haley Workshop. Before I left,

Haley communicated in many meta-ways his puzzlement at the pilgrimage. It seemed simple enough to me; Bowen's father's death was an important nodal event in his family. My being there was, I thought, as important to him as it was to me. It would be an action-demonstration in the personal side of our relationship. Basically, if the truth be known, I *felt* like going, but please don't tell Murray it was a decision based on emotion. In addition to all that, the voyeur in me had an opportunity to observe Bowen in his original context.

Most people in family therapy have by now read Bowen's classic paper on his own family. During that trip I watched the master moving in his own primary system at a time when the anxiety in the emotional field was high. I won't tell you what I observed because that is Murray's personal territory and best left to him. But the trip taught me a great deal and my knowledge of his humanness grew to balance the previously acquired knowledge of the workings of his brain.

Murray Bowen is 65 this year [1978]. People have been worrying out loud about Bowen dying since Ackerman's death. Depending on who's asking, Murray interprets this as a fear or a wish. The thought of his death never occurs to me! As a matter of fact, Fogarty and I have a bet that Bowen will deliver the eulogy at both our funerals. Not all my recollections are about funerals, however. Let's get off such serious stuff as death and funerals and go on to lighter topics, like schizophrenia.

Earlier this year I was discussing with Dr. Bowen his participation in the schizophrenia conference, "Beyond the Double Bind." I asked him how he had done and he said, "Phil, I spent a whole hour with schizophrenia and I didn't get caught once." When Bowen makes comments like that, people frequently look at one another with an expression that can only mean "There he goes talking funny again." Some explain it on his level of differentiation being so high that no one can understand what he means; others attribute it to his Tennessee upbringing. The truth is, that statement is the essence of his theory.

What does it mean "to be caught?" Let's first take an example from your own family. You're on your way home to visit your folks in New Jersey. You are an accomplished student of family systems, so those mistakes commonly made by neophytes to this process are not for you. You know that to bring your spouse and kids with you just contaminates the operational field. That people after they marry bring a spouse along in visiting their parents only for refuge and protection, and their children as currency to be offered to their parents in place of themselves.

It's Friday night and as you drive along you realize it has been a reasonably good week for you. Your records are up to date. You've settled a long-term conflict with a co-worker, and had even been reasonably calm and emotionally available to your wife in the face of her worry about the news that her sister was to have a breast biopsy on Monday. As you drive by the sign “Gotcha, New Jersey,” marking your hometown, you notice an indefinable uneasiness in your insides, but it quickly subsides.

As you enter your parents' home you find both of them sitting in the dark, in silence. Certain that at the least your brother has been run over by an oil truck, you ask "What's wrong?" In cadence they reply, "Nothing." Now you are too experienced to let that one bag you. You sit down and join the silence. After 5 minutes your mother says, "I thought you said you'd be here by six. It's 7:45." You say, "I told you between six and eight," with just a hint of defensiveness in your tone.

Your mother says, "Your father and I know Lucille is a good wife, but she doesn't want you down coming down here like this. She wants you with her family."

At this point a systems amateur would say, "That's a triangle mother, and I don't participate in triangles." But you're too advanced for that. You know your mother is uptight and that it probably has nothing directly to do with you and your wife. You say, "Come on Ma, what are you really upset about?" At this point, your father exercises a family tradition and leaves the room. Your mother, glasses halfway down her nose, glares at you and says, "It's you that's got me upset and don't give me any of that family systems stuff of yours that because your uncle Harry called today and he was drunk, is the reason I'm angry at you." Aha! You were almost caught, but that little piece of information momentarily frees your head. You decide to ask a simple question and assume the listening position. "How is Uncle Harry?" you ask. Mother then proceeds to express an expansive scenario about Harry and his problems with his wife and her family. As she tells it, mother's anxiety is rising. You find your insides growing uncomfortable and almost without knowing what is happening, a cassette slips into place in your head and your mouth is delivering a systems lecture on the extended family. In the middle of your speech the differentiation center in your brain lights up with a gotcha message. You back off your speech and change the subject to food, and call for your father, thereby exercising another family tradition – the all-clear signal.

On your drive back home that evening you wonder why you didn't just take one more year of analysis and call it a cure. As you contemplate that, it occurs to you that somewhere down deep there is an unquenchable desire for a personal relationship with your parents, even if only a small portion of one is attainable in a lifetime. As you into your driveway you know, intellectually anyway, that you're fulfilling a responsibility to yourself and your kids. Going towards the house you glance back toward the car and catch a glimpse of an old Mets bumper sticker: "You Gotta Believe." You smile, also noting that the kids' bikes are left out – again. You enter the house, go upstairs, wake up your wife and criticize her for not getting after the kids to put their bikes away. Being "caught" is a way of life. We all have triggers that get us caught. We all have people we are especially vulnerable to. Ninety percent of the time we only know we are caught by the symptoms. Generically these symptoms fall into defensive and reactive behaviors, accomplished by significant projection. The problem with my mother is my mother, etc.

How does one get uncaught? The best way obviously is not to get caught in the first place, but to do that you would have to settle for not being born. It is important to remember this for measuring the potential of the emotional cards you've been dealt on being born. This reality perspective may on the one hand raise emotional reactions of envy towards those dealt better hands, but on the other hand it may also serve to provide a reality base for where to place your expectations. The more you know about the premorbid state of your system prior to your birth, the better understanding you will have to put into perspective the intensity of the emotional system you are part of.

The opposite of *being caught* is *getting free*. Both are ongoing dynamic processes that flow into one another. They are not steady-state structures juxtaposed to one another. The program for getting free entails dealing with the day-to-day snags in relationships; being careful not to get bogged down in the minutiae to the point of losing sight of the long-term multi-generational process.

First of all getting free calls for the development of and ability to see yourself as an active participant in your own relationship system. You must give up on the character analyses of the important people in your life; such pigeonholing only serves to foster and support your own automatic projection process. Rather, those people must be seen as just other members of the same system responding to the same anxiety that your insides are reacting to. Getting free demands that you get a handle on your own anxiety and take responsibility for it and the reactive feelings and behaviors that go along with it. Stop blaming others and look to yourself. Remember that time is the currency of relationships. Just keep in mind the slogan: *Don't tell me how much you love me; just tell me how much time you have for me.* In this regard, however, keep in mind that relationship time also needs to be monitored. There are excesses in both directions.

There are those whose insides for relationship tolerance are set in a way that any time spent in a relationship that isn't spent doing something is "wasted relationship time." There are others whose insides depend on so much relationship time to keep them calm that they drive away the very contact they seek.

Relationship time is also a key in extended family exploration. Many people seeking information and bridging cutoffs don't invest an adequate amount of time in relationship-building time. They barge into a close relationship and ask a series of personal questions.

The goal is to find and deal with the toxic transgenerational issues in your family, but do it with judgment, sensitivity, and appropriate timing. Take the time to remove the accumulated debris in a relationship before expecting the personal closeness to evolve. Make your quest a personal relationship with as many biologically connected people as possible, thereby increasing the number and quality of relationship options you have to move in, in your family. The goal is to stay in contact with the family, build personal relationships so that in times of increased anxiety one can remain in contact without becoming either over-responsible or over-distant from the family. If you accomplish this your system will be able to read organize itself to a higher level of functioning.

But what is the clinical relevance of all this? In our clinical work as family therapists we are human instruments; behind us stand our own family systems. From them we bring to the clinical situation our own vulnerability, triggers, and experiences. It can be a help or it can be a hindrance, but to be responsible clinically it must always be monitored.

On the other side of the human self instrument stand our clinical families. The processes of these clinical systems by their nature move to catch the therapist up into their reactive process and thereby neutralize the potential for modification and change. 1. They demand that the therapist fix the problematic situation while they remain passive. Actually, they mean "fix him or fix her so I will be comfortable." 2. They invite the therapist in, and then bounce him or her back out again until the therapist either pursues with anger and blaming, or distances in one form or another. If the self instrument of the therapist has been developed to keep on an even keel in high anxiety fields, then theoretically change and modification should ensue in the family. This approach leads us to the important clinical question of which is the most functional course for the therapist: Confronting the family with their dysfunctional process, or using the various systems operations we have been discussing thus far?

Bowen, from his stated position as a family systems researcher, would seem to continuously vote for non-confrontation. He chides people not to be fixers, but to become observers. To stop pretending you have the answers and begin to search for the appropriate questions. When questioned on this matter he has said that the answer lies somewhere between confrontation and just going along with it. To Bowen the acid test of the therapist's ability is schizophrenia, and he sees it as a long-term process. This question of confrontation versus subtle operation is one of the more interesting research questions in the family field today.

In another way it relates to the Bowen concept of the differentiation of self scale. As a phenomenon, the differentiation of self scale is either a useful research tool or a masterful ploy on Bowen's part to stay one up on everyone. After all, since he thought it up and only he really understands it, then everyone has to assume that he is on the top, and each of us is somewhere below, jockeying for position to hide out so nobody will know where we fit, or scrambling for that last ounce of self definition that will raise us up on a scale of 0 to 100 to the dizzying height of 37.

This scale of differentiation is a byproduct of Bowen's work with schizophrenia. Families with a schizophrenic level of dysfunction are placed at the bottom of the scale. The upper levels are reserved for those people in the Bowen family who agree with Murray.

In the Bowen schema it would appear that the scale serves at least two functions. One function is that when family members are located on the scale it can be used to predict the prognostic chances for change after clinical intervention. Second, tracking the ascent of family members on the scale over a period of time can serve as a baseline for measuring change. I personally find it his least clearly developed, as well as his least understood concept. At its worst it can tend to be used as a judgmental tool about certain types of behavior. Its focus on individual family members clearly defines the Bowen principle that change in one member of the family system will eventually result in a change in the entire system.

This methodology of engaging a family across the spectrum of dysfunction raises a basic theoretical and clinical question initially raised around work with schizophrenic families and continued on through work with neurotic level families. The question is whether or not the therapist in dealing with severely dysfunctional families must become a reactive part of the system in order to shake a rigidly enforced dysfunctional homeostasis. The debate goes on. The major pitfall involved in this path evolves from the potential of the therapist becoming emotionally locked into the family. A clinical example may clarify the dilemma.

Last spring in a consultation seminar, another family therapist asked me to be a consultant for a family he was seeing in his private practice. This was a family with nine children. The father was a busy prominent professional, the mother was just plain busy. Their seventh child, a son, had had an acute psychotic reaction, was hospitalized for three weeks, and was in follow-up individual therapy for six months prior to the father’s developing interest in the possibilities of family therapy. The therapist met with the family several times, obtaining an extensive family history and a detailed definition of the process. He also made a home visit to get a sense of their interaction in their own space. After these experiences with them he sat down alone and attempted to map out a plan of intervention. He decided upon two major points:

1. He was convinced that the precipitating event had been the departure of an older brother to an overseas assignment.

2. He decided that perhaps the reason Bowen had failed to produce change in 500 schizophrenic families was his unwillingness to join the system.

Consequently he decided he would join the system and attempt as best he could to form an alliance with the symptomatic son and a relationship with the mother that as closely as possible resembled the position of the recently departed older brother. He moved ahead on this plan and within a few months the symptomatic son had improved to the point of moving to a small apartment of his own, was working and considering returning to school. It was time for the therapist to take his early spring vacation. One night during the vacation he had a dream. In that dream he had moved his practice into the home of the family involved, and was anxiously sitting in his office listening to the mother of the family, who had dropped in to tell him what a bastard her husband was, and how he had to do something about it. Indeed he had now joined the system! His question at the consultation was: how was he going to back out now and get himself some more operating room? After discussing some of the theoretical aspects of what had occurred, I suggested that he attempt to disengage slowly, modulating the disengagement by moderating the family's anxiety level in response to it, and if possible to plug a network person into the slot he was pulling out of. The last I heard he was having some degree of success – with maximum effort.

Another method to evaluate the functioning level of a family is simply to use the observation that families that seem to be functioning well demonstrate a fluid movement of impaired functioning. Each family member over a period of time takes his or her turn with the dysfunctional symptom. In systems that are functioning less well, the problem is fixed in one family member often subsequently covering a dysfunction in another family member. For example, the acting out adolescent whose behavior so intensely fixes the focus of the family that it covers the father's significant depression. The confrontational methods of dealing with the more severe dysfunctions like anorexia frequently result in the subsequent appearance of a symptom shift to another family member. This on the one hand could be viewed as freeing the family process from its fixation, and moving it toward a higher functional state. The only problem with this is that the new symptom is often also of a psychotic level magnitude. This is a high price to pay. The classic example of this phenomenon is the case of anorexia modified considerably by confrontational means with the subsequent occurrence over a two-year period of a psychotic reaction in a younger brother. Perhaps the answer lies in a combination of confrontational techniques with a longitudinal view and respect for the power of the psychotic level process throughout a multigenerational family system. Bowen, I am reasonably sure, would view confrontational techniques as dys-synchronous with this theory and therefore not justifiable. However longitudinal research on this question, although predictably muddled by an unending series of uncontrollable variables, would be a significant contribution.

In studying Bowen, and watching his work, remember it is a primary principle of his not to let the proximate noise blur the beat of his distant drummer. He is not especially interested in the noise and flak of your proximate life, but he is fascinated with your distant drummer and the challenge of putting you back in touch with it.

The Bowen theory is a significant part of Bowen the Man. He does not only preach it, he lives it. His theory is hard to know. As a Man, he is hard to know. The effort is worth it on both counts.

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Guerin wrote the following remembrance of Murray Bowen in 1991 for The Family Therapy Networker. *The piece is a fine example of Guerin's beautifully personal writing, as well as an emblem of his love and respect for Bowen.*

The Man Who Never Explained Himself

Philip J. Guerin, M.D.

> *And I won't miss his moods, His gloomy solitudes, His brash, abrasive style, But please don't get me wrong, He was the best to come along, In a long, long while.*
>
> Lyrics from *Pippin*

Bowen entered my life on a summer day in 1967, as a Georgetown professor who lectured to the second-year psychiatry residents during our rotation at the University hospital. As a lecturer, his constant focus on theory created a dryness that left something to be desired, but there were rare times when he would take on the fire of the Southern evangelist passionately spreading the gospel of differentiation in his mesmerizing Tennessee accent. That day, his message to the residents was provocative and clear: "You people are among the brighter ones on the planet. Trouble is, you think you have all the answers when you haven't even found the questions yet." Having challenged our arrogance, he went on to share a portion of his own professional history. He spoke of his days at the Menninger Clinic, his 13 years of personal training analysis, his research on schizophrenia, and how the more he attempted to explain his new theories, the more he was in trouble with his peers and mentors. From that last experience he developed a philosophy to which he firmly adhered: Operate from your principles and never explain yourself. In 23 years of Bowen-watching, I never heard him explain himself once. That summer day his message began a process that would change the course of my professional life.

Two months later, I asked Bowen to supervise me on an individual psychotherapy case that I wanted to convert into a family case. He said he wasn't interested in family therapy anymore, but was now trying out some of Ross Speck and Carolyn Attneave's methods of family networking with schizophrenia. If I were interested in that and found a suitable case, he would supervise me a couple of times a month. My response was to convert the case I had mentioned into a family network experiment. The supervision consisted of 13 meetings during a nine-month period, plus attendance at a networking meeting that Bowen himself was doing once a month. During those nine months of supervision, he never once told me what to do in the meetings of my network. Instead, he would listen, pad in lap, playing with his pen, frequently reaching into his coat pocket

for another cigarette. When he did speak, he would tell long, involved stories of his work with schizophrenia. The moral of the stories was always the same; it had to do with the intensity and power of the emotional process in schizophrenia and how only a few people could face up to it without "getting caught" by its power and behaving like anxious robots. Bowen believed that schizophrenia was the "great teacher" and that an essential ingredient in becoming a competent psychotherapist was having the experience of wrestling with its power.

By the following spring, I had decided to leave the residency at Georgetown to take a position as chief resident at Albert Einstein College of Medicine in New York. During my first year in New York, I commuted back to Washington once a month in order to continue my contact with Bowen. The first Thursday evening of each month, I would leave New York and head for Washington. By 6:30 Friday morning I was at Bowen's house, ready to drive him to the Medical College of Virginia in Richmond for a day of watching him work with families.

The rides to Richmond and back were often the most enlightening parts of the day. Having access to his considerable experience and his unique wisdom was the gold, but the rich ore had to be sifted from the dysthymia and the disillusionment of a prophet undervalued in his time. On the return trip I would pick at theory, especially as it related to my family of origin, and practice detriangulating. Bowen would sleep, smoke, speak of his beloved Redskins, and even, at times, get personal. On one return trip, he informed me that there was no rush to get back because his wife was attending a play at the National Theater that evening. I chided him as to why he wasn't going as well and how he shouldn't be so phobic of togetherness. In typical fashion he snorted and said that as far as he was concerned, plays were nothing more than "faked emotional systems."

Another highlight of those times was the annual Georgetown Family Symposium. Every fall, alumni of the Family Training Program would converge on Georgetown for the annual homecoming weekend. Instead of a football game against the Baltimore Psychiatric Institute, each graduate would compete to demonstrate the latest and the best twists that had been given to Bowen's theory. A guest lecturer was also invited. The finale would be the most recent wisdom of the master. It was a wonderful refueling ritual.

One year, Nathan Ackerman, who was that symposium's featured guest speaker, asked me if I would allow a "poor old man" one question. "Explain to me, if you can," he said, "how a cold fish like Bowen, who is so afraid of his own feelings, attracts such a large cadre of loyal sons?" The astutely observant Ackerman was somehow puzzled by the way his own dominant and emotionally pursuant temperament evoked a responsive distance from so many of his professional children, while Bowen's almost mystical aloofness seem to encourage discipleship.

Bowen's favorite stories about Ackerman always centered on a game they played in which Ackerman, often in front of large audiences, would prod Bowen to express his feelings more freely, especially his anger. Bowen would respond by telling the story of his favorite Menninger patient, a person with a world-class talent for provoking anger in others. Bowen related that on leaving Menninger’s, he expressed a wish to take the patient with him so that he (Bowen) could become the best person in the world at not being provoked to anger.

Family therapists have wondered for years about Bowen's lack of expressed emotion. Was it that he didn't believe in the value of expressed emotion and therefore was uncomfortable with it? Or

was it that he was uncomfortable with it and therefore made up a principle to minimize its expression in his presence? Bowen's goal was always to get people to speak factually about their feelings without the surrounding capsule of anxiety, that he believed produced reactivity in others.

Whatever his personal allergy to the "stickiness" of expressed emotion, Bowen could stand tall in the midst of the thickest jungle of intense emotion and anxiety, somehow connect with the person or people experiencing it, and by his own calmness, calm them and lead them out into the clearing.

How did he connect? He listened. He respected people, their intelligence, and their personal boundaries. His questions, which accounted for more than 90% of his communications, at once let people know that they were being heard while giving them the simultaneous experience of his wisdom and his strength. He believed that pushing people to express feelings did two things: produce distorted or pseudo-emotional responses and retard movement toward differentiation and improved functioning. By his fact-focused questions, he hoped to prod people's thinking about important issues and events. If he was successful, anxiety would be lowered and an undistorted flow of expressed emotion would occur. The patient was thereby offered the opportunity of and experience in distinguishing between thinking and feeling systems. The purpose of each of these steps was to produce a flow of movement toward differentiation.

From 1973, when the Center for Family Learning was founded, my contact with Bowen remained consistent. He came once a year to the center as a visiting professor in our postgraduate training program. His teaching time was divided between a formal lecture and a case consultation. His interviews were superb to watch, at least for those who knew his theory and could track what he was doing clinically. The question-and-answer periods that followed his interviews would be filled with his preacher stories of clinical encounters from different times and distant places.

One interview stands out in my mind. The patient was a woman in her early 30s who desperately wanted a baby but was fearful that her parents' concentration-camp experience might produce a genetically defective child. During the consultation, Bowen asked the question, "How in the world would you explain that?" more than 20 times. In response to his questions, the woman wove a fascinating tale of intense anxiety permeating the family, cut-offs from the extended family driven by an argument over the distribution of restitution money that the family had received from Germany, distance in her marriage, and her anxious over-functioning for her younger sister. At one point in describing her relationship with her family of origin, she spoke of "feeling like we were all wrapped in one skin" Bowen smiled, appearing just a little stunned, and told the woman she had "a beautiful problem". It was as if his concept of the "undifferentiated ego mass" had been reborn, live and on videotape. At the end of the session, in a grandfatherly way, he placed a hard candy in his mouth, raised the index finger of his right hand, and said, "Let me share a few thoughts." Bowen told her that her anxiety about potential genetically defective offspring was more "psychological than real" and that he thought it that if she decided to have a baby, "everything would work itself out okay." He encouraged her not to take her husband's distance so personally and to make a project of getting out of the over-responsible position with her sister by giving responsibility for her sibling back to her parents. Most members of the audience that day were amused by his description of the "beautiful problem." Some thought he

was turned on by the very attractive person he was interviewing, but those who knew Bowen realized he was invigorated by the validation of his theory.

The last three years of Bowen's life were often painful for those who loved and respected him. The stress of increasing infirmity amplified his irascibility. Some would have preferred his fading from the scrutiny of public appearances. But Bowen didn't believe in lying down or giving in before the time had come, certainly not in response to someone else's discomfort. Clearly, he had decided that the time had come in early October 1990. At the annual meeting of the American Association of Marriage and Family Therapists, he chose to say goodbye as he had lived, on a stage, preaching his theory with his last available breath.

When I heard of his death, I reflected back to one of his visits in the early 1980s. Bowen had spoken of the family emotional system and cancer. Blanche Kaplan, one of our faculty members, commented after Bowen's presentation, "I finally got the message. If you're differentiated enough, you won't die." On October 9, 1990, however, the master of differentiation proved Blanche to be wrong.

People like Bowen, calm in the absolute assurance of their truth, provide us with an emotional anchor, an object of constancy. When they die, only those parts of them that we have incorporated into ourselves remain. Bowen's ideas, his clinical work, his dedication to values have made a difference to the many people whose lives were touched by him, directly or indirectly. For those people, for at least a little while, when someone says "Bowen," it will matter.

The past history of family therapy has always been a major interest of Guerin, but of far greater importance to him is its future. He sees it not just as one "modality of treatment" among many, but as a different, alternative way of conceptualizing and treating human emotional suffering. In the following paper he expresses his fear that differences of therapeutic style and artistry will tear the family movement apart. He advocates the development of theory that is general enough to be open to a wide variety of therapists' personal styles. As a condition of this happening, Guerin points out the importance of therapists' having their own emotional reactivity under control – reactivity to the families they see, and reactivity to their own families.

Family Therapy: Style, Art, and Theory

Philip J. Guerin, Jr., M.D.

In this paper, I would like to share with you a few ideas on how to look at family therapy from the structural concepts of style, art, and theory.

Much has been said about style and family therapy. Some have gone so far as to say that family therapy is nothing more than a conglomeration of idiosyncratic styles and as such represents a passing fad in the field of psychotherapy. In the literature, most of the comparative studies of family therapists are stylistic in orientation; hence the descriptions of conductors and reactors, the all-together-now's, and the lone wolves. The family movement is style-oriented to the point that even when attempts are made to do comparative studies of the conceptual models of various family therapists, it is still viewed from the framework of style. For example, I presented a paper in which I included a classification of family therapists according to their theoretical orientation. That classification has since been made into a training film. In the past two weeks I have received three written and two verbal requests for the use of the film – all of which essentially said, "We've heard about the great training film you have comparing various styles of family therapists."

If one takes as a somewhat vague but working definition of style the affective way you bounce off people and field the input from others, then the component parts of style are numerous. Facial expression, speech, posturing, touching, and native operating principles would be included. As such, style should be a manifestation of a person's uniqueness, an external representation of the complex interconnected forces which comprise the totality of self.

Clinically, what would be a couple of examples of differing styles? Let's take the Hillcrest family as done by Ackerman and Bowen. Many of you have seen the films. The family membership in the session is father, mother, and four children – boy, eleven, and girl, nine, from the father's first marriage; girl, five, from mother’s first marriage; boy, one, from the present marriage.

In the Bowen film, Bowen's reading is quiet, unassuming. He seems to blot out the presence of the children and proceeds to move in on the parents, asking many measured questions, mixing straight questions with seemingly oblique ones; he tosses a few sliders in all the while getting the facts about the component parts and boundaries of the system. On the other hand, Ackerman's greeting is much more bravado, his dominance and "take charge" demeanor is much more obvious. From the beginning he provokes and tickles the family members. Focusing on the older girl he says, "You're flirting with me," and asks each of the older children if they like him.

Now there is much more than just the obvious differences in style. Ackerman prods and pokes for affect, attempting to ferret out the issues of sexuality, aggression, and mothering. Bowen moved to define system process and overall patterns. Refusing to squeeze for affect, he prods the cognitive.

Style, as such, has many definable and many indefinable characteristics. But what are some of the determinants of a therapist’s style? Two major context determinants are the cultural and social context of the family and the training context.

I believe that each of us is born with a constitutional predisposition to certain types of behavior. Add to this the written and unwritten laws of the culture and the family and you have a major portion of an individual's emotional programming. This programming, through multiple verbal and non-verbal messages, labels certain behaviors as good and to be fostered and others as bad and to be discouraged. The individual, depending on his reactivity in the system, is left with multiple responses on the spectrum from over-compliance to counter-positioning. These responses may vary throughout the lifecycle of the individual and his family.

It is this emotional programming that those of us who choose the mental health profession bring into a training context. Upon entering such a training context, one quickly picks up multiple signals, both verbal and nonverbal, presenting the message that all those pre-programmed, natural behaviors are to be left behind and a new set of behaviors learned. This new programming then will allow the trainee to do it the "right way."

In the family therapy movement throughout the country there are multiple types of training contexts. For purposes of description, I have classified them into four major types: token, monolithic, diverse, and balanced.

In the token training context the word is out that the up-to-date department of psychiatry, clinic, or whatever, has a family therapy guru in residence. After all, trainees are clamoring and everyone wants to be a progressive, broad-minded eclectic. In looking for a teacher of "family," the individual-oriented program seeks as their token one whose work often represents individual therapy with multiple family members present. The trainees then protest, "That's the same old stuff." If such a token can't be found, they do a "do your own thing-er" whose repertoire varies from "rain dances" to "therapeutic copulation." When the persons in power, being conservative in nature, get around to watching the "do your own thing-er" they say indignantly, "You can't do that around here" and throw him out. The third possibility is that once in a while they get a systems man and the comment on his ideas goes, "It's interesting; great, but could you explain it again? No, it's not quite clear yet." Until he explains himself out the door. This fulfills their obligation to teach "family" for a while.

The monolithic training context, however, tends to fuse style, art, and theory. For them there is only one way of thinking and one way of doing. An advantage of this type of training context is that it produces a strong, highly developed and reproducible theory. A disadvantage is that trainees mis-hear or misinterpret the theory and as a result get very heavily into the style of the master. The end result is often a carbon copy mimicry of style.

The diverse training context appears to produce the most creative and flamboyant technicians. Their message is that everybody's got a piece of the action. There is little concentration on theory and the message "whatever turns you on" is their motto. There is little or no attempt to pass on a body of knowledge. As a result, there is a markedly limited degree of reproducibility in the product of training.

The balanced training program to my knowledge does not exist. There is an attempt at Einstein to move from diverse to balanced with the developing relationships among therapists of different theoretical persuasion allowing listening and hearing to take place. As in any family, however, just when it looks like it's working, some stress hits and we are all back to trying to change one another to the "right way." At its best, it allows us to expand our ways of thinking and to increase our options, broadening and refining what each believes in without necessarily giving up what each one believes individually. This see-saw between a balanced training context, which stands for defined and multiple ways of doing things, and a diverse training context, which can end up standing for nothing, is a delicate process.

In my work as a family supervisor, I was watching one of our trainees at Einstein work with a family. This is a talented and creative woman, outgoing, forceful, and never at a loss for thoughts or words. She has a significant degree of clinical experience and competence. Of late she has

been getting more and more into family systems theory. As I watched her work with this couple, I was amazed. She was sitting at the point of a triangular seating arrangement, leaning back in contemplative fashion, asking very carefully worded, measured questions, cooling affect on her part and on the part of the couple, and carefully directing the flow of conversation through her. As I watched, the question came to mind: "Does theory set limits on style and confine it to a certain repertoire of behavior? Or, on the other hand, shouldn't theory, if it's valid, free a therapist or agent of change to have multiple and widely variant stylistic ways of movement with the family?"

If you take the same clinical situation, there should be multiple stylistic ways to approach it. Perhaps a therapist with a flamboyant, unmeasured, provocative, and affectively charged style might lean in toward the father of the family, place his hand on his arm, and say, "I've got this idea stuck in my head. My guess is that whenever your wife gets upset her upset is one of the most difficult things in the world for you to deal with, so you end up heading for the hills (hills being a mistress or your corner bar). When you take off, your wife handles that by getting over-involved with your son. Now, what are you going to do about that? She's already working on trying to find a way of dealing with your distance and her over-concern." Another therapist in a quiet, reserved way in the same situation might ask a series of measured and balanced questions like: "How much of your being away from home a lot would be tied into the pull of those outside things and how much would be connected to you getting out from under trouble in your relationship with your wife? When she gets upset and you get bugged, how would you go about managing to stay around?"

In either situation, if the therapist can avoid blaming, labeling a victim or a villain, becoming judgmental of the family, and keep from adding his or her emotional reactivity to the stew, he will be fulfilling his responsibility to the family as an agent of change and his responsibility to himself to be himself. A valid theory should not confine the therapist's repertoire of behavior; otherwise only those people with a particular style of behavior can make use of a particular theory. Then the theory is due to become a rationalization for a way of doing things.

One final word on training contexts: no matter what the degree of maturity and supposed or hoped for lack of "we-ness" training context possesses, it still communicates that there is a "right way" to behave. If a person from inside the system, avoiding over-compliance and counter-positioning, begins to work a re-involving of his own natural style, the system's reaction to this will be to close in. First, "What's wrong?" will be asked, (meaning, are you coming under other, evil influences?) Second, they will be pressured to change back. Third, the message will appear, "You're a heretic and must be extruded for the greater good." This is not because training contexts or the people who made them are bad, but because that's the way human systems work.

As such, styles should not be disconnected from theory, but, neither should theory dictate the personal style of the therapist. If the theory is valid, it will free its practitioners to use various styles that are natural to them.

Art in Family Therapy

So much for style, now on to the concept of art. In this context, I would like to define art as the creative pulling together and use of one's style and theory. The art of family therapy is made up of many general components and specific techniques. Two of the ones I consider important are **the art of making it safe** and **the art of dealing with feelings.**

By the art of making it safe, I mean making it safe enough to talk about anything, but not so safe that people go to sleep. Most, if not all, families enter the therapy context scared, defensive, and blaming. The projection process is usually intense. If you as the therapist can make the context of the family sessions safe, the family will be able to tolerate the anxiety that comes from opening the toxic issues and deal with the process as it evolves. The "content-safe" areas vary from family to family. Some talk freely of conflictual marriage, but find talking about kids and extended family too dangerous. Others are just the opposite. Their relationship is perfect; their children's behavior is their only problem. The experienced therapist is skilled in creating this element of safeness.

There are several aspects to the art of making it safe. One of them is **being in charge of self**. Basically, this comes from being confident in the knowledge of how families work and being aware of the kinds of behavior and process issues that raise your own anxiety level. In general, those behaviors and process issues that raise your anxiety in dealing with your own personal family system will do the same with clinical families. The therapist must be in relatively good control of his or her own anxiety level. Otherwise it is not possible to be tuned into the reactive feeling process in the family and the vulnerabilities of each family member without becoming reactive. This happens in either a judgmental way by the therapist's joining the blaming process in the family, or by his reacting in an overly responsible way in which he takes responsibility for making people feel better or for producing change. If the therapist can maintain control of his or her anxiety level, the anxiety level of family members will decrease and the therapy can proceed.

Another component of the art of making it safe is being in charge of the therapy session by **balancing anxiety.** The balancing of the anxiety level in a family session is an important part of establishing a safe context in which all the elements of change can be set in motion. All families are anxious to one degree or another.

If the therapist gets reactive to the family's anxiety in ways that increase that anxiety, it will jam the emotional circuits and send the family system into overload. In this stage of overload, no one is able to unhook from the reactive emotional process and everyone participates as the family goes away or the symptoms exacerbate.

If the therapist gets reactive in an over-responsible way by being responsible for the answers and for the methods of changing the "messed up" family member, the family anxiety level will come down but the core functioning level of the family will remain unchanged. On the other hand, if the therapist can balance the anxiety level in the family to the point at which family members are able to communicate with each other, to listen, hear, and think in different ways without taking away the degree of anxiety which motivates change, then the context wherein change is possible has been set.

Making the toxic non-toxic: Every family has its toxic issues and secrets. Whether the therapist stumbles upon them while in search of something else or picks them up from the subtle nuances of the ongoing family process, how are they best dealt with and detoxified? Again, the therapist

in charge of his or her own anxiety is of the utmost importance. If the therapist can be emotionally loose enough to be open himself to the discussion of toxic issues, the family would usually respond in kind. For example, take an instance of a family in which the husband comes to the therapist after the session and tells him that his wife is dying of cancer and that she doesn't know about it. The surgeon thought it would be better that way. As it stood, everyone in the family including the three adolescent daughters knew, but his wife didn't. With this piece of information pieces began to fall into place for the therapist. The acting out behavior on the part of the oldest daughter had been labeled as the problem. This was most likely connected to the family anxiety level, and was a response to the news of mother's cancer. In the next session, after the usual beginnings, the therapist turned to the mother and asked, "What do you think it is that keeps your family from telling you about your cancer?" The mother looked pensive for a moment and then said, "I don't know, maybe they're afraid to." She then went on to talk about how she had known since the surgery that she had cancer. Each morning before anyone else was awake she would go to the bathroom mirror and check her eyes for signs of jaundice. She would then pull herself together for the task of getting her family off to work and school. After everyone was gone, she would spend the day alone feeling sorry for herself and crying a bit. When midafternoon came around, she would proceed to pull herself together for the return home of her husband and kids. She talked of never having felt so alone or isolated before in her life. In response to this, the daughters cried and the oldest one went over and put her hand in mother's and listened. The father got nervous at first and tried jokingly to change the subject, but the therapist politely asked him just to try to relax and listen to his wife. At the end of the session, mother told the therapist that a great weight had been lifted from her shoulders and from her family. The toxic issue of mother's cancer and threatened death had been opened up and talked about for the first time; the detoxification process had begun.

Dealing with feelings is an important art in family therapy. Human feelings are very precious. To me, the absence of feeling is death. Many people, therapists in particular, however, see the expression of feelings in massive amounts daily as the cathartic formula for providing emotional regularity. It is true that a person must learn to communicate deep and intense feelings to important others, have them heard and be ready to receive the same in kind. But for this to happen, one must take responsibility for his or her own feelings and not put the responsibility for how he feels in others. For example, how often have you said to your spouse, "You make me angry." This kind of statement usually carries with it the non-verbal meta-communication "And you better do something about making me feel better." Such a statement is an accurate description of a feeling state with its automatic projective quality. The fact of the matter is, however, that your spouse did something (for example, fell asleep while you were talking) and your response to that behavior was to become angry.

This kind of stimulus-response behavior happens over and over again in an automatic reflex way in any relationship. It is also, over time, very much a two-way street. As long as each person holds the other responsible for his feeling response and demands that the other change, it is impossible for the relationship to progress to the point of real personal closeness. In a state of personal closeness, significant non-reactive feelings can be freely communicated in both directions in a calm, non-blaming, non-defensive atmosphere.

It is the therapist's job to help the family member get unhooked from the projective process that places the responsibility for uncomfortable feelings outside of self and in others. In order to bring this about the automatic emotional reflexes must be defined and defused.

As a therapist, it is important to be sensitive to the feelings of others. You should be in charge of and comfortable with your own feeling responses. There is a difference between being tuned into a feeling process and being reactive to it. The therapist's own "internal feeling barometer" is an extremely important part of the self instrument. You should be in charge of it and have it tuned into the emotional field of the therapy sessions and into the members of the family. In my work with families, I like to use this type of feeling level pick-up, interpolate it into questions, and feed it back into the system.

Another important aspect of dealing with feelings has to do with the concept of your own **"I position."** An example of the statement of an "I position" would be: "I am upset. I don't hold you responsible for making me feel that way or for making me feel better. I want to let you know how I feel because you are important to me. I would like to hear your thoughts and feelings because they, too, are important to me. However, I won't take responsibility for the way you feel or for making you feel better. I will just ride it out with you, staying tuned in on a feeling level and trying to understand so as to know you better." This obviously does not have to be expressed in so many words, but can be communicated in many different verbal and nonverbal ways. When carried over to the developing relationship between the therapist and each family member it can take a similar form which in essence communicates the message. "I hear you when you say you are upset. By listening, asking questions, and sharing with you my thoughts, I will try to help you open up the toxic and intense feelings you are experiencing. I will try not to reason back at your feelings or change your mind. Neither will I take responsibility for how you feel. Nor will I join you in judgmentally blaming the others by whom you feel victimized. By keeping my own anxiety and feeling response in check, I will try not to further worsen your plight. I will openly share with you my ideas and ways of thinking about the feeling state you find yourself in without getting into the position of invalidating your right to feel that way or judging the appropriateness of your response. I hope that my behavior will assist you in openly dealing with your own internal response and enable you to develop a plan to feed the response back into your key relationships. In this way, with your anxiety in check, the intense feelings connected to the relationship issues can be dealt with."

There are many more aspects to the art of family therapy. For the purposes of this paper, I would like to pass on now to consider briefly the importance of theory to the family movement.

On Theory

There are many who say there is no theory of family. It is merely one among many possible "treatment modalities," these people say, and we need to work on refining the indications and contraindications of this "modality." Still other therapists find no basic conflict between the psychoanalytic treatment of an individual who comes alone to their office, and the treatment of an individual, or several individuals, in the "setting of their family." True, they admit, the latter is more complicated and requires additional techniques, perhaps adapted from group therapy, but there is no theoretical conflict.

But there are increasing number of family therapists who see "family" as a different theoretical framework for understanding and dealing with the entire spectrum of human emotional problems. These therapists struggle to define and work with the family as a "system" (a currently popular term with varied meanings); they struggle to move away from the individual-oriented, cause-and-effect thinking of psychoanalysis; they struggle for new language and terminology to express this shift in their thinking; and, most of all, they struggle to both expand and unify the many "family" concepts that have gained widespread acceptance: reciprocity, fusion, triangulation, interlocking triangles, closeness, distance, anxiety transmission through generations, interdependence, open and closed communications and relationship systems, homeostasis, differentiation, automatic emotional reflexes, etc.

In the beginnings of the family movement it was a radical guerrilla operation, de-centralized, but bound together by an elite group of pioneers.

Today, we are in stage II, the period of respectability and melding in the family movement. This recognition carries with it several dangers, all of which, in my opinion, currently beset us: a bastardization of some of the major family concepts; a burying or blurring over of differences for the sake of "fraternity," this fraternity often alongside massive amounts of covert competitiveness. Also there is the risk of family becoming a current fad in the mental health field with the predictable popularity-abuse-disenchantment cycle which group therapy so recently went through in this country.

It seems to me that in order to negotiate successfully stage II, we must extend our efforts to expanding the conceptual base and continuing the development of a comprehensive theory. This means more research, and the conversion of research already done into consistent clinical procedures dealing with family process. It means developing the language and terminology with which to communicate clearly our ideas to each other and to our trainees.

But this brings us back to where we started: style and the emotional reaction to it. For if we are to advance and unify family theory, we shall have to do what we are continually asking the families we work with to do: we shall have to get beyond automatically reacting to each other's affective styles of work and presentation, and start listening to each other's thoughts on theory and technique. I believe we will have entered stage III when whole schools of thought, and years of work, and the sincere efforts of serious workers in the field, can no longer be characterized and wiped away by a catch phrase or slogan passed along unthinkingly and reactively to new generations of trainees in the various family centers. These things must happen if the family therapy movement is to pass on into stage III, wherein lies the refinement, growth, and reproducibility of a single or multiple theories of family.

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The following paper is Guerin's comparison of Bowen's theory and practice with that of the structural and strategic theorists. All three are "systems" theories and therapies, but differ on some significant points. These differences are in many ways complementary, but at the same time raise important questions for future research.

System, System, Who's Got the System

Philip J. Guerin, M.D.

"Systems" is the password of the day in the field of family therapy, but this was not always the case. In the 1950s, "research" was the cover for developing "family systems" concepts as the Bowen NIMH project in the East and the Bateson communications project in California laid the groundwork of the family systems movement as it is known today. By the 1960s, family systems therapy had come out from under the cover of research into the clinical arena. These were the "war years" in which the ideological battles between psychoanalytic and systems viewpoints were fought. The current decade is the age of the "family system."

Currently there are three forms of family systems therapy and research going on in the country. The first is Bowenian family therapy, a continuation of the work begun by Murray Bowen in 1950. The family systems theory developed by Bowen originally centered on concepts closely tied to psychoanalysis and schizophrenia. Since the 1950s, however, he has consistently moved to develop an extensive, all-encompassing system-based theory of emotional dysfunction. His working field is the 3 to 4 generational view of the family in which he especially notes the processes of triangulation, marital fusion, and reciprocity. Bowen began his work on the family with a study of mother/child symbiosis back in 1950 at the Menninger Clinic. This interest in mother/child symbiosis has carried over to his present-day family systems work in the form of the importance he places on the maternal axis in the 3 to 4 generational family system. The second and third forms are strategic and structural family therapy, the two descendants of the work begun by Bateson, Haley, and Jackson, and influenced strongly by Haley's association with Milton Erickson.

Minuchin made his major entry into the field with his Wiltwyck Project. Taking an ecological systems approach he attempted to intervene with chaotic, disorganized, poor families with two delinquent boys. This work is described in detail in Minuchin's book *Families of the Slums.* In the mid-1960s Minuchin and Haley joined company at the Philadelphia Child Guidance Clinic. Minuchin developed structural family therapy and Haley expanded Erickson's work in further developing strategic therapy. The purpose of this chapter is to compare in some detail Bowenian family therapy with structural family therapy à la Minuchin.

Before moving onto the comparison I would like to consider briefly the issue of ownership of ideas. Bowen has always taught his students and his families that these are my ideas, if you find them useful and pick them up, they then are no longer my ideas, but yours. This I think is both a basic ethic and a fact insofar as each person's thought processes put a somewhat different twist on ideas. There is such a thing, however, as referencing one's ideas to whether they are (1) directly borrowed from someone else, (2) directly borrowed and altered and how they have been

altered, (3) ideas which occurred in isolation seemingly simultaneously with the ideas of another, defining the sameness and differences between these ideas.

One only has to look to a recent issue of the *Journal of American Psychiatry* in which an article on family therapy calls for the need of a theory that includes the extended family. This article refers to the Minuchin framework as confined to the nuclear family and emphasizes the need for theory which includes the extended family. While there is adequate reference made to Speck's work on network therapy, there is not a reference or mention of Bowen's extensive work on the extended family. This is not an isolated incident.

Articles are all too frequently published by people in this field full of the ideas of others without the slightest reference to the origin of the thinking. It is, I think, a fact that the family therapy movement, especially its first generation of guerrillas, rarely gave each other credit for anything. On the other hand, polarization of the kind that sets up an ownership of ideas is destructive to the job at hand, which is the further development of concepts and corresponding clinical techniques that can produce documented clinical change. There is a distinct need for a more careful referencing of ideas without invoking the paralyzing curse of "I thought of it first." Each systems-based ideology differs in its *scope, philosophy of what is possible in life via therapy, and definition of education*. Both the strategic and structural approaches are pragmatic and context-determinant in their philosophy and their focus is symptom-oriented. Their belief is in the implicit education of experience. Their outlook is more pessimistic. The Bowenian model on the other hand is cautiously idealistic and optimistic about the inherent potential of humans for growth and change. It is strongly based in a philosophy of free will. Education at its best is seen as a combination of the implicit knowledge of experiences, solidified and reproduced by cognitive appreciation of its form. The differences in philosophy, focus, and outlook are probably a combination of the personal characteristics of the people involved and the characteristics of the majority of their patient populations and the context limitations of each.

This having been said, let's move on to considering these two models of family therapy, their major samenesses and differences conceptually and operationally. This comparison will focus on (1) the definition of the family as a unit, (2) the clinical definition of the family as a system, (3) the typology of the family, (4) joining, accommodating, and clinically operating the system, (5) the marital relationship and the nuclear family, (6) the extended family and the therapist's own family, and (7) triangles.

Definition of a Family as a Unit

Both series are systems-based in that they both define emotional dysfunction as a manifestation of relationship process rather than confining it to the intra-psychic process of the individuals involved. The family system, as each defines it, differs clinically. Minuchin's definition of the family is usually confined to the members in the household of the symptom bearer. This membership may, but most often does not, cross over more than two generational lines. Bowenian theory, on the other hand, consistently defines the family system as an interlocking series of relationships bound together by blood and marriage extending over 3 to 4 generations.

Defining the Family as a System Clinically

In the days preceding the development of structural family therapy, Bowen wrote and talked about the problem of the necessary shift on the part of the therapist from cause-and-effect thinking to systems, and the importance of clinically moving the family to relabel and redefine their problem as a family problem. There was however some difficulty in communicating the art of accomplishing this clinically, especially with the child-centered family. As a result of Bowen's artistry at doing this, many family therapists would be unable to match it clinically and would end up trying to sell the family the idea that it was a family problem. The predictable result of this maneuver was reinforced denial and projection on the family's part, producing a more intense fixation of the problem in the child. One of the major contributions of a structural family therapy is the refinement of restructuring techniques that reconstruct the family in a way that will alleviate the presenting symptom. An unanticipated but predictable side effect of this technique was the shifting of the symptoms elsewhere in the family. This phenomenon automatically takes the problem out of the head of the original symptom bearer, thereby redefining it as a systems or family problem. This bypasses the "selling" pitfall.

To demonstrate this, let's examine a clinical case. "The boy with the dog phobia" is one of the first training films produced at Philadelphia Child Guidance Center by Minuchin and Barragan. It beautifully demonstrates a clinically induced structural alteration of a child-focused family. The result of the structural alteration is to alleviate the symptoms in the boy and shift them to the mother. This automatically defines the problem as a family problem rather than a child problem.

On closer scrutiny the problem can be conceptually defined in the following way. The central nuclear family triangle is defined as one involving the boy, his father, and his mother. The relationship between the parents is defined as distant but not openly conflictual. The relationship between the mother and son is defined as intense and over-involved. The relationship between the father and son is defined as extremely distant.

Other information of interest in light of the symptom is that the father is a mailman. The strategic intervention that is planned combines two facets: (1) prescription of the symptom with its paradoxical effect, and (2) introduction of an object around which to organize the father-son relationship in the hope of closing off the distance. The intervention is instructing the father to bring a puppy into the sessions. The results demonstrated on tape show the boy and his father obviously enjoying playing with the dog during the therapy session. The perhaps unanticipated side effect is the clearly observable developing depression in the mother. The problem has now been redefined as a family problem.

Minuchin in his work with anorexia has added two procedures to this type of structural alteration. One is what I would call a *symmetricalization of the problem* and the other *engaging the boundary guard*. The symmetricalization process is one in which the problem is parceled out in pieces to family members other than the symptom bearer. This can be done in many ways. In working with the "hot dog" family, Minuchin took as an assumption that if the basic individually oriented research on anorexia was valid, in that there was a pervasive feeling of defeat on the part of the anorectic, then that assumption could be generalized to the whole family. Clinically therefore he prodded the parents to force-feed the child until they gave up in defeat, thus symmetricalizing and making visible a system-wide problem of feeling defeated. Bowen would conceptualize the deceit issue as one manifestation of the family projection process leaking down one or two generations to the anorectic child. In addition, whereas structured family therapy would confine its investigation and intervention to the nuclear family and the central parental

triangle, when faced with a child centered family the Bowenian family therapist will think not only of the central triangle between the parents and the symptomatic child but will also look for triangulation over three generations involving a grandparent, parent, and the symptomatic child, other nuclear family triangles including the symptomatic child, a parent and an asymptomatic child, and also the possibility of an inter-sibling triangle involving the symptomatic child and two siblings.

It should be remembered that in almost any clinical situation approached by a traditional Bowenian he would initially gather a genogram and all the factual data about the general configuration and functioning of the three generation system. This is based on the theoretical belief that a 3 to 4 generational overview of the family is necessary to place the emotional symptom in its appropriate context. This means that, in order to understand the inputs of anxiety and upset and the potential relationship options for dealing with them, it is necessary to define the component parts and boundaries of the family system.

The appropriateness of this ritual is demonstrated clearly in families wherein the exacerbation of marital conflict or the appearance of a behavioral symptom in a child can be traced to the preceding death of a grandparent. A family I saw recently serves as another example of its value. This was a family which was referred because of the wife's depression. In the initial stages of the evaluation the wife explained her depression as a reaction to her husband's being out of work for over a year after many years as a successful businessman. A family therapist could easily have framed that as the problem and proceeded to work on the process toward some solution. However, in doing the standard 3 to 4 generational genogram evaluation, I discovered the following directly relevant information. The wife had been married once before and had two children by that marriage. Her first husband had committed suicide when her children were small and the suicide was a complete surprise to her. The second husband's loss of employment and his reactive withdrawal into himself had set off anxiety in her about his possibly committing suicide. This thought content was being withheld from the relationship with her second husband, and subsequently had triggered a reexperience of her first husband’s suicide, the facts of which she had kept from her children. Further investigation revealed the wife to be emotionally cut off from her own mother and quite close to her first husband's family.

In the 12 months preceding the onset of her depression, her first husband's father had died and his wife had ended up in a nursing home on the West Coast with a surviving son. This information provided a clear picture of the marital conflict in response to the second husband's job loss, the wife's increased vulnerability to his withdrawal based on the loss of important extended family relationships, and its triggering a previous toxic life experience around her first husband's suicide.

In the face of this, the wife's isolation and depression made sense. The suicide issue was automatically opened up by the extended family probe, the conflictual marital process surfaced enabling it to be dealt with, and the wife's vulnerability could be decreased by having her open and expand relationship options in her extended family.

Bowenian systems represent a longer range and broader view systems approach. It is not without problems however. It is important to keep in mind that there are different types of families with different types of problems that may respond to one method or the other, or a combination of both. Families in general as they present clinically can be broken down into three categories.

1. *Reject Families*. These are families that fail to engage with the family therapist in the process of moving toward change. Most often this phenomenon is a byproduct of either the intensity of the family's projection process which places the problem in the head of one family member (at times this is so great that the very fact of being in family therapy is too much of a confrontation), or the therapist may fail to relate to the family in a relevant way.

2. *Symptom Relief Families*. These are families that engage, move on to accomplish symptom relief, and then choose not to go any further.

3. *Long Term Families.* These are families that engage and go beyond symptom relief to long-term work on improving the definition of self and self's functioning and the development of one-to-one personal relationships in as many relationships as possible. This last form involves extensive work in the extended family and is most often carried out by the use of a model in which the family seeks consultation whenever it is deemed necessary after acute symptoms have dissipated. In this model there is a progression from the family's being seen once a week to once every other week to monthly and then to three or four times a year. It should be noted that in recent years Bowen has gravitated toward the belief that the more quickly a therapist is able to move the parents in the nuclear family unit to working on the generation above of their family of origin, the more quickly the symptoms in the nuclear family will subside without ever having been directly approached and the more chance there is for a longer project between the family and the family systems consultant.

The Minuchin model is much more simple and concrete and aims toward symptom removal and increased family function in a more narrowly defined area. Its simplicity and concreteness perhaps make it easier to teach and reproduce on a clinical level.

It makes good sense to me that when faced clinically with a child centered family in particular, the intensity of the projection process determines which methodology is indicated. Sometimes the intensity of the projection process in a family firmly locks the problem in the head of the symptom bearer and denial is rampant. This situation calls for a subtle and sophisticated strategic maneuver and structural alteration, after which the family will be engaged in spite of itself.

Often a combined approach is possible. By doing this the therapist can remain relevant to the family and presenting problem while still obtaining an overview of the entire system. After introducing the strategic intervention, he can then proceed to follow the symptom shift and track the process over 3 to 4 generations. It is my clinical experience that the process in the family can be easily tracked over 3 to 4 generations if one's observing lens adjusts to take in that larger field. Over time in working with the family the symptom focus will shift back and forth throughout each of the generations depending either on what is being stirred up in the system by moves towards change or on the natural recycling of the process over time.

Typology of Families

Individual theory and medical model psychiatry have elaborate diagnostic categories to organize and communicate clinical process. Many attempts have been made to form a typology of families, but none has been successful.

The most useful categorization of families to date has been broad descriptive terms mostly designating the symptom type and focus on a special structural configuration of the family (for example, child centered family, psychotic level family, one-parent family).

These two theories use several general descriptive terms about the family system that are useful clinically. One set is used to describe boundary configuration, the other to describe the degrees of dysfunction.

The family typology terms used by both theories center around the concept of boundaries. Minuchin, coming as he does from a child therapist background and working in a child guidance setting, places extensive importance on generational boundaries. His concept of boundaries is probably the central concept of his theoretical position. He classifies families as those with enmeshed, disengaged, or clear boundaries, placing families as they present clinically somewhere on this continuum. He defines a blurring of generational boundaries as leading to triangle formation. Families with clear boundaries facing an emotional crisis are seen as passing through a transitional phase of disruption and are labeled transitional families. Minuchin sees these as the easy ones to deal with clinically. Those families with an overabundance of enmeshment or disengagement are seen as having more rigidly fixed patterns of response to stress and fewer options for dissipating emotional crisis. The enmeshed family is unable to set up sufficient boundaries and thus in chaos its anxiety runs wild. The disengaged family has such fixed and rigid boundaries that it is unable to relax or open them to the point of providing emotional support. All families are seen as having some degree of enmeshment and disengagement. Those predominantly enmeshed or disengaged are seen as pathological families. This category has special operational significance in the Minuchin schema. It is these pathological families that Minuchin sees calling for a special kind of intervention on the part of the therapist. He states it this way:

> "In pathological families, the therapist needs to become an actor in the family drama entering into transitional coalitions in order to show the system and develop a different level of homeostasis."

Bowen's family typology is tied into his emphasis on the extended family and the importance he places on the presence or absence of emotional cut offs in the extended system. He classifies family systems as being either cohesive or explosive. Cohesive family systems are those in which nuclear and extended family units are clustered together in a relatively small geographic area. There is frequent visiting and communication among members. The explosive family system is one in which there is considerable fragmentation. The family begins in one location, and in less than two generations only one dysfunctional member remains, with everyone else scattered over a wide geographic area. The explosive type system is full of emotional cut offs with infrequent, often ritualized, visiting and communication. In addition to Bowen's concept of explosive and cohesive families, and tied into the concept of boundaries, is his highly developed clinical art of successfully engaging the family while remaining exquisitely sensitive to their boundaries but being careful not to violate them. In this light and in reference to what has been said about Minuchin, it should be stated that the way a therapist moves clinically is dependent, one hopes, on at least three things: 1. his theoretical orientation, 2. his own personal affective style, and 3. the type of families he sees and the context they are seen in.

Bowen's concept for measuring dysfunction on a continuum is the poorly understood scale of self-differentiation. This scale is a byproduct of Bowen's work with schizophrenia. Families with this level of dysfunction are placed at the bottom of the scale. The boundary concept has moved from ego boundaries to undifferentiated ego mass and then to family emotional oneness.

In the Bowen schema it would appear that the scale serves at least two functions. One function is that when family members are located on the scale it can be used to predict the prognostic chances for change after clinical intervention. Secondly, following the ascent of family members on the scale over a period of time it can serve as a baseline for measuring change. Personally, I find it his least clearly developed as well as his least understood concept. At its worst it can tend to be used as a judgment tool about certain types of behavior. Its focus on individual family members clearly defines the Bowen principle that change in one member of the family system will eventually result in a change in the entire system.

This methodology of engaging the family across the spectrum of dysfunction raises a basic theoretical and clinical question initially raised around work with schizophrenic families and continued through work with neurotic level families. The question is whether or not the therapist, in dealing with severely dysfunctional families, must become a reactive part of the system in order to shake a rigidly enforced dysfunctional homeostasis. The debate goes on. The major pitfall in this path evolves from the potential of the therapist’s becoming emotionally locked into the family. A clinical example may clarify the dilemma.

Last spring in a consultation seminar another family therapist asked me to be a consultant for a family he was seeing in his private practice. This was a family with nine children. The father was a busy prominent professional, and the mother was just plain busy. Their seventh child, a son, had had an acute psychotic reaction, was hospitalized for three weeks, and was in follow-up individual therapy for six months prior to the father's developing interest in the possibilities of family treatment. The therapist met with the family several times obtaining an extensive family system history and a definition of the process. He also made a home visit to get a sense of their interaction in their own space. After these experiences with them he sat down alone and attempted to map out a plan of intervention. Two major points were decided upon: 1. He was convinced that the precipitating event had been the departure of an older brother to an overseas assignment. 2. He decided that perhaps the reason Bowen had failed to produce change in 500 schizophrenic families was his unwillingness to join the system.

Consequently he decided he would join the system and attempted as best he could to form an alliance with the symptomatic son and a relationship with the mother that as closely as possible resembled the position of the recently departed older brother. He moved ahead on this plan and within a few months the symptomatic son had improved to the point of moving to a small apartment over the family garage, was working, and considering returning to school. It was time for the therapist to take his early spring vacation. One night during the vacation he had a dream. In that dream he had moved his practice into the home of the family involved and was anxiously sitting in his office listening to the mother of the family who had dropped in to tell him what a bastard her husband was and how he had to do something about it. Indeed he had now joined the system. His question at the consultation was how he was going now to back out and get himself some more operating room. After discussing some of the theoretical aspects of what had occurred, I suggested that he attempt to disengage slowly, modulating the disengagement by moderating the family's anxiety level in response to it, and if possible to plug a network person

into the slot he was pulling out of. The last I heard he was having some degree of success with maximum effort.

I am not suggesting that the way this therapist moved is the way Minuchin would have moved at all, but he does talk of the therapist's joining and accommodating approach.

These two terms sound like callback to the heyday of experiential family therapy. But on closer examination I see them in a different light. Watching Minuchin clinically, it does appear at times he is walking a tightrope extended over a pit of reactive emotional lava, and I suppose anyone walking such a tightrope runs the risk of falling in. However, in the hands of the best of operators with the most difficult clinical situations the result may be worth the risk. Bowen would prefer to be patient, set reachable goals, but see these situations as long-term problems requiring time and patience. In talking about joining, there is a way of using one's internal feeling barometer to register and process the feeling experience in the family without getting caught up in it reactively. I do not see Minuchin letting go of himself to the degree his written word might suggest. Perhaps his ideas on this matter need to be qualified with a statement similar to the above, adding that the feeling level of experience of the therapist has to be qualitatively and quantitatively different from that of the family members or he is indeed caught up in it and rendered powerless as in the example of the therapist and his dream.

Accommodating is another term Minuchin uses. From observation of his work it does not seem to me that the therapist changes himself into a pseudo-self so that the family will accept and engage, but rather that he operates a system to the point of engagement. The therapist who reads the system as one in which the husband is the boundary guard and therefore directs his questions through the husband and asks his permission to speak to other family members while clearly remaining in charge of the session is operating the system perhaps in an accommodating way.

As Bowen has said, "The road to change lies somewhere between confrontation and just going along with it."

The Marital Relationship and the Nuclear Family

Minuchin terms the marital relationship the spouse subsystem. While using the concept of the triangle, Minuchin tends to divide the segments of the family on a horizontal plane. (Spouse subsystem, children's subsystem, etc.) This is consistent with his child focus and, as has been mentioned before, triangulation is then seen as a byproduct of boundary blurring. Bowen on the other hand defines the triangle as the basic segment or building block of the family, dividing the family along a more vertical axis, frequently defining triangulation over three generations.

Minuchin's least productive contributions have to do with his thoughts on the marital relationship. He talks in terms of role complementarity and fosters a "weness" image of the marital relationship. There is no definitive consideration of the phenomenon of reciprocity which is such a central concept in Bowen's elaboration of marital fusion. The two most important and useful interlocking parts of this concept are reciprocity and over functioning-under functioning interdependence of the marital pair. These are spelled out in detail in Bowen's 1966 paper "The Use of Family Therapy in Clinical Practice."

The most detailed and definitive conceptualization on the marital relationship from a systems viewpoint has been done by Fogarty. Initially this was done by him based on the extensive

clinical experience of seeing 35 to 40 families a week and later in collaboration with me. Moving away from Bowen's concept of marital fusion and into the concepts of operating principles, Fogarty and I focus on the interlocking and balancing of operating principles commonly used by marital pairs. The effects of stress on operating principles and relationships balance. The concepts of the emotional distancer and pursuer, the distinct function of time in the relationships, closeness and distance, the definition and development of the personal relationship, etc. are concepts which are spelled out by our contributions in *The Book of Family Therapy* and the recent book *Family Therapy, Theory and Practice*, as well as the journal of the Center For Family Learning called *the family*.

It is important to mention that whereas Minuchin perhaps overemphasizes the role of complementarity to the point of weness, Bowen on the other hand too frequently in his war against weness tends to underemphasize the importance of the refuge function of the marriage relationship and the impossibility of obliterating role complementarity in a marriage.

I would re-label the goal of family systems work, changing it from “differentiation” to the "attainment of emotional freedom in a context." This relabeling leaves plenty of room for the ability either to be fused into a period of relationship refuge or to clearly draw one's boundaries and hold a functional position against the weight of the system.

It would appear from his work and his writings that, from his overly responsible oldest stance, Bowen views most people as going overboard in allowing themselves to bask in the refuge of fusion, never making the move to get out of it. Rather, when it gets too hot at the refuge center of marital fusion, they will reactively bounce over to the frigid periphery of the same marital fusion and call that an "I position." In face of the prevalence of togetherness forces in our society that description would appear to be warranted. However, it may also serve to draw to his theory an overabundance of individuals with one operating style rather than expanding and diversifying the theory by attracting adherents with varying operating styles.

The Extended Family and the Therapist's Own Family

Throughout this paper, the importance of the extended family in the Bowenian model has been emphasized. Minuchin makes use of the extended family only in instances where the resources of the nuclear family unit cannot sustain a structural shift that will ensure symptom relief. For instance, when several strategies in a family with an asthmatic child failed, Minuchin placed the child with his maternal grandparents with excellent results. This is an especially effective clinical operation in the face of chaos in the nuclear family unit and can be effective in settling down chaotic one parent families. Apart from this clinical operation however, there is little extended family emphasis in the Minuchin method unless a grandparent resides in the nuclear household or there is significant "leakage" in what Minuchin would term the appropriate boundaries between the various subsystems in the family.

Another central point of distinction between the two models is the place of the therapist's own family. Minuchin dismisses it as irrelevant and a callback to the training analysis. Bowen, since his presentation of his work in his own family system in 1967, has made this project an essential part in the training of family clinicians and researchers.

Triangles

Both systems deal with the concept of triangulation differently.

The Structural View

Structural therapy views triangles in a simple and one-dimensional fashion.

1. They are seen as the direct result of the blurring of the boundaries within the family subsystems. Father and mother distance from one another in response to marital conflict. Mother then becomes overinvolved with son, with a subsequent blurring of the boundaries between the marital and sibling subsystems.

2. Triangles are thought to be fixed in configuration.

3. Triangles are thought to operate as single modular units over two generations.

The Bowenian View

1. This method works against the notion of triangles as a concrete reality to be held in one's hand. Triangulation is defined as the byproduct of emotional reactivity within the system.

Father at work receives a call from his mother, who was worried about his brother. Father calms down his mother, but on the way home finds himself angry at mother and brother. He comes home irritable and instead of being available to listen to his wife's news of the day, opened with "hordes of people under 10," he criticizes the state of household cleanliness. Wife gets upset, son picks up on it and heads out the back door, proceeding to put a baseball through the neighbor’s garage window and swear at the neighbor when reprimanded.

2. Triangles are not fixed in time and space but are potentially in constant motion with instant reconfiguration depending on the issue involved.

3. Multiple interlocking triangles occurring over three generations are evaluated in terms of their influence on the emotional functioning of relationships in the nuclear and extended family.

Summary

My own extensive training in Bowenian family theory and therapy makes my own prejudices obvious. In this paper I have attempted to remain as objective as possible in the light of my understanding of these two models and in relation to my own clinical and personal experience. By way of summary it might be said that Bowen, as one of the founding fathers of the family movement, remains its major conceptualizer, a position he has perhaps held from the beginning. In addition to his conceptual skill, Bowen's clinical artistry is considerable. Minuchin, by his own admission, is basically a concrete thinker whose major contribution is related to his native inborn sense of people and process and a highly sophisticated clinical artistry. His lasting and major contribution to the field has to do with the demonstration of this artistry and the development of system ideas and techniques for working with poor, chaotic families, child centered families, and psychosomatic families (anorexia, asthma, and diabetes). The magnitude of this contribution should never be minimized. It would serve the student and the experienced family therapist as well to study the work of both these men in detail.

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PART II: THE THREE GUERIN MODELS OF SYSTEM THERAPY

Perhaps the most important and permanent contributions of Guerin and his associates at CFL to the family therapy movement will turn out be their articulation of treatment models for three types of clinical presentations: marital conflict, the symptomatic child, and the troubled individual. Papers representative of each of each of these contributions follow.

SECTION II-A: MARITAL CONFLICT

The following paper, written for CFL's journal, is an attempt to convince therapists of the importance of taking a broad, contextual view of marital conflict. It has been a hard sell, but the authors remained convinced to this day of its value. The paper formed the basis for an early chapter in The Evaluation and Treatment of Marital Conflict.

The Envelope of Marital Conflict: Social Context and Family Factors

Philip J. Guerin, Jr., M.D. and Leo F. Fay, Ph. D.

Tom and Nancy Prescott presented to CFL's clinical service with the complaints that their marriage was on the verge of collapse. Tom, a 44-year-old attorney, had sought the referral and made the call to begin therapy. He expressed the fear that Nancy was ready to leave him because of an affair he had had, and he wanted "to save the marriage." Nancy, 42, was tense and furious in the first session. She expressed her mistrust of Tom and of the therapy process he had initiated, and said that she was convinced that the marriage could not be saved.

Nancy is a full-time housewife and mother who has not practiced her profession, teaching, since the birth of their first child 16 years ago. In the past year, however, she had begun part-time work as an instructor for a local health club. As the therapist talked with her about her view of the problem, she focused on Tom's history of infidelity, but also mentioned her belief that "the whole family," not just the marriage, was falling apart. They had recently moved to Westchester from Ohio; she and the children hate Westchester; and the children have been having social and school adjustment problems.

As they talked, both Nancy and Tom spoke angrily and bitterly about the others responsibility for their troubles, and were defensive and unhearing in the face of the other's complaints. As the

therapist listened he felt himself being pulled into the whirlpool of their bitterness and conflict, feeling trapped by the isolation of this angry and anxious couple.

Trapped is a good word to describe the situation of any therapist who buys into this couple's narrow definition of the problem without attempting to broaden the perspective from which he looks at it. The clinician who decides to focus only on Tom's affairs, on whether or not Nancy has the right always "to throw it up to him," or on whether or not they should've moved from Ohio, is starting down a road which, whatever its fascinating scenery and interesting byways, will eventually prove to be a dead end. Rather, the therapist is best advised to remain relevant to the specifics of his patients' pain while broadening the context to include all the factors and variables that feed into that pain. If the therapist fails to remain relevant, he loses the couple. If he fails to broaden the context, he duplicates the couple's own process of fighting about episodes, and limits his therapeutic options to agreements that will fall apart the next time anxiety goes up.

The Envelope of Marital Conflict

Every marriage, conflictual or not, is surrounded by a two-ply "envelope" that constitutes its environment. The two plies of this envelope are, first, the social context in which the family is situated, and second, the multigenerational family unit of which the marital dyad is a sub-system. In much the same way that the developing fetus absorbs nutrients (and poisons) from the uterine environment, the marital dyad absorbs from its surrounding envelope two critical elements of its makeup: expectations and stress.

Expectations are a major part of the relationship process that supports or damages the emotional bonding in a marriage. Fogarty speaks eloquently of the process by which expectations can damage the marital relationship. Since expectations are almost always the result of the idealization of an ordinary human being, expectations will sooner or later be disappointed. People feel hurt when they are disappointed, and hurt comes out in the form of anger. Anger becomes translated into lingering resentment, and gradually the bitterness in the marriage grows and grows. Thus we can picture what Guerin has called "Fogarty's Litany:" idealization leads to expectations lead to disappointment leads to hurt leads to anger leads to resentment leads to bitterness.

Stress, whatever its source, does several things which can increase anxiety and elevate the level of conflict in the marriage. First, stress can trigger whatever vulnerabilities are already present in a marriage. For instance, where a wife's long family history of alcohol abuse makes her vulnerable to alcoholism, stress can trigger an episode of heavy drinking. Second, stress tends to raise the level of emotional arousal in people who are subject to it, thus escalating whatever dysfunctional emotional processes are already at work in the marriage. Third, stress inevitably triggers reactivity and people's automatic, reflexive behaviors, and thus relationship conflict ensues. It is a general principle that people become more like themselves under stress, and so the toxic behaviors – those irritating to others – which they engage in automatically and unthinkingly, are even more likely to occur, and to occur more intensely, under stress.

Two major sources feeding our expectations of what close personal relationships are supposed to be are the society we live in and our family of origin. Likewise, the social context, especially

change in the social context, and our extended families are or can be sources of stress for a marriage. Therefore, any conceptual framework upon which clinical strategies and interventions are planned must take into account the social context and the multigenerational family unit in which the marital dyad exists.

The Social Context

By the term "social context," we are referring to the broad sociocultural environment in which marriage as an institution exists at a specific historical moment. Marriage as such is not a creation of our biological natures, nor is the specific form marriage takes at a particular time and place in any sense inevitable or natural. Rather, the existence of marriage in any form, as well as the specific forms marriage takes at various times and in various societies, are social products. They are arrangements which human beings, living collectively, invent to solve certain problems and accomplish certain goals. It should not be surprising, then, that what is going on in a particular society at a particular time can have an impact, not only on the institution of marriage in general, but also on the clinically observable marriages of particular people.

One way of analyzing the social context and its relationship to marriage is to think of the social context as having four parts. First are the written and unwritten laws of the culture and society about marriage. For instance, it is likely that the spread of "no-fault divorce" through many states has made some people less hesitant about seeking a divorce. Second, there are the historical events that have direct or indirect effects on marriage. For instance, the inflation of the last 15 years has contributed to a substantial rise in the number of married women who work outside the home. Third, there are the other cultural attitudes towards marriage that are prevalent at any given time. For example, there has been a real shift in recent years away from the attitude that marriage is permanent, almost no matter what happens, to the attitude that people ought to live together first, to try it out. Fourth, there is the emotional climate that surrounds marriage in a given culture. For instance, the media have begun to popularize the notion that divorce can be a beneficial solution to human relationship problems. All of these can directly impact marriages, and can help to produce symptoms which then present clinically as marital conflict.

The pioneers in family therapy recognized the importance of the social context in thinking about the family. Nathan Ackerman showed an early appreciation of the impact that events outside the family may have on the structure and internal emotional processes of the family. As early as 1938 he observed the effects of the Great Depression on the power hierarchy in coal miners' families. He reported on how fathers, out of work and thus deprived of the only socially legitimated role they could play in the family, were extruded from their families and rendered powerless in them.

A visit to the Museum of Natural History in New York can get one in touch with the power of the social context in affecting human development. Indeed, investigators like Margaret Mead and Albert Scheflen, who became immersed in the natural history method, were so impressed by social context as an influence on the family they ended up in the position of interventional nihilism. As a matter of fact, interventional nihilism is only one of three possible responses to the problem of social context, all of which we believe to be clinically inappropriate. A second response, closely related to interventional nihilism, is the blaming posture that some families get

into, where they lay all their problems at the doorstep of environmental forces over which they have no control. The third response, characteristic of many clinicians, is simply to ignore the social context on the grounds that nothing can be done about it anyway and that it is therefore clinically irrelevant.

It is our belief that there is a real need for clinicians to be aware of the social context and to weave it into their theory and clinical strategy in working with families. They need to make it relevant to what they are seeing clinically and find a way to work with it in choosing interventions and in teaching families about themselves.

We have said already that the social context is one source of expectations and stress for the marital dyad. The social context is relevant to expectations insofar as it provides validation or invalidation for our values and ways of being and relating, and forms or changes our expectations of life and all of our personal relationships. The social context is relevant to stress particularly during times of socio-cultural change. Change should not be viewed negatively by the clinician; it is a natural and inevitable process which presents the opportunity for growth and adaptation. It is, however, stressful. It increases anxiety, disturbs the status quo, and removes cultural and institutional props for established, taken-for-granted ways of doing things. As normal and even desirable as change is, it will bring vulnerability to the surface in families who are already vulnerable, they will get reactive to the change, and so change will have intense and harmful fallout in these families.

A Socio-Historical View

Let us begin our consideration of the social context and its impact on marriage by taking a broad historical viewpoint. Such a viewpoint can help the therapist put marriage – its existence, forms, and functions – into perspective and so be neither defensive about his own view of marriage, nor ethnocentric and judgmental in his opinions of the marital behavior that he sees clinically.

It is a truism in sociology that a person's behavior towards any other person or thing or situation depends on the meaning he attaches to that person or thing or situation. For example, let us imagine two people, one a criminologist and one a police officer, who come upon a street corner where drugs are being bought and sold. The criminologist has been trained to see such an event as an interesting example of human behavior, and because that is what it means to him, he will probably proceed to observe and analyze the action. The police officer on the other hand has been trained to see the same event as a violation of the law, and because that is what it means to him, he will probably proceed to break up the action and arrest the participants. Clearly, the different behaviors of the criminologist and the police officer are largely determined by the different meanings that each has learned to give to the same situation.

The same principle can be applied to the way people behave in a marriage and in family life. The way people think about marriage, the meaning they attach to it, determines to some extent the way they behave when they are married. For example, the Chinese peasant of the 18th century, who sees a wife primarily as a means for having children and as an assistant for his mother, will treat her very differently from the way a young Israeli "kibbutznik" who sees a wife as an equal partner in a mutual quest for emotional satisfaction.

There have probably been as many ideas of the meaning and purpose of marriage and family life as there are human beings who have ever married or ever contemplated marriage. Nevertheless, sociologists who study this question think that most of these millions of ideas can be conveniently classified into three categories: (1) the religious, or sacred, meaning of marriage; (2) the communal, or social, meaning; and (3) the personal, or individualistic, meaning.

One thing that must be remembered about classifications such as this one is that they exist in their pure form only in the mind of the scientist. They are no more than abstractions of complex natural processes. In real life, among real, live people, the categories and classifications overlap, they combine and recombine in numerous blends, and they appear inconsistently and sporadically. When we look at the attitudes of the real people we see clinically, we are not going to find total consistency. We are going to find that people give more than one meaning at a time to marriage and family, or that they hold onto one meaning while they are moving toward another, or that they shift from one meaning to another depending on the circumstances.

(1) Defining the *sacred* meaning of marriage calls first for a disclaimer. The definition to be presented here is a sociological concept, *not* the theological viewpoint of any specific religion. To the sociologist, the "sacred" refers to what is beyond and above the everyday experiences of human life. The sacred is that which is set apart and totally transcendent. This distinction between the sacred and the secular is an important part of the sociologist's way of thinking about and analyzing religion, regardless of whether the religion being analyzed is Buddhism, Islam, Christianity, or any other.

With the understanding that this sociological concept of the sacred refers to people's beliefs about what is transcendent, we can see what the sociologist means by the sacred meaning of marriage: marriage and the family are divine and holy (that is, transcendent) institutions, founded by God and governed by religious functionaries. People who hold this view in its extreme form would maintain that personal or earthly considerations in marriage (such as money, sexual attraction, personal satisfaction) must be subordinated to considerations of God's will and purposes. For them it would follow that everything about a marriage, including whether and with whom it may take place, the details of how it should be lived out, and whether and under what conditions it may end, is to be decided according to the laws of religion.

This meaning of marriage, even in its purest and most extreme form, has had a very long history, and it has often been combined with the social meaning of marriage, as in the Middle Ages of Western Europe. It is widely perceived to be the view of marriage held today by Orthodox Judaism and Roman Catholicism.

(2) The second meaning of marriage in this system of classification sees marriage as involving primarily *social* obligations. In this view, a couple's marriage is seen primarily as the business, not of God, nor of the couple being married, but of their families and community. The rules and preferences of the families and of the community govern who may marry whom, how the married couple is to live, and whether or not the marriage may end. Considerations such as family property, lineage, and appropriate race, religion, or ethnic background in the spouse, are all-important in this view of marriage. The obligations which the bride and groom have to their parents and to the rest of their extended families are seen as far more important than their obligations to each other.

In terms of the total sweep of human history, this has probably been the most common and long-lasting view of marriage. Most traditional societies throughout the world have had, and continue to have this view. A good example of it is family life as it was lived in traditional China for thousands of years prior to the 20th century.

(3) Most recently, a third view of the meaning of marriage and family has made its appearance, especially among the middle classes of the industrial nations of the world. This view holds that marriage and family life exist for the *individual*. People who give this meaning to marriage see themselves as marrying, not for God or for their own extended families or communities, but for their own happiness and personal fulfillment. Happiness and personal fulfillment, under this view, become the criteria for deciding whom to marry, for deciding by what rules to live as a family, and for deciding if and when the marriage is over. The authority for these and all other decisions concerning family life is not God or clergy, nor extended family or community, but oneself.

There are literally hundreds of trends in American family life that suggest the increasing dominance of the individualistic meaning of marriage over the other two. Among them may be cited the following:

(1) For every 100 marriages that take place in the United States today, there are 48 divorces. In addition, almost 85% of divorced people remarry, usually within three years of the divorce. Further, 59% of second marriages dissolve, and the majority of those twice divorced will marry yet again. These data indicate people's increasing willingness to divorce and remarry in a restless search for personal fulfillment in the marital relationship.

(2) For 87% of people 30 years of age or older, according to a recent survey, "a happy family life" is their most important goal in life.

(3) Over half of American married people feel it's a bad idea to share one's home with the parents of either spouse.

(4) The overall rate of fertility (births) per woman has gone from 3.7 in 1960 to 1.9 today. There are, of course, many reasons for this, but whatever the reasons, the decision to have fewer children and to have them later suggests a decline in the extent to which people place either a sacred or a social meaning on marriage and family.

Almost all observers would agree that the overwhelming trend in American society is toward the individual view of marriage. Of course, there are some groups in the United States for whom that is not true, but by and large there seems little doubt that the sacred and social meanings of marriage are declining in the importance people give them, and that the individual meaning is growing in importance.

Another way of saying this is to talk about levels of commitment and about contracts. In both the social and the sacred views of marriage, a blind commitment, whether to God, the church, the extended family, or the community, tended to be the operative attitude with which men and women approach marriage. The stakes, in terms of both this world and the next, were very high, and the people involved directly and indirectly in the marriage were numerous. High stakes and a large number of people raised the level of commitment with which people approached marriage,

sometimes to a point where they were unable to recognize their own and the other's emotional needs and limitations.

The individual meaning of marriage, although it maximizes the emotional stakes, minimizes both the temporal and eternal stakes involved in marriage, and cuts the number of people who are thought to have something to do with the marriage down to two. Marriage thus becomes a contract to which these two deeply commit themselves, but with a sometimes explicit, sometimes implicit view that the marriage is subject to termination if either or both do not have their needs met in the relationship.

Recent Trends

That kind of broad historical change has, of course, been in the works at least since the beginning of the Industrial Revolution. While such sweeping changes can create a large-scale "paradigm shift" in the very nature and social basis of marriage, more recent shorter-term changes are proximate sources of factors that have immediate fallout, at least in vulnerable families.

Two such shorter-term changes over the past 20 years or so have been the invention of chemical contraception and the economic need for two incomes in most families. The Pill has freed women in sexual relationships from fear of and subordination to pregnancy. Inflation, broad-based aspirations for middle and upper-middle class lifestyle and changes in the nature of the workforce have given women the leverage of economic importance in the family. In a study of Catholic families in eastern Connecticut in 1980, Fay discovered that nearly half the women in the study listed their primary occupation to be outside the home and another 10 to 20% said they had a secondary occupation outside the home. This raises the question of whether a significant shift has occurred in women's attitudes about their primary role orientations.

Changes such as these have been largely responsible for triggering, or at least making possible, the women's movement and the sexual revolution. Perhaps more than any other social context factors, these movements have had tremendous impact on family life and the marital relationship. Let us look briefly at each.

From a sociological point of view, what the women's movement has done chiefly is to change the social definition of the woman's role, without modifying the underlying emotional reactions that over time came to be associated with women's traditional roles. This has created some interesting, if painful, clinical situations.

Since the movement has taken hold, the subsequent undervaluing of the roles of mother and housewife has created a lack of fulfillment and validation in many women who have not achieved the "ideal" balance of professional accomplishment and marital intimacy. Clinically this may present as a marital conflict in which the wife feels trapped and unfulfilled, and it often accompanies a marriage in which the emotional distance between the spouses has become considerable. Another clinical variant is the situation in which the wife has already made a move toward a career, a move supported intellectually by a liberal husband who is committed to equality between the sexes. However, the emotional reality of the wife's not being where she used to be shakes the marriage in a camouflaged way and may present as an actively conflictual marriage or as an affair on either the husband's or wife's part.

The sexual revolution also impinges on marriage in a myriad of ways. Although the world certainly needed to be freed from the restrictions and repression of Puritanism, Jansenism, and the like, the human animal, quite predictably an all-or-nothing creature, goes from one extreme to the other. Sexual bliss is more and more seen as a panacea for all our pain, and has come to be a taken-for-granted expectation in many marriages. In clinical work it must be kept in mind that spouses may differ in their responses to the sexual revolution, but in general the sexual revolution has raised people's expectations of how they should perform sexually and how much pleasure they should be giving and getting. While this can serve the positive purpose of helping people to realize this sexual potential more fully, it can also raise anxiety and generate considerable hurt and conflict.

This is especially true when people find themselves comparing sexual experiences in a new, short-term relationship with those of a long-term marital relationship. The short-term relationship is not burdened with the piles of relationship debris which are the inevitable products of the conflicts of any long-term relationship. In addition, the novelty, the excitement of discovery, and perhaps its illicit character, often make sexual experience in a short-term relationship erotic. In the long-term marital relationship, however, erotic sex and nurturant sex are present in a mix. Sex in a long-term relationship, fueled by its many subtleties, can be erotic, but in most marriages erotic sex is in significantly lower proportion to nurturant sexual experience.

The Multigenerational Family Unit

Expectations and stress are also fed into the marital dyad from the multigenerational family unit. Every marriage is a joining, not simply of two individuals, but also of two family systems, each of which has an ethnic and cultural background, developmental history, and a given level of maturity, of baseline anxiety, and of premorbid functioning. There are at least three organizing concepts required to understand how the flow of expectations and stress from the multigenerational family unit impinges on the marital pair: the family emotional field, transition times, and the nature and availability of relationship options.

The Family Emotional Field

The family emotional field is a metaphor taken from physics to describe the indefinable but palpable experience of a climate that surrounds the important relationships in our lives. Just as a magnetic field is composed of invisible but powerful forces that control the movement and behavior of objects that are present in and subject to the field, the family emotional field is experienced as a set of invisible forces that operate on and influence the movement, level of anxiety, and automatic behavior of family members in the field. People enter the field, perhaps by going to visit their parents' home, or even by calling another family member on the telephone; they pick up the intensity of the field, their own anxiety begins to rise, and at once they begin to behave in predictable, automatic ways.

The family emotional field is most dramatically demonstrated by entering the home of a family with a chronic schizophrenic member. One of the authors participated in two studies which did just that at the Family Studies Section of Albert Einstein College of Medicine. These studies were federally funded projects aimed at studying families in their natural environment. The principal investigators in each were Albert Scheflen and Andrew Ferber, respectively. These studies involved the "naturalistic" observation of project families in their homes by the use of

time lapse video equipment and by live-in research assistants, and clinical observation of the families over a five-year period.

From observation of families in the home setting the notion of a family emotional field was validated. The video cameras failed to pick it up but the project observers experienced the phenomenon consistently. The observer's internal emotional radar quickly registers the continuously high level of emotional arousal within the bounded space. Schizophrenic families have less permeable family boundaries than less dysfunctional systems. Wynne demonstrated this in what he termed the "rubber fence" phenomenon. These less permeable boundaries increase the families' isolation, thereby increasing the intensity of the emotional process within the relationships. This increase adds to the charge of the emotional field in the house which can be described in terms of intensity and emotional climate. Climate can range from safe and warm, in which there appears to be an increase of relationship time and functional connectedness, to unsafe and frigid, where there is rapid movement of the individuals away from one another toward boundaried sub-territories within the home. When the individuals emerge from the sub-territories (which they frequently don't do) for meals or other family functions, there can be a rapid shift to an overheated actively conflictual climate with rapid return of the individuals to their respective sub-territories. This type of observation is recorded nicely by time lapse video apparatus and is frequently described as having varying levels of intensity by clinic families depending on the severity of their dysfunction.

The intensity of the emotional field was found to be highest in psychotic level families, less intense in families with severe alcohol abuse and considerably less intense but definitely present in asymptomatic control families. The project observers found intensity decreasing in the emotional field as more time was spent in the families' homes and decreasing even further as more observers were added. This led to questions about how much the observers' own projected anxiety was distorting the experience and how much the presence of additional observers created safe connections for the observers, thus lowering their own anxiety. There were also questions about how much the initial breaching of the families' boundaries by the observers raise the family's level of emotional arousal initially, which after an adjustment over time returned to its baseline. Nevertheless, the studies' observations were in keeping with Bowen's concept of the scale of differentiation, in which more dysfunctional families possessed higher chronic level of anxiety than less dysfunctional families. Even for the less dysfunctional, as well as "normal" families, however, the family emotional field is a powerful source of expectations and stress.

Transition Times

Like the individual, the multigenerational family unit can the conceived of developmentally as going through a series of predictable, evolutionary changes that can legitimately be referred to as the family life cycle. For example, the family with grandparents in their 50s, parents in their late 20s, and children in pre-school is obviously at a different stage in the family life cycle than the family with retired grandparents, parents in their late 40s, and children in or ready to go to college. For one thing, the sheer number of stresses that have piled up due to things like retirement (and perhaps illness or depression) of grandparents, the mid-life uncertainties and self-doubts of the parents, and the adolescence and separation from the family of the children, is far greater in the second family than in the first.

This multigenerational lifecycle involves changes, and, like changes in the social context, they increase anxiety and have the potential for significant fallout, particularly in families that for one or another reason are vulnerable. The evaluation of families in order to get a handle on the potential for fallout, however, can be extremely complex, just because the multigenerational family life cycle is itself so complex. At any given moment, numerous individuals and subsystems within the multigenerational family unit are themselves going through developmental life cycle changes of their own, and in concrete family systems the pictures can become extremely complicated, cumbersome, and difficult to remember in clinical interviews.

For this reason, we suggest that, for purposes of evaluation at least, the clinician use instead the concept of transition times. These are times when there is an addition to the family system, a subtraction, or a change in the status of a family member. The most important transition times are: marriage, birth, adolescence, mid-life, retirement, and death. If the clinician simply watches the extent to which these transition times have accumulated in a particular multigenerational family unit, he will have a good diagnostic and prognostic reading of the potential for fallout and its possible sources in that family. While he may very well wish to get involved for treatment purposes in the content of the particular lifecycle stages the family is going through, evaluation will be much simpler if he focuses on transition times.

Although it is obvious that sorrowful transition times such as death and divorce will be stressful and will raise anxiety, is equally true that joyful transitions are the source of considerable stress and anxiety as well. People usually have unrealistically high expectations for family relationships when the occasion calls for celebration or the transition is defined as a joyous one. New problems associated with that transition now run head on into those positive expectations, and anxiety shoots up. Marriage itself is a prime example of that. When two people get married, their expectations are that the spouse will be the ultimate refuge from anything that might happen, that the marriage itself will reinforce all the good and eliminate all the bad from the extended family, and that their problems will be over. What happens instead, of course, is that the new problems arising in the marriage and the old ones that each party brings to it collide with those expectations, and the litany of disappointment, hurt, anger, resentment, and bitterness is activated.

Often, a series of transition times takes place at the same time in the family. The stress produced by such a series of transitions can appropriately be called "cluster stress," and cluster stress can set off a pattern of automatic behaviors and symptoms in one or more members of the family. A common cluster, for example, consists of death in the grandparental generation, mid-life for parents, and adolescence or leaving home for children. One family who presented recently at CFL had suffered the loss within the past 18 months of both grandmothers, both of whom had been very significant figures for this nuclear family, and mother had returned to work *and* school as her fifth and last child was ready to graduate from high school and go off to college. The family requested treatment because of the youngest daughter's sexual promiscuity and general acting out, and because of marital conflict.

It is important for the therapist to be aware of and to define the number and kinds of transition times different family members or subsystems are experiencing, so that the amount of cluster stress in the family system be defined. Following the observation and definition of cluster stress, the family members in whom the anxiety has been raised most significantly can be located, and the therapist can follow the reactive process that ensues. Doing this in therapy, and teaching the

family to do it on their own, helps to avoid fixing the psychological fallout from such circumstances in one individual. It makes everyone in the family part of the problem, and, more importantly, part of the solution. If someone is depressed, or serious conflict develops among family members, connecting it to a transition time in the family system enables everyone to see it in a different way and deal with it or constructively.

Relationship Options

In every multigenerational family system, the way its relationship system and interaction patterns are structured has both direct and indirect impact on marital relationships in the system. In other words, the nature and availability of relationship options in the extended family system is an important variable in understanding the origins, the course, and the eventual outcome of marital conflict.

One such pattern is typified by the marital dyad which is embedded in a multigenerational family unit that is physically close together and that involves substantial, even daily, contact between the marital dyad and the rest of the system. When this kind of system is seen clinically, the therapist will usually have little difficulty making the connection between problems in the marriage and stresses in the larger family system. There typically is substantial, proximate leakage from the extended family into the marriage, and the leakage is often fairly obvious. The most common example is the over-involved mother-in-law, but there are others as well: fights with siblings, an alcoholic uncle, a depressed widow, etc.

While the pattern of physical closeness and over-involvement is by no means extinct in our culture, it is becoming less and less common. The more usual pattern, one that is seen clinically in connection with marital conflict time after time, is a process in the multigenerational family unit in which the marriage being presented has ended up isolated and cut off from its families of origin. The marital dyad is, in effect, on its own, without relationship options in the multigenerational family system to turn to for support or emotional connectedness.

There are two kinds of cutoff that could be seen in this sort of situation. The first is an explicit cutoff, in which the couple has little or no contact with one or both sides of the multigenerational family unit. Sometimes such an explicit cutoff is the result of one dramatic conflictual event in the family system, which alienates everyone from each other and produces the classic pattern of no one speaking to anyone else. One couple who came to CFL's clinical service with marital conflict had had no contact at all with the husband's family of origin for several years because of a bitter fight over his father's estate.

An explicit cutoff can also be the result of a less dramatic process in which the segments of the multigenerational family unit drift out of contact with one another because of physical distance and perhaps the death of the family "switchboard:" the person who held the pieces of the family together by acting as the pivot for information and getting people together. For instance, one couple who lived 800 miles from their families of origin only realized how cut off they were when they were asked how long it had been since they had spoken to their families. It turned out that there had been no dramatic conflict, in fact no overt conflict of any kind in the family; but since the wife's mother had died, their "just hadn't been any reason" to call or go home.

The second kind of cutoff is the ritualized cutoff. This is a process in which families manage their upsetting conflicts by placing a rigid structure around their time together. They may celebrate holidays, birthdays, and family events by coming together for dinners, parties, and cookouts. They may have regular patterns of telephone or personal contact (for example, the daughter who calls her mother on the fourth Saturday of every month). But nothing of personal significance ever happens in these contexts, and when stress hits, the members of the family cannot turn to each other for support, input, or a sense of emotional connectedness.

These two patterns (physical proximity with overinvolvement, and the cutoffs) are reactive process phenomena that can be observed clinically and labeled. As a result of these processes, families over time develop adaptive structures in which these processes are congealed and become family characteristics. The terms "cohesive" and "explosive" seem appropriate labels. The cohesive multigenerational family unit is one whose members are in close physical proximity to one another, and whose members have a lot of contact as a result of that physical proximity. The cohesive family is usually characterized by ritualized cutoffs, if cutoffs of any kind are present. Where an explicit cutoff occurs in a cohesive family, over time the family structure will almost certainly evolve into the explosive type.

The explosive multigenerational family unit is one whose segments are widely scattered, geographically and/or emotionally, and characterized either by explicit cutoffs or by highly ritualized contact. Although the connection between this type of structure and marital conflict is harder to make clinically than with the cohesive structure, the connection is there. For example it is very common for a marriage that is embedded in this kind of extended family structure to present in what we refer to as the "cocoon" phenomenon: the marriage is cut off from other segments of the multigenerational family unit, isolated, and turned in on itself. This serves the function, of course, of cutting down on the leakage from extended family problems, but it prevents the development of sufficient relationship options. The couple does not have the choice of turning to family members to dissipate anxiety and upset in times of stress, and to provide a source of emotional connectedness over time.

A Clinical Example

Let us look again at the Prescotts from the perspective of the two-ply envelope with which their marital conflict is surrounded. Although the presenting problem centered on Tom's infidelities and Nancy's bitterness about them, a moderate amount of digging revealed a number of social context and multigenerational family issues. These issues all turned out to have substantial relevance for therapeutic strategy and clinical interventions.

The influence of the women's movement on this marriage has been indirect, interesting, and, we believe, far more common than most contemporary theory might suggest. Both Tom and Nancy consider that Tom's job is far more important, both intrinsically and in terms of financial reward, then anything Nancy could possibly do. Her role as wife and mother is taken for granted by both of them as the natural and inevitable structure of their domestic life. Both of them, in fact, defend the arrangement and deny that it is the source of any problems.

If one is looking, however, one discovers a substrate of uncertainty and conflict about Nancy's role. Nancy, in referring to her part-time job says things like: "If it weren't for my exercise classes I'd be lost," and "Tom doesn't seem to realize that the health club means a great deal to

me." While Tom approves of Nancy's involvement, his way of talking about it makes it clear that he sees the health club (and anything else Nancy might want to do) as a good way for Nancy to fill time that is not required by him or the children, while his own job is intrinsically important and has first call on his time and concentration. We believe that the substrate of uncertainty and conflict about Nancy's role can be explained by the fact that the social support for the definition of her role has been removed. What the sociologist Emile Durkheim referred to as "anomie" is operative here: the cultural rules which both mandated and legitimated the wife-and-mother role in the past have been removed, without substituting new rules that have the same clear-cut and taken-for-granted quality that characterized the old rules.

As Durkheim pointed out so vividly in his study of suicide rates, anomie in the social context produces significant stress in individuals and relationships. Uncertainty about knowing what the rules are, lack of confidence that one's behavior and values are appropriate, and fear that one is out of step with everyone else are all feelings that are highly stressful. In spite of Nancy's ready defense of her role, therefore, the substrata of uncertainty and conflict are always present and ready to come to the surface whenever anxiety goes up.

The sexual revolution has affected Tom and Nancy's marriage, though not only in the obvious sense that Tom has had affairs, or even because Nancy has "thought about" having an affair as revenge. Rather, the effect of the sexual revolution has been in the sexual expectations which his affairs have produced in Tom *and* Nancy.

When Tom is asked, in therapy sessions alone, about the differences between his relationship with Nancy and his relationship with Laura, his most recent affair, he speaks in positively lyrical terms about the intense highs, the constant emotional excitement, the acute sexual ecstasies of his time with Laura. Statements like, "When I was with her I walked in the sun," and "No one has ever cared about *me* or worked so hard to please *me* like that before or since" are not uncommon. In contrast, his statements about sex with Nancy run to such rewrites of history as, "It was always okay, but never that great." At any rate, at the time Tom and Nancy came in, sex had become very infrequent, with Tom rarely if ever initiating it and refusing to participate on the increasingly rare occasions when Nancy made an overture.

When Nancy was alone in the sessions, she spoke, with an honesty that came very slowly over a number of sessions, and of how Tom's sexual criticisms of her gradually became believable to her. She admitted that although several other men had made clear their attraction toward her, she had serious doubts about herself as a sexual being. These doubts, she says, lower her self-esteem and make her feel awkward and inept when she and Tom do interact sexually (thus, of course, ensuring that a vicious cycle will be activated).

It is obvious that for Tom and Nancy the sexual revolution has not been the liberating, sexually fulfilling cultural change that it has been for some people. Rather, it has served to set up a series of expectations that cannot be met and has produced the disappointment and hurt that result from unmet expectations. Tom has expected the same high level of erotic sex from his 20-year relationship with Nancy that he experiences in the intensity of new affairs. These expectations lead him to discount the importance of a more nurturant kind of sex that he and Nancy had long ago moved into. By the same token Nancy has been led to expect herself to have the ability to "provide" Tom with a high pitch of erotic excitement sustained over 20 years. She ends up, then, in the position of seeing herself as a failure for not doing what is impossible anyway.

These effects of the women's movement and of the sexual revolution are examples of how the social context has had an impact on the Prescotts' marriage. The other ply of the "envelope," the multigenerational family unit, also operates on this marriage. Let us look at some of the specific ways in which the family emotional field, transition times, and the family's relationship options contributed to the situation in which Tom and Nancy find themselves.

From the very first session with Tom and Nancy, an exquisite sensitivity was noticed in both of them to any mention of their extended families. It became clear that part of that sensitivity could be explained by the fact that each had long been highly critical of the other's family and both were quite reactive to that criticism. However, that did not seem to explain all the sensitivity, and at any rate their reactivity to each other's criticism itself required explanation.

When during separate sessions each was able to talk about his own parents and family, it became clear that a highly charged emotional field existed in both families. As for Nancy, she was resentful of Tom for his unwillingness to spend much time with her family, but she described her own feelings of dread when some contact between herself and her family was impending, and a high level of discomfort whenever she entered the family field. It turned out that since her father's retirement from the practice of medicine, her parents' life with each other had settled into a pattern of mutual bickering and criticism that they indulged in constantly, no matter who was present. Nancy's anxiety would go up just thinking about this from a distance of 800 miles; when she was actually present to see and hear it, her anxiety knew no bounds.

Although this situation with her parents appeared to be the dominant characteristic of her family's emotional field, there were several other historical or chronic features of that field that tended to keep anxiety within it at a high level. One was a history of mental illness on Nancy's mother's side. Nancy's maternal grandmother, the wife of a minister, had had a psychiatric hospitalization for serious mental illness at some point in her life, and that woman's daughter (Nancy's aunt) was lobotomized in the 1940s and is still a patient in a public psychiatric hospital. This aunt was, like Nancy, a teacher.

Nancy's younger sister and brother are chronic sources of anxiety in the family emotional field. Neither have ever married or succeeded in pursuing any particular career that meets the family's expectations. In addition, her sister is a recovering alcoholic and is defined by all in the family as selfish and irresponsible. Nancy, by contrast, who has married a professional, pursued a career, and provided her parents with grandchildren, is defined as the successful one. All of this tends to aggravate a climate of resentment and distance in the family emotional field.

There are some interesting parallels in Tom's family's emotional field. Since his father's retirement from an executive position in an investment company, his parents moved to the isolated small town in the South from which his father came. Since that move, his mother has become increasingly depressed and dysfunctional and his father has taken over more and more of the household tasks and decisions. By the time the Prescotts entered therapy, Tom's mother had become nearly completely helpless and his father was doing everything. Tom, in fact, wonders aloud whether his mother has become schizophrenic. Tom finds it extremely difficult to talk about the situation, and handles it by structuring his contact with them as rigidly as possible. He describes his mother as "lunging" toward him and clinging to him whenever he does have contact, and he speaks vividly about his discomfort when this happens.

An historical feature of the family, which may parallel the history of mental illness in Nancy's family, is the history of alcoholism on Tom's side of the family. Tom's paternal grandfather and maternal uncle were both alcoholics.

Tom is an only child and has no siblings to be compared with, but like Nancy he is considered a great success. Indeed, Tom's lifelong string of successes – scholastic, athletic, occupational – has apparently made him the object of near idolatry by his parents. This contributes to a drive for perfection in Tom that he finds very difficult to handle successfully, whether at home or on the job.

Besides the family emotional field, the transition times currently being experienced by the Prescotts and their multigenerational family unit create a "cluster stress" that powerfully impacts their marriage. The transition that was most on the minds of Tom and Nancy was their recent move to Westchester from another state. The move was required by a substantial advance in Tom's career, but Nancy and the children were resentful of the move, and in the time they had been in New York have consistently expressed their distaste for the people, the facilities, and the environment of Westchester. They miss their former home and tend to blame many, if not all, their problems on the move. In addition, the job Tom took has turned out to be less than he had hoped for, and even he is wondering about the wisdom of their move.

Less obvious to them, but clearly present nonetheless, is the "triple threat" of transition times: aging parents, midlife crisis for both Tom and Nancy, and adolescence for their children.

Finally, the number and structure of relationship options in the multigenerational family unit create problems for this marriage. Both extended families live a considerable distance from Tom and Nancy. Tom has no siblings, and Nancy's sister lives in Hawaii. In addition to physical distance, relationship options are curtailed by the fact that both families appear to operate on the principle that bad news in any segment of the family ("bad" being defined as any news that violates family myths or ideologies) is best not communicated to any other segment. Thus, secrets play a significant role in this multigenerational family unit, the best current example being Tom's reluctance to share his marital failings and problems with his parents, "lest it upset them." (More likely, their knowing about his infidelities would attack the image of Tom's perfection that is now dogma in his family.) Tom and Nancy, then, are part of an explosive family system: their marriage is in a cocoon, and they deal with their families of origin through ritualized cutoffs.

Summary

In looking at the social context and its impact on marriage, we have pointed to a long-range change in the paradigm of marriage, from the sacred and/or social paradigm to an individualistic one. We've also singled out the women's movement and the so-called sexual revolution as changes of more recent vintage which have had effects on marriage and marital conflict. In general terms, these effects include an increase in stress as well as expectations that are doomed to disappointment and so produce hurt, anger, and bitterness.

We suggested three organizing concepts for understanding the influence of the multigenerational family unit on the marriage: the family emotional field, transition times, and the nature and availability of relationship options. We saw how stress and expectations which arise in the

multigenerational family unit feed into marital conflict and influence its origins, course, and outcome.

We have proposed that the therapist who deals with marital conflict broaden his view of the presenting problem by considering two "plies" of a contextual envelope in which all marital conflict is situated: the sociocultural setting and the multigenerational family unit. The advantages of doing so are that, while remaining relevant to the specific issues and symptoms of the conflict, the therapist acquires a fuller understanding of its origins, can evaluate more accurately its likely course and prognosis, and broadens the range of possible interventions and therapeutic options.

References

Fogarty, T. F. “Emotional Climate in the Family and Therapy.” *The Family*, 2, pp. 22-26

Ackerman, N.W. “The Emergence of Family Diagnosis and Treatment: A Personal View.” *Psychotherapy: Theory Research, and Practice,* 4, pp. 125-29.

Fay, L.F. “The Family in the Diocese,” unpublished monograph, 1980.

Wynne, L.C. *et al.,* “Pseudo-Mutuality in the Families of Schizophrenics,” *Archives of General Psychiatry*, 9 (1963), pp. 161-206

Carter, E. and McGoldrick, M., *The Family Life Cycle: A Framework for Family Therapy.* New York, Gardner Press, 1980.

Durkheim, E. *Suicide*. New York: Frees press, 1966 (first published in France in 1897).

In the following paper, Guerin presents his idea of staging marital conflict by degree of severity. The clinical significance of this idea comes from the fact that, although stages one and two are likely to respond well to any competent work on the marital relationship, most marriages that come to clinical attention are in stage three. Guerin's great contribution here is to point out that stage III marital conflict is likely to be made worse by direct work on the relationship until some degree of self focus is achieved, the major triangles neutralized, and the bitterness in the marriage is reduced. The paper became the theoretical framework for much of The Evaluation and Treatment of Marital Conflict.

The Stages of Marital Conflict

Philip J. Guerin, Jr., M.D.

It has been the consistent clinical observation of this author that couples in the throes of marital conflict can be divided into four naturally occurring sub-groups as follows:

Group 1 is comprised of those couples with a preclinical or minimal degree of marital conflict who respond favorably to educational input about how marriages work and don't work. They are then able to take that information and convert it into some form of positive change in their relationship.

Group 2 are those couples with active relationship conflict including a significant degree of projection and loss of self-focus. However, with skillful dissection of the conflictual marital process on the part of the therapist, both spouses can move to self-focus within 6 to 8 sessions, with a resulting reduction in the intensity of the conflict.

Group 3 are those couples who present clinically with severe marital conflict. The projection is intense. There is a high degree of mutual blaming and a total inability to obtain or maintain self-focus on the part of either spouse. In these cases the clinician spends all or most of his or her time trying to keep the instantaneous reactivity in the relationship under some degree of control. The more the therapist tampers directly with this degree of marital conflict in an attempt to modify it, the more conflictual it seems to get.

In addition, when a positive result is obtained from therapy, there is inevitably a recycling of the conflict within 6 to 8 months. While this is not an uncommon phenomenon in all levels of marital conflict, in over 25% of this particular group, upon recycling both the individual spouses and the marital relationship itself seem to have lost their resilience and are unresponsive to further treatment.

Group 4 are those couples who present to treatment after one or both spouses has already engaged the services of an attorney. When an attorney is engaged an adversarial context replaces a potentially conciliatory one. Any attempt aimed at keeping these marriages from dissolution appears doomed to failure in a high percentage of cases. The work of the therapy is more profitably aimed at diminishing emotional fallout for the spouses, their children, and the grandparents.

The recycling phenomenon characteristic of the third group and the inevitability of dissolution in the fourth group remind the author of a similar response of certain types of cancer to chemotherapy. Oncologists, in an attempt to improve the strategy and results of treatment, stage the severity of a malignancy based on certain cellular characteristics and the degree of invasion of surrounding healthy tissue. The structure of their staging includes a division into four groups of severity, labeled stages one through four. Stage I is often a pre-cancerous lesion that requires no specific treatment or just a simple excision of the lesion. This is combined with an education of the patient as to what to watch for as indicative of a recurrence. The more advanced stages of the cancer require more invasive treatment approach. Chemotherapy often produces an initially positive result even in the most advanced cases, only to have a recurrence within a relatively

short period of time. Upon recurrence of treatment the patient's biological defenses have often lost the ability to join forces with the chemotherapeutic agents in order to produce another remission. The observation of the similarities between the responsiveness to treatment of certain types of advanced cancer and severe marital conflict raise the following questions: would an attempt at staging the levels of severity of marital conflict improve the precision with which techniques already available are applied and stimulate creative efforts at developing new techniques for the more severe cases?

Would a successful effort at staging marital conflict also assist in the evaluation of treatment results and the formulation of more accurate prognostic guidelines? Prognostic guidelines are important in helping both therapist and family develop reasonable expectations for treatment outcomes.

With these considerations in mind, using the before mentioned naturally occurring groups the author has hypothesized the existence of four corresponding stages of marital conflict. The stages are defined by a set of criteria. The criteria are divided into three sub-groups, those pertaining to the functioning of the family system surrounding the marital relationship, those pertaining to the marital relationship itself, and those pertaining to the functioning and emotional well-being of each individual spouse. Some of the criteria are difficult to define and the ability to measure them with precision somewhat limited. However, in the author's opinion an awareness of each of them is essential to the evaluation and treatment of marital conflict.

The *family system factors* most consistently relevant to the staging of marital conflict are: (1) emotional climate; (2) transition times and cluster stress; and (3) intensity of triangulation.

Emotional Climate

Emotional climate refers to the atmospheric conditions in the space surrounding the marital relationship. It is a combination of temperature, turbulence, and safety factors. Temperature readings may range from cold to intense heat in the presence of reactive conflict.

Turbulence refers to the stability of the climate in terms of mild, moderate, or severe changes in temperature and the amount of time required to produce such a change. In severe conflict, atmospheric conditions are marked by an instability in temperature that can quickly swing cold to hot with the slightest provocation.

Safety in the emotional climate refers to the way in which temperature and turbulence conditions affect the degree of risk entailed in approaching another member of the system for connection or support. The therapist uses his own highly developed internal "radar" to evaluate the emotional climate. Unless there is an accurate reading of the emotional climate by the therapist and something done to make it stable and safe, any intervention attempted will inevitably fail.

In addition to observation and an effective use of the therapist's internal radar, a set of simple questions can assist in evaluating the emotional climate. The following is an example of such a question: "Is it safe to be vulnerable in this marriage?" The safety of being vulnerable in a marriage is affected by many parts of the emotional process. The baseline level of anxiety in the family and the present level of emotional arousal in reaction to a period of cluster stress, will affect the safety. The higher the anxiety and emotional arousal, the more unstable the emotional climate, and under these conditions the family members either distance and isolate from one

another into their own territory and emotional compartments, cling together in a togetherness that fosters denial and covering over, or come together in severe conflict. In any of these situations there is an absence of safety. Individuals are unable to seek each other out for a listening ear, advice and counsel, feedback, validation, and emotional connectedness. All of these factors are important to well-functioning individuals, dyads, and family systems as a whole.

Another pertinent question is, "Can you tell if she's upset when you first come into the house, before you have seen her or spoken to her?" Asking this question of both spouses will not only provide a reading on the emotional climate but will also provide information about how much each spouse is tuned into or sensitive to the emotional climate.

Readings on the emotional climate are described in terms of the warmth, calm, and safety present in a stage-one marital conflict to the extremes of hot and cold, the instability and lack of safety in stages three and four.

Transition Times and Cluster Stress

Transition times are simply defined as any addition, subtraction, or change in status of a family member. Periods of transition are times of vulnerability for any system, whether it be our current economic system or a basketball team shifting from offense to defense. It is at these times that a system is most apt to show its deficiencies. The family as a relationship system is no exception. Marriage, birth, adolescence, midlife, retirement, and death are all examples of significant transition times in the family.

Transition times produce a sense of loss of control. As such they are stressful and raise the family's general anxiety and level of emotional arousal. In the lifespan of every family, there are periods in which a cluster of transition times piles up in a short period of time producing a condition we call *cluster stress*. It is in these times of cluster stress that emotional and physical symptoms or relationship conflict are most likely to surface. As a general rule, couples in stages three and four of marital conflict are feeling the impact of a significantly higher index of transition times and cluster stress than those in the less severe conflict of stages one and two.

Intensity of Triangulation

An assessment of the activity and intensity of the process of triangulation surrounding the marital relationship is essential to an accurate staging. Triangulation can intensify marital conflict, as in the classic mother-in-law triangle. However, triangulation can also stabilize or assist in covering over conflict as in the likewise classic extramarital affair. Those two triangles plus those involving the children are the ones most commonly found in the process of marital conflict. The activity and intensity of triangulation escalates considerably in stages three and four and are less prominent in less severe conflict.

A charting of the correlation between these three family system criteria and the severity of marital conflict reveals an escalation in the disturbance of emotional climate, amount of cluster stress, and the intensity of triangulation from stage I through stage IV.

The criteria for the evaluation and staging of the conflictual process in the *marital relationship itself* are divided into two categories: relationship maintenance functions and fusion functions.

Relationship Maintenance Functions

The process that takes place in the formation and maintenance of any relationship can be conceptualized in terms of communication, and relationship time and activity. Communication includes the exchange of simple information, and of more personal information in the nature of "self-disclosure." In addition, for purposes of this paper, the concept of communication includes a consideration of the character of the communication as regards the levels of criticism and credibility.

Relationship time and activity assesses the amount of time invested in the relationship by both spouses as well as the kinds of togetherness activity around which some of this time is organized.

In order for a relationship to begin there must be an initial exchange of information between the principals. A young man meets a young woman at a party. Initially they exchange a series of non-verbal courting behaviors that communicate information to one another about a topic of one-sided or mutual interest. If a successful connection is made the next step is the beginning of a verbal exchange of information. Often these exchanges take a ritualized form such as "What movies have you seen lately," "Who do you know that I know," "What's your favorite rock group? etc. If all goes well this information exchange will continue over time and eventually progress to a proposal by one party or the other that they undertake some activity together. The form the activity takes may well evolve from the information exchange, such as going to a movie or concert. It may be a spectator activity or a participatory activity, such as swimming or dancing. If this activity together it successful it will foster stability in the relationship. This stability, reinforced by continued success in information exchange, will eventually create a relationship climate in which self-disclosure becomes safe and appropriate.

This step of self-disclosure initiates the process of serious emotional investment in expectations of the other person. It is the beginning of trust and an escalation of risk taking, and creates a vulnerability to disappointment and hurt. These interwoven steps or phases continue to be a part of any relationship as long as the bonding remains intact. The better a marital relationship is functioning, the more fluid the information exchange, the greater the comfort and enjoyment of both activity together and time alone. In addition, self-disclosure will be a non-reactive communication of personal thoughts and feelings rather than the reactive emotional dumping that spouses in the heat of active conflict or the retreat of hurt try to pass off as self-disclosure.

Activity remains an important part of relationship maintenance. However, the concept needs to be broadened to include the time married couples spend just "being there" for each other without any specific organizing activity. It might be said, "Don't tell me how much you love me, tell me how much time you have for me." Time is perhaps the most important currency in relationships in general and combines with sexual compatibility as the two most important currencies in a marriage. Any evaluation or ongoing assessment of a marriage in conflict therefore must include a look at the amount and quality of relationship time and togetherness activity available to the relationship.

In addition, two of the most important aspects of marital communication are the levels of criticism and credibility that are present. Criticism not only increases distance, feeds bitterness, and dampens libidinal impulses, but it also often represents the external expression or projection of hurt. In general, the greater the marital conflict the higher the critical communication index in that relationship. It should be kept in mind when evaluating the level of criticism in a relationship that it may take both explicit and implicit forms. Credibility or the degree to which one spouse can believe or trust the information coming from the other spouse is also important to measure. In the absence of credibility much of what gets communicated becomes irrelevant.

It is clear communication becomes compromised, reactive, and critical with a loss of credibility as the stage of conflict becomes more severe.

Fusion Functions

The fusion functions criteria are subdivided into (1) the pursuer-distancer synchrony; (2) the interactional sequence; (3) power polarization.

The Pursuer-Distancer Synchrony

In the 1950s and 60s, studies of the marital relationship focused on the interaction between the personality types and character structures of the spouses. The classical combination was the obsessive male and the hysterical female. Therapy based on these constructs often attempted to elicit the psycho-genetic determinants in the coming together of these personality types. Although based on valid observations of the connection between the relationship with one's parents and the subsequent relationship with one's spouse, these methods left us with two major dilemmas. The first was that by using these constructs, the vast majority if not all marriages put under such scrutiny could be labeled as neurotic or existing in large measure to meet the neurotic needs of the individual spouses.

The second dilemma was that these constructs represented fixed structures and left little room for interventional modification of the interactional relationship process within the marital dyad. In struggling with this dilemma, Fogarty introduced the idea of the importance of studying the movement patterns of the spouses toward and away from one another in response to stressful stimuli. He organized these ideas into the concept of the emotional pursuer and the emotional distancer as descriptive of the relationship movement. He observed that in times of stress and conflict the emotional pursuer, usually the wife, would move toward her husband, who, as the emotional distancer in response to stress and the pursuing movement of his wife, would distance from her, usually moving toward involvement with an object.

In working with this idea clinically the present author has attempted to expand the concept to include a more detailed description of the characteristics of the emotional pursuer and the emotional distancer. The phenomenon can be defined as representing both constitutionally- and contextually-determined behavioral operating styles, the synchrony of which provide the balance in long-term relationships. The interplay between these two operating styles has been further elaborated into a five-step interactional sequence discussed later in this paper.

An emotional pursuer is a people-oriented communicator of feeling who tends to take the lion's share of responsibility for maintaining relationships and has an internal and interpersonal rhythm that runs on two speeds, full speed ahead and dead stop. The emotional pursuer tends to be a

night person as opposed to a morning person and to value free access across boundaries into others' and their own personal space. The emotional pursuers of the world enthusiastically undertake new tasks and adventures, taking more than reasonable risks with unbridled optimism. Errors made are errors of commission. Apology and making things explicit come easily, while endings and goodbyes come hard.

The emotional distancer on the other hand is an object- and-productivity-oriented person with little proclivity for communicating personal thoughts and feelings and a rhythm that is steady and predictable. He tends to be a morning person who would prefer that you not ask into his personal space and will gladly return the favor by rarely if ever asking into yours. Temperamentally he approaches new tasks and adventures cautiously and with a "healthy" seasoning of pessimism. Errors committed are usually errors of omission. Apologies come especially hard, while leaving things implicit is easy, and endings and separations appear to cause much less proximate upset and emotional pain.

When the emotional climate is right, the transition times minimal, and stress low, these two types of operating styles complement each other beautifully and bring out the best in both. Under the opposite set of circumstances the very factors that provide the balance and synchrony become the problem.

It should also be noted that whereas individuals seem to operate with the same behavioral style in the majority of their relationships there are always a few circumstances and relationships in which the tables are turned and the emotional pursuer more than meets her match and in response finds herself operating with at least some of the characteristics of an emotional distancer and vice versa. Thus while individual factors are important, contextual factors which highlight or suppress certain elements on the pursuer-distancer spectrum are also highly influential.

The Interactional Sequence

The interactional process that occurs between the emotional pursuer and the emotional distancer is organized into a sequential set of steps. This allows for a step-by-step tracking of the relationship from synchrony to fixed distance. Five steps are proposed for the sequence.

Step one finds the relationship in a low stress environment with a synchrony or balance of operating behavioral styles. *Step two* marks the introduction of significant stress (for example, a cluster of transition times) with both spouses reacting by moving in a direction predicated on restoring their individual levels of internal comfort. In response to the stress the emotional pursuer, in an attempt to reestablish internal emotional comfort, moves toward the emotional distancer for an emotional connection. In response, the distancer, also to reestablish internal comfort, moves away. In *step three,* in response to the distance the emotional pursuer intensifies the movement toward the distancer, and the emotional distancer responds with increased distance. In *step four* the emotional pursuer tires of moving forward for connection without success, and begins to withdraw with anger and resentment. It is at this stage that the expectation-alienation progression is activated in the emotional pursuer with hurt, anger, and resentment building toward bitterness. The withdrawal on the part of the pursuer is the beginning of reactive distance. At the completion of this reactive distance, the emotional pursuer sets up behind a wall of hurt. From this position "mortar shells" of criticism are communicated in waves by the emotional pursuer. This criticism rains down upon the emotional distancer, who has just

begun movement toward the emotional pursuer. The criticism activates the expectation-alienation progression for the distancer, who above all requires acceptance. This brings us to *step five:* the distancer, in response to the criticism, again withdraws, setting up a state of fixed distance between the spouses.

The steps fit into the staging scheme as follows. Step one fits into stage I while stage II encompasses steps two and three. Step four fits into stage III while step five with its establishment of a fixed distance is a part of stage IV or V.

Power Polarization

For all of the togetherness images of marriage in our culture, marriage is in fact a struggle from its very beginnings. At its best it is a playful struggle full of challenge and mystery; at its worst it is a deadly struggle for emotional survival. Individuals obtain and maintain a sense of internal emotional comfort by being in control of their environment, including their important relationships. This need for control inevitably produces a struggle regardless of the quality of the relationship. Control may be exercised in an active or passive way. Active control is effected by establishing dominance in a relationship. Passive control is effected by withholding (for example attention, affection, approval, sex, or money). These represent the levers used to exercise power and gain control in a relationship. The two major power levers are sex and money. The more these levers are exercised in an effort to establish control, the greater the polarization in the relationship, and the more severe the conflict.

In stages one and two the struggle is playful in character or maintains the potential for playfulness. In the more severe conflict of stage three there is an increasingly intense struggle with the deadly struggle for emotional survival present in both stages three and four.

Individual Criteria

Any comprehensive methodology for treatment of marital conflict must include evaluations of the emotional states of each of the individual spouses. This author uses three major criteria in evaluating the individual spouses: (1) projection; (2) self focus; (3) position on the expectation to alienation progression. For purposes of clarity, projection and self focus are considered together.

Projection and Self Focus

In reaction to emotional pain or upset there is an automatic emotional reflex in all of us that places the source of that pain or upset outside of self. The more intense this projection becomes, the more it produces an experience of victimization and a holding of others responsible for the way we feel and act. It demands of others that they change, instead of taking responsibility for one's own behavior and emotional reactions. Projection is the opposite of self-focus, which is the ability to see one's own part in a reactive emotional process. Instead of "You made me angry," which is a projective response, a person with self-focus is able to process the same interaction in the following way: "You behaved thus, and so I responded by getting angry and going away." In the self-focused response, there is an acceptance of responsibility for one's own emotional response and subsequent behavior. Self-focus can be reached by obtaining a sufficient degree of detachment to be able to see the variety of responses that constitute our options in any given interaction.

It is important to note however that the process of detachment in the service of self-focus carries with it the potential pitfall of emotional disconnection which is just a cover for projection. This is most graphically demonstrated in a system with alcohol abuse. The dry spouse attempts detachment but in the process of attempting this difficult task disconnects with significant amounts of covert anger. The implicit message in this development is the communication that the problem is yours and I have no part in its maintenance. This response is projective and different from the detachment that allows a self-focus on one's own part in a relationship process that produces dysfunctions as a byproduct.

In the treatment of marital conflict, assisting the respective spouses to attain self-focus is of the utmost importance to a successful outcome. In the early stages it is relatively easy to produce, and can be worked on directly and early in the course of treatment. In stage III, it must wait for a reduction in emotional arousal, the establishment of an improved emotional climate, and the detoxification of the bitterness in the individuals. In stage IV it may take up to a year after the divorce is final, if ever, before self-focus can be attained.

Expectation to Alienation Progression

Fogarty has taught and published extensively on the subject of expectations. He has developed a progression of responses to unmet expectations that this author has previously labeled "Fogarty's Litany." In summary, the progression hypothesizes an individual's response to unmet expectations as beginning with disappointment and progressing over time to bitterness. Initially disappointment is followed by hurt and/or anger. If the anger is sustained by a lack of resolution in the relationship or further disappointment, it results in the development of resentment, and eventually, over time, bitterness. This bitterness is synonymous with the concept of the bitter bank developed by this author in the previously described pursuer-distancer interactional sequence. This progression is activated during step four of the interactional sequence. In addition there are two additional steps to this progression. These steps follow a prolonged state of bitterness. The additional steps take place at the point at which one spouse, following a prolonged period of hurt, resentment, and bitterness, decides that he or she can no longer afford to remain vulnerable to the relationship. "It just hurts too much." At this point they move across a symbolic bridge to what I have termed an "island of invulnerability." On this island all hope for the future of the relationship is abandoned and alienation sets in.

In order to produce movement in the face of this development the therapist must be successful at preparing one or both of them to take the risk of being vulnerable again. In the process of doing this it is the therapist's responsibility also to prepare them to be disappointed and hurt again. To do otherwise simply sets up a recycling of the same process with the subsequent entrenchment of the alienation. The position of each individual spouse on this expectation to alienation progression is in synchrony with the severity of the conflict. In stage I and II the position varies from one (expectation) to three (hurt and anger). Resentment and bitterness are found in abundance in stage III and alienation is present in late stage III and in stage IV.

Thus far we have considered criteria descriptive of the family system as a whole, the marital dyad, and the individual. The author believes these criteria to be necessary for an accurate staging of the severity of marital conflict. The remainder of this paper will proceed to consider a descriptive summary of the four stages and their implications for therapy.

Stage I

The couples in this stage correspond to group 1 in the beginning of the paper. The family system surrounding the marital relationship in this stage is characterized by a safe, warm, non-turbulent emotional climate, and the number of transition times and the amount of cluster stress is minimal. The level of anxiety in emotional arousal is well within the ability of the relationship to contain it without psychological or physical fallout. The synchrony between the behavioral operating styles of the spouses is either in place or easily restorable. The intensity of the relationship reactivity in the marriage is low, as is the level of criticism, while credibility is high. The communication in the marriage is open, and there is minimal polarization in the major levels in the power axis. Individual spouses are mostly self-focused with occasional bursts of a low intensity projection process. Their productivity and personal well-being are high. The presence of reactive toxic behaviors is low, and the response to unmet expectations is at the level of disappointment.

The reaction to this description of stage I by most mental health professionals is either disbelief or nausea. My experience is that stage I is in fact a limited reality. It occurs mostly in the early months of marriage and when both spouses come from well-functioning family units which have endured only minimum amounts of cluster stress for a significant number of years. This stable launching pad allows for a smoother course of separation and an emotional climate conducive to a secure marital bond evolving over time. Less stable family of origin conditions produce either incomplete bonding or an overheated bonding, both of which are more vulnerable to lesser amounts of stress. Since these ideal family of origin circumstances aren't present in the majority of marriages, most couples don't begin their marriages in stage I. In an effort to maintain this state of affairs and reinforce the tensile strength of the relationship in preparation for the inevitability of an increase in transition times and cluster stress, we offer these couples an education-prevention program called Family Systems Training. FST is a six-week course that teaches how family systems work. It provides a family systems perspective for understanding normal problems and personal relationships. This course attempts to give a perspective which views people not just as individuals, but as members of a complex multigenerational network of relationships called the family. Participants are taught about normal stresses that alter the family system in predictable ways. This is done with the hope that if these events are understood in terms of one's family system, stress is minimized, change becomes possible, and crises are avoided.

FST uses a classroom format and offers feature films and videotapes to dramatize family situations. Participants make a “genogram" of their own families to help them see how relationship scripts tend to repeat from generation to generation. The goal of FST is to enable participants to see themselves as part of relationship system, to ask new questions, and to see that change is possible.

The curriculum centers around five topics with one review session at the end: (1) the genogram; (2) the marital relationship; (3) parenting issues and triangles; (4) the extended family; (5) toxic issues such as sex, money, alcohol abuse, and death; (six) review, questions, and answers. The group usually numbers between 40 and 50. As follow-up, specialized shorter courses focusing more in depth on the marital relationship, the single-parent family, adult children and their parents, alcohol abuse, and other pertinent topics are offered.

It is our experience that FST works best when the level of anxiety and emotional arousal are sufficiently low for intellectual information to get through and have an impact. This would correspond with stage I relationships. FST is also a useful adjunct in therapy of stages II and III, but only after sufficient work has been accomplished in therapy to lower the level of active conflict. Stage I couples do well with FST. Other couples enroll and discover that they need more help than just educational input, and subsequently enter therapy.

Stage II

The couples in this stage correspond to group 2 at the beginning of the paper. The family system surrounding the marital relationship in this stage is characterized by changes in the emotional climate with cooling in the relationship temperature, an increase in turbulence, and a diminishing index of safety. There is a moderate buildup in the number of transition times and corresponding cluster stress. The level of anxiety and emotional arousal is moderate but sufficient to override the relationship's ability contain it, thus producing explicit symptoms in the form of active marital conflict.

Communication remains open with adequate exchange of general and personal information. There is still ease in doing things together. Criticism is on the increase while credibility remains high. The Interactional Sequence is in either step 2 or 3 but there is little polarization, and the control struggle is more playful than deadly. Each spouse is in a projective mode and not able to restore focus on their own. The expectation to alienation progression is at the level of hurt and anger, with a degree of resentment beginning to build.

The level of disturbance in stage II is such that the therapist moving in directly on the marital conflict, either working on the relationship maintenance functions, the fusion functions, or both, provides a structure for the couple. This structure in and of itself lowers emotional arousal and supports a reestablishment of self-focus. It is in the treatment of stage II that the close tie between the maintenance and fusion functions of the relationship is most easily seen. For example, a relationship experiment can be easily set up that gives the emotional distancer responsibility for initiating the exchange of information and the planning of some of the relationship activity, while instructing the emotional pursuer to create the verbal and emotional distance necessary for him to do that, and to refrain from critical commentary on how he does it. This will give both spouses the experience of behaving in opposition to their own feeling level inclinations, and observing what goes on in their insides and in the relationship when they do it. If effective, the end result of experiments like this is to get people in touch with how much their behavior serves the purpose of keeping their insides calm and how much they depend on their spouses to fill in the blanks. This kind of experience helps each spouse to take the other's behavior less personally and to regain some degree of self-focus.

It is important to present such tasks as therapy experiments rather than as solutions. Obviously there are many variants to the strategy just presented. At times the emotional pursuer is skilled in general information exchange and at planning activities, but rarely indulges in episodes of self disclosure. Under these circumstances he can be given the task of talking to his spouse about himself as a son, father, and husband. In a case such as this the emotional pursuer may be sexually distant and withholding; she can then be put explicitly in charge of increasing the frequency and pleasure index of their sexual time together. After successful completion of tasks such as this and with the beginning of the return of self-focus, an attempt can be made to get

each spouse to enlist their respective creativity in developing new ways of dealing with the other's toxic behaviors. This reinforces self-focus and the taking of responsibility for one's own emotional and behavioral responses. A comprehensive presentation of treatment planning and implementation in each of the stages is not within the scope of this paper and better left for subsequent papers dealing with each stage separately and in more detail.

Stage III

In stage III the number of transition times and the level of cluster stress is significantly elevated. The emotional climate is marked by sudden and dramatic changes in temperature and turbulence. The level of anxiety and emotional arousal is high, and the intensity of triangulation is high, although it may be covert and not immediately visible.

There is an impairment of information on both the general and personal level. Self-disclosure is either a "feeling dump" or is misheard as criticism or complaint, and further raises the level of upset. The level of criticism is high and credibility is fading. Activity togetherness often resembles parallel play with considerable distance and without engagement. The pursuer-distancer synchrony is disturbed to the point that what formerly had been assets to the relationship are now experienced as problems. The therapist may have difficulty defining who is the pursuer and who is the distancer. The control struggle has lost all its playfulness and most of the power levers have been engaged. The interactional sequence has advanced to step four.

The individual spouses have lost a significant part, if not all, of their self-focus and the projection process is rampant. Both spouses are marinating in their "bitter banks" and one or both may have passed over the bridge to the “island of invulnerability."

In the treatment of stage III a direct move on interactional process in the marital dyad will either have no impact or will escalate the conflict. There are a series of steps that the therapist can take to avoid this trap and foster more positive therapeutic movement. Using a combination of split and conjoint sessions, the first two orders of business are to define the sources of "cluster stress," making them explicit, and to work on improving the emotional climate. The former allows the spouses to view their marriages as suffering from stress rather than being intrinsically bad. The latter sets the necessary environment for further clinical experimentation. One useful technique in altering the climate is to move the husband, especially if he is in a distant critical position, in toward the children. This maneuver demonstrates his willingness to make an effort, and often softens the climate surrounding the marital relationship. The father could be motivated to do this by simply pointing out that if the marriage fails they are still his children and he will want a relationship with them. A detoxification of extended family leakage may also be helpful in improving the emotional climate and may dramatically relieve pressure on the marital relationship.

In focusing on the marital dyad the therapist can instruct the couple to confine their information exchange to topics of general interest, dropping discussions of any toxic issues and any attempts at heart to heart talks. Both spouses can be encouraged to diminish their implicit and explicit criticism of one another. Their togetherness activity also ought to be kept light. Meanwhile in the individual sessions an attempt can be made to decrease the projection process and increase self-focus. This is often facilitated by focusing on the expectation to alienation progression. Each spouse is usually either at levels five and six of profound resentment and bitterness or level seven

and eight of invulnerability and alienation. In order to reverse this process, an attempt is made first to explore the risks of becoming vulnerable again. The inevitability of being hurt again if they take this risk, and whether or not the risk is worth it, are given slow-paced lengthy consideration. If this is successful, significant effort is made to detoxify each spouse's' bitter bank and to walk them back up through the progression, eventually getting in touch with their anger and hurt, their disappointment, and finally their expectations. If these interventions are successful it will open the way for direct access to the interactional patterns of the marital dyad, which can then be addressed clinically with less chance of fallout.

Stage IV

Stage IV is marked by the extremes in all of the criteria used for the evaluation and staging of marital conflict. The major factor in this stage however, is the engagement of the attorney on the part of one or both spouses. In the vast majority of cases this move closes the door on the conciliatory context and places the marriage in an adversarial context. It is the attorney's job to protect the client and to foster a pessimism concerning the credibility of the adversary, the other spouse. Otherwise, the strength of the client's bargaining position is seen as weakened considerably. When a couple has reached this stage, focus of the therapy is most profitably invested in helping the individual spouses work on their internal emotional experience and successful disengagement from the relationship. An effort is also made to minimize the emotional fallout for everyone involved, especially the children and grandparents. Divorce mediation provides an interesting alternative for dealing with some of these matters. As divorce mediation matures as a discipline, an evaluation of its results will be important in judging the best way for it to be incorporated into the therapy of marital dissolution.

Summary

The rationale and criteria for staging marital conflict into four levels of severity have been presented. A descriptive summary of the stages has been provided with a brief overview of their therapeutic implications. Our preliminary clinical experience in using this method of staging has validated the purposes for which it was designed.

Further extensive clinical experience in evaluation are necessary along with substantial refinement of criteria and interventional techniques before this methodology can be considered generally applicable. A plethora of pertinent questions remain. For instance: How, while using linear measures in an attempt to facilitate the staging, does one maintain a systems view which allows for the flow and movement of process on a continuum? In what stage do married people start, and how does this progress in one direction or another over time? Does this method offer better results than "behavioral contracting" or other methods of marital therapy? These and many other questions will form a focus for further investigation.

The following paper is also a predecessor of The Evaluation of Marital Conflict. *It is a summary of a major element in the book, the importance of neutralizing triangles in couple therapy.*

Triangles in Marital Conflict

Philip J. Guerin, Jr., M.D. and Leo F. Fay, Ph.D.

Triangles, and the emotional process that operates within them, are important to the understanding of marital conflict. Their centrality in marital conflict is documented by popular perception and cultural convention, as well as by the family therapy literature (Bowen 1966, Jackson 1967, Guerin and Fogarty 1972, Haley 1973, Fogarty 1975, Guerin and Guerin 1976, Kerr 1981, Hoffman 1981, Nichols 1984). The extramarital affair has long been thought of as the eternal triangle, and triadic configurations in dysfunctional interpersonal relationships have been recognized as significant clinical phenomena since the time of Freud.

We believe that understanding triangles and triangulation in marital conflict is essential to defining the dysfunctional process in the marital relationship and to mapping out appropriate strategies of intervention. Our presentation of triangles and triangulation in this paper will have three parts: a review of the nature of triangles and triangulation; a presentation of the triangular mechanisms in marital conflict; and a typology of the most common kinds of triangles that occur in marital conflict.

The Nature of Triangles and Triangulation

Freud may be the originator of the concept of the relationship triangle in his work on the oedipal phenomenon. Although he saw the Oedipus complex as an intrapsychic problem for the individual, Freud also described the oedipal triangle as an interactive, libidinally driven process involving mother, father, and child:

> The child takes both parents, and especially one, as an object of his erotic wishes. Usually he follows in this the stimulus given by his parents, whose tenderness has very clearly the character of a sex manifestation. ... As a rule, the father prefers the daughter, the mother the son; the child reacts to this situation. (Freud 1957, page 28).

This view, though limited in its scope and tied to a recent controversy over "the seduction theory," remains an observable dimension in the relationships between parents and child. The relationship process itself is there to be seen whether or not one accepts the involvement of libidinal forces in driving the process.

In family systems theory, Bowen was probably the first to describe the triangle. He considers it "the basic building block of any emotional system" and the smallest stable interpersonal relationship set (1966, page 160). The dyad remains stable only so long as the process within it is calm and non-reactive. Under stress the dyadic process forms a triangle through the incorporation of a third person, thus shifting the attention from between the original dyad to between one member of the original dyad and the third person (Bowen 1978, pages 478-80). This begins a predictable interactive process in which "the emotional tensions shift about in an

orderly series of emotional alliances and rejections" (Bowen 1978, page 160). As the tension rises, the process intensifies, incorporating more and more people into the reactive process, forming a series of interlocking triangles through which the emotional circuits of the system run.

Haley views the triangle primarily as a structure. He focuses on what he terms the "perverse triangle:" a coalition between two people against or at the expense of a third. It has two other structural characteristics: first, the three people in the triangle include two from one status level (i.e., generation) of the family and one from another status level; second, the coalition is between two people from different status levels. Although in Haley's view the perverse triangle is primarily structural, he does include in his description a process characteristic: in the triangle, no one is permitted to talk about the cross generational coalition; if it is raised, it must be denied (Haley 1967, pages 16-21).

Satir describes the triangle as a series of three two-person relationships, in each one of which the third person is an "observer" who is in effect left out of the relationship. In functional families, each member of the threesome feels good enough about himself to allow the other two to have their relationship. In that situation we observe clinically three one-on-one relationships. According to Satir, in a dysfunctional family, all three are in fear of being left out and the triangle results, with one person in the triangle either running from one to the other, or getting both of the other two people in the triangle to focus as a unit on him or her (Satir 1967, page 58).

Fogarty views triangles as both structure and process. From his perspective, the concept of triangle describes by definition a dysfunctional relationship structure. Such a relationship set is always a closed system in which "the sum of the distances between the points is a constant" (Fogarty 1975, pages 41-42). Triangles usually take the form of an over close relationship between two members of the triangle, with the third person in the distant position. Shifts in the triangle take place through realignments of this structure.

From a process perspective, Fogarty sees triangles as emotional avoidance phenomena aimed at stability without change. According to Fogarty, two people try to avoid fusion by distance. As the distance necessary to accomplish this increases, the relationship will either break off or triangle in a third person to dilute and confuse the emotional issues and tensions between the original twosome. Thus Fogarty's consideration of triangles follows from his description of dyadic relationships in terms of closeness and distance.

Our concept of the relationship triangle begins with the assumption that the emotional process in any dyad is unstable. Such instability can be demonstrated empirically in therapy sessions by the simple experiment of asking the couple to talk to each other about their own relationship, and noting how long it takes them to introduce a third person into the conversation. Dyadic instability is tied to individuals' conflicting needs for autonomy and connectedness. Efforts to achieve autonomy and connectedness at the same time are tied to alternating cycles of separation anxiety and incorporation anxiety (Bowen 1957 [1978], pages 5 to 61), and this is likely to trigger reactivity. As this happens, one or both members of the dyad begin to experience internal discomfort, anxiety, and emotional arousal, and the tension escalates in the relationship. At this point the dyad is set up for the formation of one or more triangles as a means of stabilizing the relationship process.

Two basic mechanisms operate in the formation of triangles. In the first, one member of the dyad moves away from the other and connects with a third person as a way of calming down his internal emotional upset or of gaining an ally in a conflict. The second mechanism involves a third person (often a child) who is or becomes sensitized either to anxiety in one member of the dyad or to the intense relationship conflict. This third person moves in to calm down the upset, or is caught up in the process and act out in some way. (See Guerin and Gordon, 1984).

Guerin has proposed a distinction between triangles as a relationship structure and triangulation as a relationship process. He defines a triangle as an abstract way of thinking about a triadic structure in human relationships, and triangulation as the reactive emotional process that goes on within that triangle. In all relationship systems, there are any number of potential triangular structures, and the emotional process of triangulation within them can be either dormant or active, with varying degrees of dormancy or activity.

The clinical description of the structure of a triangle is an attempt to describe how the three-way relationship looks at a given moment or the modal pattern to which it regularly returns after temporary realignments. For example, at the time a couple presents for treatment, the triangle with their son may have become relatively fixed so that mother and son are over close with father in the distant position. This alignment may occasionally shift, so that there are times when either mother or son is in the outside position and father has some closeness with his son or his wife, but the usual situation is a relatively fixed, predominant structure in which mother and son are over close and father is distant.

Triangulation is the emotional process that goes on within the triangle, among the three people who make it up. For example, in the triangle just described father probably misses his son and feels resentful of his wife's monopoly of the boy's affections; mother is usually angry at father's distance and feels needy for her son's affection and closeness; and son may be resentful of his father's inattention and criticism, and warm with mother, but nervous about his over closeness with her. As the emotional process of triangulation makes the circuit around the triangle, it can produce changes in the triangle's structure as, for example, father trying to reduce his loneliness by moving toward son or wife, or son trying to avoid fusion with mother by distancing toward peers, causing parents to draw together in their concern for him.

The triangle as structure, triangulation as process, and the interaction between structure and process, are all relevant to clinical intervention. A given structure serves a process function, which in turn may lead people to attempt structural realignments, which change the emotional process again, and so forth. Thus triangles can shift their structure at any time, and the process of triangulation always has the potential for motion.

There is a relationship between structure, process, and function in triangles, with a hierarchical order of functions for any particular system at any particular time. As one function replaces another as the more important for a given system, demands are placed on the individuals and the system to realign in a way that ensures the emotional comfort of the most powerful individual and preserves the stability of the system. As Bowen points out (1978, pages 306-7), the most uncomfortable person in the triangle may move toward increasing his level of comfort by lowering his anxiety or emotional tension. If he succeeds, another person becomes the uncomfortable one and he will move toward increasing his level of comfort. The triangular

structure, therefore, is always subject to realignment, and the process of triangulation is potentially in constant motion.

Triangles and Triangulation in Marital Conflict

The tension and emotional upset of the conflictual marriage is a demonstration of the dyadic instability that inevitably leads to triangulation. The function of the third person in the marital triangle is to allow stability without change, dilute the tension in the dyad, and create a displaced issue around which husband and wife can organize their conflict.

Triangles can intensify marital conflict around an external issue, as in the classic case of the mother-in-law triangle, or they can stabilize or cover over marital conflict, as in the case of the extramarital affair before its discovery. Both these triangles serve the purpose of externalizing the conflict. By fighting over the mother-in-law's interference, say, the couple's conflict may intensify, but the issues of their own relationship are obscured. By having an extramarital affair, a husband or wife satisfies a need for closeness or sexual satisfaction without dealing with the problems of distance or sexual dysfunction in the marriage.

Triangulation in marriage always has to do with an unstable dyadic process. Either the spouses have difficulty getting the kind of closeness and connection they are looking for without the anxiety of feeling controlled, or one of the spouses has experienced an elevation of anxiety and emotional arousal in some sphere external to the marriage and the marital relationship is not up to containing the upset and anxiety of that partner. It is at this point that triangulation mechanisms are activated: either one person in the dyad moves to connect with the third person, as in an affair, or a stabilizing third person moves in, as with a "special" or problem child.

Our treatment of triangles so far has been somewhat general and theoretical. In order to work with them clinically, it is important as a first step to identify the important triangles operating around the marital dyad and to assess the intensity of triangulation. The following section presents a typology of the triangles most commonly found in marital conflict and will assist the clinician in identifying them.

Types of Triangles in Marital Conflict

Our clinical experience has led us to suggest that certain kinds of triangles are far more common in marital conflict than are others. There are six main types, several of which have variations or sub-types. Of the six main types, two, the extramarital affair and the social network triangles are extra-familial. Four are intra-familial: the in-law triangles, triangles with the children, stepfamily triangles, and the primary parental triangle of each spouse.

It is worth noting here that extra-familial triangles almost always represent leakage from unresolved intra-familial triangles. usually, when the clinician sees an extra-familial triangle, he can assume that it is connected to an intra-familial triangle or to an interlocking set of intra-familial triangles, and that the dyad or the multigenerational family unit has been unable to contain the reactive emotional process in that triangle or set of triangles. The result is that the process spills out and incorporates people from outside the system by forming an extra-familial triangle.

We will discuss first the two extra-familial triangles and then four intra-familial triangles.

Extra-familial Triangles: The Extra-marital Affair

The most uncomfortable person in the marital dyad or in another intra-familial triangle (for example, the excluded husband in a triangle with his wife and children, or the wife who is the object of criticism from both her husband and her mother) moves towards an affair in an effort to reduce his or her level of discomfort and anxiety by externalizing the process.

Moving into an affair can have any of several effects on the marital dyad. One possibility is that the affair can calm down the uncomfortable partner without disturbing the other spouse, thus stabilizing the marriage and covering over its underlying dysfunction. This effect is often temporary, and usually ends when the other spouse finds out about the affair.

A second possibility is that upon discovery, the affair itself becomes the central issue between the spouses, thereby covering over the conflictual process in the marriage that triggered the affair in the first place. When the affair is an open issue, it is especially important for the therapist to remember the distinction between participation in a relationship process and responsibility for one's own behavior. In the extra-marital affair triangle, the spouse having an affair must take responsibility for his or her own behavior and not attempt to excuse it based on pre-existing relationship problems. On the other hand, both spouses must take responsibility for their parts in the relationship process that preceded the affair.

A third possibility is that the covering-over function of the affair is not totally successful, and the couple present for treatment around other issues with the affair still a secret. This situation raises for the therapist the issue of how much and what kind of confidentiality is functional. It is not within the scope of this paper to address this theoretical and clinical issue in detail. However, it is important to emphasize that there are no hard and fast absolute rules for and against disclosure. The decision must be based one's best clinical judgment. Just as a bull-in-a-china-shop approach is inappropriate, a therapist's tentativeness based on his or her own anxiety is equally unacceptable in dealing with this difficult clinical problem.

If and when the therapist learns of the affair, he must decide whether to raise the affair in a conjoint session. While a theoretical argument can be made for doing so, it is our position that this should not generally be done. Informing the ignorant spouse of the affair will have the effect of raising the couple's anxiety at the very point in treatment when a major goal is to reduce anxiety. The major exception to this rule is the case in which the ignorant spouse, convinced that something is going on but confronted with constant denial, is becoming severely depressed or even psychotic.

When the therapist learns of an affair during the evaluation process (or later) he or she faces three important tasks. The first is to make a clinical judgment as to whether a "secret" affair, past or present, ought to be made clinically explicit. The second is to make it clear to the spouse having the affair that the affair must be terminated if progress is to be made in marital therapy. Third, while doing this the therapist must also recognize and validate the pain and sense of loss which the person having an affair will experience. This is done in individual sessions.

Social Network Triangles

These triangles involve people outside the family system as the third parties. There are two main sub-types: the "social-network-feminist" triangle, and the "beer-buddies" triangle.

In the *"social-network-feminist" triangle*, a not uncommon complaint from husbands is that their wives are involved with women friends who are "giving them the wrong ideas."

Triangles are often a matter of influence, and this is especially true with the social-network-feminist triangle. A triangle may be described as a "competition of influences." As individuals, we are influenced by our parents, siblings, teachers, friends, spouses, lovers, children, and a myriad of contextual influences, the most powerful of which is the media. During our adolescence the importance of influence becomes explicit for the first time in our lives as our romantic interest, our same-sex social network, and our parents vie for primary influence. We strive for autonomy, but often end up gravitating toward different sources of connectedness and influence.

This pattern does not cease with marriage. In our culture, a common pattern emerges when the children are "settled" (for example, the youngest is in school). The wife begins to turn her attention to self-fulfillment. Along the way she may form a relationship with a woman whose beliefs may be in conflict with those of her husband, and as her consciousness is raised, a very intense triangle is activated. If the husband is conservative in outlook, the conflict will be overt and the battle for dominance of influence will be right on the surface.

If, on the other hand, the husband is more liberal, the conflict will be more subtle. The husband who is from the outset supportive of his wife's career, equality, and independence becomes reactive to the loss he feels when part of his wife's attention and emotional investment is directed elsewhere. When, as is often the case, the husband is an emotional distancer, his wife's not being where she is supposed to be creates internal discomfort. Because it is not intellectually acceptable to be upset at wife's movement or to be angry at the new influence on her, the conflict is often expressed in covert ways.

The wife in this situation is often tripped up by her expectations that her liberal husband and informed children will applaud her movement toward self-actualization. They do of course, but within certain limits, and these limits are defined by their own levels of internal discomfort.

Both male and female therapists must be alert to the subtle triggers that dealing with this triangle presents. The male therapist must be in touch with his residual emotional reactivity even in the face of adamant intellectual commitment to equality between the sexes. The female therapist must avoid viewing the reactive husband as a Neanderthal in his approach to life.

As the women's movement continues to make progress, younger marriages have more or less explicit understandings around these issues. How explicit they are depends in large measure on the couple's political philosophies, the characteristics of their social networks, and where they live. The question of influence is important in all marriages, however, and the therapist must be diligent in looking for this triangle when dealing with the marital conflict.

The "*beer-buddies triangle"* is a triangle with the husband's pre-marital friends. He stays connected with them after the marriage, and the connection can cause several difficulties: the wife may see them as infringing on the time husband has for her and the children, and she may resent, or have difficulty with, the input they have on her husband's decision-making.

Connie and Dennis H., both age 23, presented for treatment with severe conflict in their brief marriage (but long-standing relationship). The number of triangles surrounding their marriage

was very great, and the intensity of triangulation in most of them was extremely high. One of the hottest was with Dennis's friends from high school. Connie complained bitterly about Dennis's frequent absences from home to be with them and about the fact that he appeared to care more about them than about her and their children. She was extremely critical of the character and immaturity of these friends, and was not on speaking terms with several of them. Dennis pointed out that he had a hard job which he hated, and needed time and space to relax with his friends in order to release the tension he felt each day after work. The more Connie complained, the more time he spent with them. Helping couples like this sort out the problems of influence, individual versus couple and family time, and the underlying difficulty, always present, of balancing closeness and distance is the prescribed clinical protocol.

Intra-familial Triangles: In-law Triangles

Triangles consisting of both spouses and one member of their extended families are so common they have been the subject of song and story in our culture for decades. There are four main sub-types that we have observed to be particularly important in marital conflict: (1) the wedding-gift triangle; (2) the loyalty-alignment triangle; (3) the shape-up-the-dysfunctional-wife triangle; and in (4) the daddy-dominates triangle.

The wedding-gift triangle. One spouse, usually the husband, "gives" his mother to his wife. Guerin often asks family therapy trainees: "What is the most common gift for a groom to give to his bride on their wedding day?" Answer: "His mother." A culturally acceptable way for a man to avoid the pressure of a relationship with his mother without cutting her off is to hand her over to his wife, giving his wife the responsibility of keeping in touch with his mother, seeing that his children have a relationship with her, buying gifts and birthday cards for her, etc. The wife's response can be one of two kinds. If she has a big investment in her mother-in-law's approval, she may accept the gift and do her best to keep her mother-in-law happy. If she has a strong allergy to this kind of obligation, she may take a position equivalent to "Keep her, she's yours."

In a case like this, until the husband accepts responsibility for dealing with his mother and their relationship, and until the wife accepts responsibility for giving him the time to do it, the potential for relationship fallout remains high. Clinically this can be dealt with by husband accepting this responsibility directly or by coaching the wife to lower her reactivity and use her creativity indirectly and subtly to reject the attempted transplant while creating a climate that gives the husband and his mother the best chance for a successful relationship.

The loyalty-alignment triangle. One spouse and his or her mother usually remain overly close, with the other spouse in the distant position. This triangle represents incomplete attachment and bonding in the marriage. One spouse, perhaps the husband, is bonded in an over close relationship with his family of origin and his wife is in the outside position, unable to get the kind of membership she is looking for in her husband's family, or the appropriate type of bonding with her spouse. When a conflictual or toxic issue arises, such as money, the people who have the most influence over the husband may still be his family, and especially his mother. Thus does the influence of the loyalty alignment take precedence over the marital relationship.

Sal and Maria T. provided a good example of this triangle. Maria complained that Sal was constantly in contact with his mother – calling her several times a day and visiting her every day on his way home from work. In addition, every time he and Maria had an argument and he

walked out "to cool down," he went to his mother's house. Sal complained that Maria's behavior was "crazy" (the symptoms he described in her fit almost perfectly the DSM-III description of a borderline personality) and thereby drove him out of the house. What he did not see, but what the therapist was able to surface, was that Maria's angry outbursts and her feelings of depression were related to Sal's distance from her, and his overly close link with his mother.

The shape-up-the-dysfunctional-wife triangle. This triangle is a variant of the loyalty-alignment triangle. In it, wife's mother and her husband are united in criticism of her. Both agree on what is wrong and what needs shaping up.

Anne and Michael F. were such a couple. Anne's mother and Michael agreed that Anne was an imperfect mother and a sloppy housekeeper. Their unity in criticism tended to occur in cycles, and as each wave of criticism from them built, Anne became increasingly negligent of both child care and housekeeping. The climax came when Anne became incapacitated by depression, began to speak of suicide, and had to be hospitalized. This further convinced Anne's mother and Michael that something was wrong with Anne, but it also provided the opportunity for the in-patient unit's family therapist to surface the process and deal with it under controlled circumstances.

The Daddy-dominates triangle. In this triangle, wife and her idealized father are united in implicit criticism of the husband. This triangle can be significant in marital conflict even when the wife's father is dead. Madeline V., who came to treatment alone because her husband refused to come, complained that her husband was a poor provider, was abusive, and drank too much. Her father had died 10 years earlier, just one year after Madeline's marriage. In questioning her the therapist learned that her father had never approved of Madeline's husband and except for that issue Madeline and her father had always been very close. Madeline admitted that she had begun to compare her husband unfavorably to her adored father after he died, and when she was asked what she thought her father's advice would be in her present circumstances, said without hesitation that he would insist she and the children leave her husband and "come home."

There are other, slightly less common sub-types of the in-law triangle, and sometimes several sub-types occur together. A case in point was Gerald, a surgeon, married to Marie, a teacher. Both are in their 40s, and they have three children. One of the major conflicts that organizes their marital dysfunction for them is his mother's criticism of their oldest son. She always asks lovingly about the younger two, but when she speaks of the oldest son, she says things like "How's the case?" (referring to the fact that the son has been in therapy).

The husband is very successful and competent, but is an only child. Thus, when he and his wife were married, both at age 28, the wife "stole the prince" and robbed the cradle. The husband's parents are retired real estate entrepreneurs from whom he keeps his distance. Every time he visits them at their retirement home in Arizona, they want to show off their son the doctor. His wife has banished her in-laws from visiting their home, and on their trip East they stay in a local motel.

One way of detriangling in this situation is to try to reduce the level of anxiety and emotional arousal in both spouses about the situation while helping them to define the structure and the interactional patterns in that triangle. Then the therapist may experiment with the clinical situation either by attempting to shift the structure in the triangle or by trying to bring about

some experimentation with the reactive process in it. For example, husband can be coached to stop distancing from his mother and to spend more time alone with her. In doing so, he should be instructed to leave his wife and children at home, and monitor his insides so that he can gradually define and lessen his reactivity while gradually increasing the amount of tension-free time he can spend with his mother. In addition, the husband should observe the relationship patterns that develop when he is visiting his parents. One pattern to which Gerald became instantaneously reactive was his parents' insistence on constant negativity about everything in the universe. As an experiment he might preempt their negativity by bringing them his negativity about his own life and problems. This reverses the usual process where he is on the receiving end of their negativity and attempts to neutralize it.

On the wife's side of the triangle, it is important to work with her to recognize that her in-laws' feelings and behavior toward her are based to a large extent on displacement: their feelings come from the parents' upset at this son for leaving them (and for continuing to be distant). It has little to do with her personally, and when she can understand that and accept it, she may be better able to take her mother-in-law's criticism of her less personally.

She must also take a look at her own expectations about membership in her husband's family. Marie was in fact disappointed and angry about never really having been initiated into full membership. No one ever achieves full membership in the spouse's family, and it often helps people to come to grips with that fact.

Finally, Marie has to learn a way of dealing more actively with her in-laws instead of just swallowing her feelings about their behavior. One possibility might be to suggest to her that when they call her oldest son a "case," she might say something like, "Well, all of us M.'s (her maiden name) are crazy, everybody knows that." This might give her less of a sense of impotence in dealing with them and a way of dealing with her own upset, while potentially increasing her in-laws' respect for her for finding an effective way of dealing with them.

Triangles with the Children

Children are ready-made targets for a triangle. It would be difficult to imagine a more convenient way of confusing issues or diluting tension between husband and wife than by triangling in one or more of their children. The ways these triangles can work are many, and families play innumerable variations on the theme. Three major sub-types are the most common, and all three are dealt with extensively in Guerin and Gordon (1984). A brief summary of each follows.

In the first sub-type, one parent is over close to and overinvolved with one or more of the children, and the other parent is in the distant position. This is the pattern which every mental health professional with even a smattering of exposure to family therapy looks for, in marital conflict as well as when the presenting problem is with the children. There is good reason to look for this pattern: it is very common. Wives who are emotional pursuers, frustrated with their husbands' distance, turn to pursuing their children. The husband's resentment over this triangle, especially as it involves male offspring, may underlie a significant portion of his bitterness about the marriage.

Another common subtype occurs when the husband and wife join in an artificial "we-ness" vis-à-vis a troublesome child. Roger and Barbara C. provided a classic example of this pattern. A

couple in their early 40s, they presented with a 13-year-old son who was doing poorly in school, had several seizures a year earlier, and was now on Dilantin. As usual with this type of triangle, the family presented around the child's problem, not with marital conflict. These families see the child's problem as primary, and want that solved before anything else is mentioned by the therapist. In fact, in the case of Roger and Barbara, when the child's problem was "solved," therapy was terminated. The therapist's job is to assess whether an underlying marital conflict exists, and to take the family as it presents – a child-centered family – avoiding the temptation of premature conversion to marital conflict.

A third subtype occurs when husband and wife are in conflict with each other about the child or children, with both parents attempting to be closer and more influential with the child. Rosalie and Harry B fought incessantly about whether or not the children should be brought up Jewish. Harry was Jewish and Rosalie was a Catholic, although neither had practiced his religion for years, and both had agreed that any children they might have were not to be brought up in either religion. Harry changed his mind about this agreement when his first son turned 12, and their dispute about this issue rang from the rafters day in and day out.

Triangles with the children can take these or many other forms, and must be treated carefully by the therapist. When the presenting problem is not the marital conflict, the therapist must avoid the temptation to raise it prematurely.

Step-family Triangles

When one or both spouses have been previously married, the potential for triangling escalates at an astonishing rate. The most common, and most intense, triangles are those with ex-spouses and step-children. In the authors' experience, even when stepfamilies present clinically with marital conflict, the underlying issue has to do with the acceptance of the other's children by one or both.

The frequency of triangles with ex-spouses is an indication that formerly-married spouses rarely if ever resolve the issues outstanding between them at the dissolution of their marriage. The ghost of the ex-spouse is present regardless of whether the marriage was terminated by divorce or by death. In the latter case there tends to be in idealization of the deceased spouse, while in divorce there tends to be the opposite. This phenomenon has an obvious impact on the structure and the process in this triangle.

Patrick and Teresa C presented for treatment of marital conflict in which the major issue was the wife's serious depression. Teresa age 67, had attempted suicide four times in the past seven years during episodes of acute depression. Patrick, 72 was at his wit's end and professed to be bewildered by, among other things, Teresa's angry advice that he return to his former wife – whom he had not seen for over 45 years. This vignette illustrates the durability of ex-spouse themes in remarriages.

As in first marriage families, stepfamilies most often present with a combination of interlocking triangles, mixing ex-spouse, step-children, and three-generational child-centered triangles, the latter often involving a divorced, excluded grandparent.

The Primary Parental Triangle of Each Spouse

Invariably, the place each spouse has occupied in his or her family of origin will have significant impact on the marital conflict. This is particularly true of the process encompassing each spouse in the triangle consisting of himself and his parents. That triangle is the basic training ground for each spouse's emotional maturity. We would go so far as to say that the emotional maturity of spouses can be measured by the degree to which each of them is able to operate within that primary parental triangle with a relatively low amount of anxiety and emotional arousal. It is also a measure of how much each of them is available for bonding in the marital relationship.

The therapist must get a clear picture of each spouse's primary parental triangle in the evaluation of every marital conflict he sees. This is accomplished most easily and efficiently while taking the genogram.

Ellen N. wanted to divorce her husband Arthur because of his emotional distance over many years and his apparently uncaring attitude to her and her needs. She also felt that the obligations of marriage were too much for her. Arthur, panicked now, wanted the marriage saved. In the course of taking the genogram, the therapist learned that Ellen was the oldest of six and a nurse, had been over-responsibly involved in her parents' divorce when she was 18, and right up to the present has been seen as her family's problem-solver. Arthur, the younger of two children, had been protected and disciplined but otherwise ignored in a household where his father had been primarily concerned with taking care of his schizophrenic and depressed wife (who died while Arthur was in college).

Ellen was caught by her overly responsible position in her primary parental triangle. The impact of this triangle on her marriage was vividly demonstrated by the feelings that she must be a "perfect" wife and mother, and her statements that she simply could not stand the feelings of obligation this imposed on her.

Arthur was caught by his position on the outside of his mother and father's relationship: mother involved with getting caretaking from father, father absorbed by mother's needs. The impact of this triangle of Arthur's marriage appeared in his need to control his wife and keep her attention focused on him. This fed Ellen's feelings of being overwhelmed by the obligations of marriage, and so these two people's primary parental triangles were a major factor in their marital dysfunction.

Summary

The triangle as an element in human social behavior has both structural and process components. Structurally a triangle describes three people with one of the three usually in an emotionally distant or excluded position. Structure is always tied to process, and in a triangle, emotional reactivity is the basic process.

Marital conflict always involves triangles, usually several at once and always fairly intense. Triangles can organize the marital conflict, providing a focus for it, and they often cover up the dysfunctional process in the marriage itself.

It is been the purpose of this paper to provide the clinician with an overview of the theory of triangles in marital conflict, and with a guide to the clinical management of the most common triangles in marital conflict.

References

Bowen, M. "The Use of Family Theory in Clinical Practice." *Comprehensive Psychiatry, 7* (1966), 345 – 74.

Bowen, M. *Family Therapy in Clinical Practice*, New York: Jason Aronson, 1978.

Fogarty, T. F. "Triangles." *The Family*, to (1975), 11-20.

Freud, S. "The Origin and Development of Psychoanalysis." In Rickman, R. (ed.) *A General Selection from the Works of Sigmund Freud*, Garden City: Doubleday, 1957.

Guerin, P. J. and Fogarty, T. F "The Family Therapist's Own Family." *International Journal of Psychiatry*, 10(1972), 6-22.

Guerin, P. J. and Gordon, E. M. "Trees, Triangles, and Temperament in the Child-Centered Family." In Fishman, C. and Rozman, B. (eds.), *Models for Family Change*, New York: Guilford, 1984.

Guerin, P. J. and Guerin, K. B. "Theoretical Aspects and Clinical Relevance of the Multi-generational Model of Family Therapy." In Guerin, P. J., *Family Therapy: Theory and Practice*, New York: Gardner, 1976, pages 91-110.

Haley, J., *Uncommon Therapy: The Psychiatric Techniques of Milton Erickson, M. D.* New York: Norton. 1973.

Haley, J. "Toward a Theory of Pathological Systems." In Zuk, G. H. and Boszormenyi-Nagy, I. *Family Therapy and Disturbed Families*, Palo Alto: Science and Behavior Books, 1967, pages 11-27.

This paper is a case study about an important, but often neglected, triangle that can be operating in marital conflict. The consultation dialogues are among the best examples on record of Guerin's therapeutic style. They demonstrate his ability to avoid being triangled by the couple and to follow a plan without getting derailed.

The Social Network-Feminist Triangle: A Triangle of Influence

Philip J. Guerin, Jr., M. D. and Susan Burden, CSW, ACSW

A previous paper in this journal presented an overview of triangles of marital conflict. It is the purpose of this paper to focus on the social network-feminist triangle.

Triangles are often a matter of competition for influence. This is especially true with the social network-feminist triangle. The wife is in fact being influenced in a new way by her social network, and her husband is experiencing a loss of at least part of his previously held influence.

The Evolutionary Pattern

In our culture, a common pattern emerges when the youngest child enters school: the wife who has been at home raising children begins to turn her attention more towards self-fulfillment. Along the way she may form a relationship with a woman or women whose beliefs support her desire to change and may be in conflict with those of her husband. As her consciousness is raised, a very intense triangle becomes activated. If the husband is conservative in outlook with traditional expectations, the conflict and the battle for dominance of influence will be overt.

On the other hand, the more liberal husband who is from the outset supportive of his wife's career, equality, and independence eventually becomes reactive to the sense of loss he feels when part of his wife's attention and emotional investment is directed elsewhere. However, because it is not intellectually acceptable to him to be upset at his wife's new interest or to be angry at the new influences on her, the conflict is often expressed in covert ways. For example, he may criticize her lack of availability to the children. Frequently, in both of these circumstances the implicit demand is for the wife to do whatever it is she has to do but on "her own time." In addition the wife who has patiently listened to her husband's "hero stories," his triumphs in the big world, now has some hero stories of her own. The husband often has great difficulty even listening much less being enthusiastic. The wife is often disappointed and emotionally upset that her liberal husband and informed children do not applaud her movement toward self-actualization and do not listen to her tales of accomplishment.

A Case in Point

(The following is a case in therapy with one of the authors: Burden.)

Stephen, 40, and Andrea, 36, married for 17 years, sought treatment because of the acute conflict over Andrea's quest for autonomy. Five years prior Andrea started going to Al-Anon during the period when Stephen's alcohol consumption increased. She and six other women from Al-Anon formed a support group that continued to meet up to the time the couple entered treatment. Encouraged by her group, Andrea began exploring ways to change her life. By the time therapy began she had been taking courses at a local community college for a number of years. She had escalated her quest for autonomy by starting a part-time job and pressuring Stephen to allow her more involvement in their family finances.

Stephen, who had started with practically nothing when they were first married and now owned and directed a very successful company, flew into a rage whenever she broached the subject of money. There was no way he would give her more financial responsibility because she could not handle what she already had. Suspicious and negative, he believed her every move was orchestrated by the "group" and would counter her requests for more financial involvement with "Whose idea was that one?" Or he would suggest that the "group" pay the taxes that "your ridiculous job that costs me money" incurred. Andrea would defend herself and her group, and the relationship dance would repeat itself over and over. The almost daily sequence was usually triggered by Andrea's absence from home at dinnertime, a call from one of her group members, or demands for more financial autonomy.

Early in the therapy Mrs. Burden supported Andrea's goal of achieving greater autonomy and maturity. However, she encouraged Andrea to review the three major efforts she was making with an eye toward evaluating how well they were working. Andrea decided that her return to school was constructive and that she needed to focus her energy on setting academic goals. She

decided to continue her part-time job but to postpone an increase in hours to give the family a chance to calm down. A review of her quest for more financial control revealed it to be premature. On the one hand, she attempted to persuade Stephen to put more of their financial holdings in her name and to give her more access to their bank accounts. On the other hand, she frequently wrote checks against insufficient funds and then would appeal to Stephen to help her straighten out the mess when the monthly statement arrived. Andrea was demanding more financial autonomy from Stephen rather than taking more effective responsibility for the money matters already in her control. In therapy Andrea explored the sources of sensitization to this issue in the extended family, worked to objectify her perception of the conflict with Stephen, and experimented with her behavior patterns in order to increase her functioning in this area.

If a couple is to have a decent chance of surviving a major shift, the spouse who is making the changes needs to be sensitive to the impact those changes have on the family. At first Andrea was defensive when the therapist explored this area. She said she thought her two adolescents, one son and a daughter, were supportive and proud of her and expressed little concern about the change. She labeled her husband a chauvinist and attributed his angry response to her efforts to his desire for absolute power and his lack of sensitivity to her needs. Not only did his critical reaction disappoint her own expectations for approval, but it also triggered her own ambivalence about the steps she was taking. Her fears about the changes surfaced and were explored. Mrs. Burden worked with her to understand the impact her new direction had already made, to observe the current reactivity of other family members objectively, and to predict the fallout that was likely to occur with each new step she took. The focus was on Andrea’s being able to stop her defensive behavior and to lower her own reactivity while she continued her steps toward personal growth. Mrs. Burden encouraged Andrea to address the way the group was influencing her thinking and behavior. Clearly, she valued this support; however, she decided that some of their suggestions had increased her bitterness, which led to an increase in provocative behavior toward Stephen. When she used the group as a sounding board for her rage at Stephen, they often responded with direct advice that, when tried, inevitably escalated the conflict. Andrea felt caught. She worried about the way the group would see her if she did not "stand up for her rights" with Stephen. Coached to explore and experiment, Andrea learned that moving toward individuals in the group for emotional connection and companionship organized more around her own struggle, minus the negatives about Stephen, worked in a more functional way.

Stephen's experience of the triangle was that he had lost influence over his wife. She was listening to someone else, “the group.” He was encouraged to reach for neutrality and to stop openly attacking Andrea's group. He quickly understood that the digs were not helpful but felt unable to control them. Mrs. Burden was able to surface the emotional loss he was experiencing since Andrea had moved out of her old familiar role, as well as his fears that she might leave him. Stephen discovered that part of his emotional discomfort was linked to Andrea's dropping off his internal radar when she was not doing what she was "supposed" to be doing. He spoke of his fantasies of finding another woman, one who would appreciate him. As his dependence on Andrea continued to surface, he became more aware of his feelings of loss and their connection to his angry and critical behavior. He was encouraged to redistribute some of his emotional energy into improving his relationship with his kids and adult siblings. Some of this exploration was done in sessions with Stephen alone and later brought into the sessions with Andrea. When she heard him talk about his sense of loss and his fear that if she had more financial independence she would leave him, she was surprised that he could admit his emotional

vulnerability. She began to listen in a different way and modify some of her polarized perceptions of their relationship.

Early in the work in this triangle, Mrs. Burden asked Dr. Guerin to see the couple in consultation. The following dialogue is from the consultation session.

Andrea: I do feel that I did put the blame on Stephen for many years. I was very dependent on him from my happiness as well as the guilt feelings I was having. About four or five years ago I started to step away from that and took control over my own life. Since then I have experienced things that now have led me into becoming more independent, more self-reliant. I feel more like a partner now, and I don't think Stephen likes it.

Guerin: What doesn't he like – that you don't feel like a victim or that you feel like a partner?

Andrea: Well – both.

Guerin: Do you think he liked you as a victim?

Andrea: Yes.

Guerin: What's your evidence for that?

Andrea: I think Stephen enjoyed a pattern of fighting and making up, and I accepted that for a very long time, and he expressed his gratitude monetarily on many occasions – whether it had to do with his drinking or not is another question.

Guerin: You mean he'd make it up to you by giving you more money?

Andrea: Yeah – you know like mink coats and stuff like that. And it worked.

Guerin: So you become more independent, and instead of giving you mink coats, Stephen's complaining about $250 phone bills. Your independence has cost you a lot.

Andrea: I know.

Guerin: Did your independence cost you anything in the relationship apart from money?

Andrea: I feel that I'm the kind of person that takes a long time. I'm a slow mover. I think that I've been able to become independent slowly, and that Stephen has accepted it very slowly. I know he's becoming very resentful of my new job.

Stephen: It interferes with my dinner.

Andrea: It's interfering now with his life, and I recall him saying last night that he felt that the reason our son was having problems was that I was never home.

Guerin: Do you think it's really the absence of dinner, or is it something else?

Andrea: I think Stephen will find fault anywhere, whether it be taking film to the Photomat or picking up the dry cleaning or sweeping crumbs under the table – I think you will find – I don't think I'll ever be able to please him at this time in the way he'd like me to.

Guerin: Have you stopped trying?

Andrea: Yes.

Guerin: How long ago did you stop trying?

Andrea: Not too long ago. I'd say ever since I started school this semester.

Guerin: So you're on the track of getting independent; are you on strike as far as Stephen goes?

Andrea: I'm not on strike. I have to honestly say that the things Stephen has asked me to do have been very low priority for me, and on the other hand, I try to do everything and be the super mother so I can have time to do the things that are important to me.

Guerin: But have you lost in that whole process the ability to let Stephen know how important he is to you?

Andrea: Maybe I have.

Guerin: How did you lose that?

Andrea: Well – I think our relationship has been clouded by many things. (*Begins to cry*) Like his health.

Guerin: What has you crying?

Andrea: I just feel very emotional.

Guerin: I understand, but do you know what has you feeling so emotional?

Andrea: No.

Guerin: It seemed to come when I asked you if you had lost the ability to let Stephen know he's important to you.

Andrea: I think maybe it isn't important to me anymore.

Guerin: Do you feel badly about that?

Andrea: I guess I do feel badly about that. I feel our relationship has been clouded by many things: family issues with our children, his health, my going to school, and I do feel Stephen is important to me, and I do love him, but I'm tired of trying to express certain things to him, and I feel very frustrated. It's like I don't want to bother anymore.

Guerin: How come he doesn't hear you?

Andrea: I don't think he does hear me. I think Stephen is devastated by my small steps towards independence.

Guerin: You mean like if you really loved him you'd stay in place and march to the same tune?

Andrea: Right.

Guerin: When you mean what you'd like is to get a piece for yourself and somehow have him understand that doesn't mean you don't love him?

Andrea: Exactly.

In this exchange Dr. Guerin spells out the direction of Andrea's movement away from Stephen in pursuit of other things. At the same time he attempts to validate her experience of the bind she finds herself in. The therapist then proceeds to explore Andrea's expectations about what response her move for autonomy would evoke.

Guerin: Did you expect your moving out to have a fallout with Stephen and the kids?

Andrea: Well, I've been trying to achieve the moving out for a very long time. It's always been on my mind – having gotten married directly out of high school, and I think Stephen's nature has always told me I'm very stupid and I'm not worthwhile. And I believed that for many years. It's been very difficult for me to fight all that and finally break through it, and now that I'm here I can't even discuss my schooling because he doesn't want to hear it.

Guerin: And that upsets you?

Andrea: I'm exuberant about my experiences at school, and I want to share it with him.

Guerin: Let's go back to whether you expected your moving out when it got to a critical point, I mean you know you can think about moving out forever, but when you actually start doing it, then something's going to happen. Did you have a set of expectations that there were going to be ripples in response to it?

Andrea: Yes, and I think what that's why it's been so delayed.

Guerin: That's why you hesitated for so long?

Andrea: Yes. I think I've tried and pulled back and tried and pulled back, but I feel like nothing's going to stop me now.

Guerin: Do you get angry when Stephen has a snitfit about you being more enamored of your job that you are of him?

Andrea: No, I don't get angry anymore.

Guerin: Are you disappointed?

Andrea: Yes. I would like him to know that just because I'm doing some things for myself it doesn't mean I'm moving away from him or moving out of the house. I feel better about myself.

Guerin: How come that isn't carrying over to everybody feeling better about themselves?

Andrea: I don't know.

Guerin: Did Stephen never say to you, "You know, I really miss you now that you're out of here doing all that stuff for yourself?

Andrea: No.

Guerin: Would you like that?

Andrea: I wouldn't mind if he said he missed me.

Guerin: You wouldn't mind, but you wouldn't be particularly moved by it?

Andrea: I think if he expressed it that way, I would then be able to be a little more empathetic. But when he expects that I'm not going to school, or that I'm doing something else …

Guerin: When he suspects maybe there's some other character out there you're interested in, that itches you, because he doesn't trust you?

Andrea: Yes.

Guerin: If Stephen had ever said to you, "Dammit, Andrea, I never realized how dependent I am on you until you moved out and got all involved." Has he ever said that?

Andrea: No.

Guerin: What would be your response?

Andrea: I feel like it might put us back on the same ground again.

Guerin: Is it hard for Stephen to make statements like that – even if he realized it?

Andrea: I think so – yes.

Guerin: You'd have to fill in the blanks? He wouldn't put into words?

Andrea: Yes.

In addition to exploring Andrea's expectations, Dr. Guerin begins to surface Stephen's dependency and loss, while modeling alternative ways Stephen might communicate with Andrea. The focus then turns to Stephen to see if he is picked up the message.

Guerin: Stephen, how many years would it take to put that into words?

Stephen: I guess I'm a cold person in that respect, and I suppose that's why I give gifts. I supported her college education. I was annoyed when she took the job from 6 PM to 9 PM; dinner's at 7.30.

Guerin: You get the feeling she's trying to avoid you?

Stephen: What annoyed me most is the fact that I wasn't included in the decision. (*To Andrea*) You just told me you were going to do it!

Guerin: Let me go back. Are you cold inside or outside?

Stephen: Probably outside.

Guerin: Inside you're not so cold. You have trouble getting it out there? You think that's because you never learned it?

Stephen: Probably never learned it.

Guerin: Have you made an effort? Do you think an effort would be worthwhile?

Stephen: Could be.

Guerin: You might think about beginning that. Do you think Andrea would pick it up, or would it fall on rock?

Stephen: I don't think it would make a difference. We are going to have to cancel vacations which the kids look forward to. I look forward to them. Because Andrea says she won't miss a class, this kind of thing. So there are new conflicts coming into play. The kids' vacations don't coincide with mother's vacation so Andrea says she'll have to take her own vacation. I don't know how to react to that.

Guerin: When you agreed to Andrea's going to school and being out there, did you know it would be as hard as it's been?

Stephen: I thought it would be a daytime thing. I never gave a thought to vacations being canceled.

Guerin: So it wasn't going to be on Stephen time; it was going to be on free time, and now it's gone over to Stephen time. Did it have more of an impact on you than you thought it would? Did you feel it?

Stephen: Well, Andrea's gotten very… She wants to… I wasn't aware she was going to school all day and work at night when we still have two children, and the oldest one's having a lot of problems.

Guerin: So you think she's overcorrected?

Stephen: Yeah, I do. I think she's going out faster than she should. My daughter doesn't like it either, coming home to an empty house.

At this point Dr. Guerin decides he's done what he can to validate Stephen, give him a potentially new pathway of perception, and engage him into the process of therapy. He now turns and attempts to slow down Andrea's movement and modify her reactivity. Finally he closes by reminding Stephen of his dependency.

Guerin: What do you think, Andrea, without defending yourself? Have you overcorrected? Have you gone too fast?

Andrea: No.

Guerin: How do you know? The system is bouncing over there. It's twitching away like crazy.

Andrea: (*Starts explaining herself, giving detail of the hours she's away*.)

Guerin: But as you pull out, there's bound to be fallout from it. That's totally predictable. The pace at which you pull out and the way you handle your move will have more or less fallout depending on how you do it. That's not your responsibility to control all of that. The other folks have to handle their piece of it, but how do you know when you're moving too fast or too slow, or losing your momentum or whatever, or haven't you bothered to evaluate that?

(*Andrea again gets very defensive, intermittently crying*.)

Guerin: It's such a toxic issue for you that it's hard for you to entertain questions about what you're doing without getting defensive and without getting scared of falling back, and that doesn't allow you to see the whole picture and deal with some of the pieces of it. I'd encourage you to do that.

Guerin: Stephen, I want to get back to something. When I asked you before whether you could say to Andrea that you never realized how dependent you were on her, if you experienced that, could you tell her?

Stephen: I think I have probably told her.

Guerin: Do you remember him telling you, Andrea?

Andrea: No.

Guerin: You didn't tell her loud enough, Stephen.

Stephen: I think I have told her. As far as holding down the home fort and keeping the kids in line.

Guerin: How about just your internal feeling of well-being?

Stephen: Well, I haven't thought about that.

Guerin: If Andrea is going to look at the impact of what she's doing on the family, I think you need to look at your angle and at the internal, deeper feelings that it's covering up.

The couple's reaction to this session was mixed. Stephen found it helpful and felt supported by Dr. Guerin. Andrea initially felt angry and defensive. She heard Dr. Guerin telling her that the steps she was taking toward independence which she had considered painfully slow were too ambitious. In the ongoing therapy Mrs. Burden supported Andrea's frustration but continued to encourage her to evaluate the impact her change was making on the family. By the time they watched the videotape of the consultation several months later, Andrea's reactivity was significantly lower, and she was able to hear what was being said with much more objectivity.

Stephen and Andrea made progress on their work on this triangle. Progress was slow because of the intensity of their conflict. In time Andrea learned to use her group in a more productive way. During one session when she and Mrs. Burden were discussing why she sometimes felt weak for staying in the marriage (a pattern we've noted with many women today), she was able to connect it with the group's influence. She realized that she was the only one of the seven women who had not left a husband or lover and felt that there was an underlying theme that said if you're strong you strike out on your own. In therapy she began to entertain the possibility that it takes a great deal of strength to stay in a marriage and to work on making it better without giving up the goal of autonomy. When Stephen fell back into criticism, she was often able to say with sincerity that she was sorry he was having trouble with it, rather than defending herself. She learned to pace her moves in a way that minimized the impact on the family, and she made progress on taking more responsibility for financial matters. Stephen learned to control some of his criticism and began to take some emotional risks like talking about his dependence on Andrea. He also made some progress in dividing the responsibility for financial matters.

The Interlocking Triangles

In order to reinforce and amplify the change in the acutely reactive triangle, it is important for the therapist to look for the interlocking triangles and to work on detoxifying their impact on the central triangle. This work took both Andrea and Stephen back into their families of origin to explore their primary parental triangles. Andrea's mother died following a long illness when Andrea was 18, shortly after she married Stephen. Andrea remembered her mother as a very stoic, selfless woman, deeply committed to her role as a mother and wife. When Mrs. Burden asked whether she thought her mother was at all dissatisfied with that role, Andrea recalled an incident before her mother got sick. She found her in the bathroom crying. Her mother said that she was upset about her husband's angry reaction to her announcement that she was going to take a class in landscaping. This was a side of her mother that Andrea had never seen, and she remembers being upset by it and angry at her father.

In therapy Andrea began to consider that her mother might not have been as happy with her role as she had always thought; maybe she wanted more for herself. Mrs. Burden encouraged her to find out more about that period of her mother's life by going back to talk to her mother's two living sisters who had been cut off from the family since her death.

Andrea's relationship with her father was a warm one, but she described him as a chauvinist who likes women in their place, which meant at home. He and Stephen had always been close, and he consistently supported Stephen when he criticized Andrea's absence from the home and laughed at his jokes about her group. Andrea was as defensive with her father as she was with her husband and often felt ganged up on and victimized when she spent time with the two of them. It was suggested that she work on getting out of the defensive position with her father and try to

develop a less reactive relationship with him. Two specific suggestions were made: first, that she talk to her father alone about her own fears about the steps she was taking, and second, that she ask his advice about a way to deal with Stephen's upset with her. This put her in a more active position with him which gave her a greater feeling of control over her own emotions. She lowered her expectations about his potential responses and was pleasantly surprised when he listened and talked with her in a serious and concerned way, and let her know something about his own struggle with the same issue, in his marriage to her mother.

Stephen's primary parental triangle also had a significant impact on his position in the central triangle of the therapy. He had a very distant relationship with his mother and described her as a domineering woman who was untrustworthy and immoral. He thought his father was weak and passive and resented the fact that he never stood up to his mother. As an adolescent Stephen had walked in on his mother in bed with another man when his father was at work. He told his father whose only response was to tell him to mind his own business.

Stephen held a long list of grievances against his mother, most of them tied to the issue of trust. In therapy he explored his feelings about other women in his family of origin and discovered that he did not trust any of them. This led to two pieces of work, one in his extended family and one with his wife. The therapist focused his attention in a new direction; rather than dwelling on his anger at his mother's behavior he began to look for an understanding of the personal dissatisfaction that must have predated this behavior. Stephen was coached to ask her about the dreams and ambitions she had as a young girl and to get her talking about the expectation she brought to her marriage and role as a mother. The goal of Stephen’s work with his mother was to get his reactivity down so that he could begin to listen to her with some objectivity. With his wife he was encouraged to begin taking risks around the issue of trust. He came up with the idea of beginning that process in the area of financial control. As Andrea and Stephen made progress on these interlocking triangles, they learned something more about what each of them brought to their positions in the social network-feminist triangle. Stephen's relationship with his mother sensitized him to the changes in Andrea. If she was not in her old familiar role, then she must be doing something out there that would be hurtful to him. His automatic response was to tighten the reins. Andrea was the distant daughter of a man who held very traditional views about women and the over close daughter to a mother who had never been able to verbalize her own dreams and desires. This experience increased her sensitivity to the issue of personal freedom and marriage and her reactivity to a husband who did not fully support her goals. Both brought scripts from their family of origin that activated and reinforced the social network-feminist triangle operating in their marriage.

In summary, the clinical management of the social network-feminist triangle involves the following steps:

The therapist must first identify that the social network-feminist triangle is operational, then the process within the triangle can be surfaced and clinically managed.

Introducing the theme of influence is an excellent way of surfacing the process and engaging the husband in the work of therapy. The husband will often zero in on this theme, expressing his disapproval of his wife's new friends. Predictably she will get defensive and the locus of intervention has been established.

Work with the husband is a two-phased process. Initially an attempt is made to put him in touch with his emotional reactivity to the changes in his wife and how this feeds into his critical posture towards her. He can be instructed to experiment with decreasing his criticism, and getting beyond his anger to his hurt and loss. From there he can experiment with communicating his newly discovered dependence. He can tell her, in his own way, how important her being in the right place at the right time doing "what's she supposed to be doing" is to his internal emotional comfort.

When the husband has gained sufficient facility at this, is ready for phase 2. This begins when the husband, his reactivity at least under conscious control, can begin to neutralize his negative feelings towards his wife's friends by working to establish a relationship with them as people rather than perceived enemies.

Meanwhile the wife is asked to sort out the multiple influences on her thoughts and feelings, to get her as free of influence from either side of the triangle as possible. The therapist should help her set her own agenda for change based on a careful assessment of her goals and what will work for her as well as her family. Pacing is an important part of this experimentation. One of the most difficult aspects of this part of the work is to help the wife not falter in her efforts when they are met with criticism, blaming, or lack of applause from husband, children, and parents. She must be creative with her methods and pacing if she is to achieve her goals without fracturing the family system.

The following paper is chapter 9 of The Evaluation and Treatment of Marital Conflict: A Four-Stage Approach *by Guerin, Fay, Burden, and Kautto (1987, Basic Books). It describes the treatment of severe (stage III) marital conflict, which involves each spouse achieving taking responsibility for his or her own part in the process, reducing bitterness, and neutralizing key triangles.*

The Treatment of Stage III

Philip J. Guerin, Leo F. Fay, Susan L. Burden, and Judith Gilbert Kautto

The hallmarks of stage III marital conflict are high emotional arousal, a polarized position of fixed distance, and a rampant projection process in which each spouse blames the other for the state of the relationship and has little or no self-focus. Attempting to negotiate the conflictual process or address it directly with structural tasks or experiments, without first preparing the way, will inevitably fail. The first two goals in treating stage III conflict are therefore to create a safe climate by lowering the emotional arousal and to increase self-focus in each spouse, which will help to neutralize the intensity of the reactive emotional process. These goals must be

achieved before the third major goal, strengthening the marital relationship itself, can be addressed.

The work toward the first two goals begins during the engagement process and continues throughout the entire course of therapy. To reach these goals, the therapist and the couple work in three key areas:

1. *Reactivity in the marital dyad.* The intensity of reactivity in the marital relationship must be lowered. It is especially important in stage III that the therapist keep his or her own anxiety down and help the couple to discipline their automatic reactivity.

2. *Key triangles.* During the evaluation period the major active triangles are identified and the process within each is determined. The therapist needs to be aware of the intensity and importance of each triangle before deciding on the sequence in which to address them.

3. *The individual.* The focus of the individual work is on reducing bitterness and helping people to take greater responsibility for their own lives. The degree to which disappointment and anger have turned into bitterness is assessed in each spouse, and each is put to work neutralizing those feelings of bitterness. Once the bitterness is less intense, both spouses are encouraged to develop personal goals in the areas of productivity, personal relationships, and personal well-being.

If progress is made in these three areas, the climate will gradually improve. Spouses will be better able to see their own parts in the conflictual process and to accept responsibility for change. Direct access to the marital relationship is then possible. In the final phase of therapy, the therapist attempts to prepare the couple for the inevitable recycling of the conflict and to reinforce the positive forces in their relationship by working on partnership, companionship, and intimacy in the marriage.

Stage III couples enter treatment in two major ways: in overt conflict or in covert conflict that is camouflaged by another symptom in one of the spouses or in a child. The largest percentage enter therapy in overt conflict and explicitly label the marital relationship as the problem they want to address in treatment. The possibility of divorce may be an open issue, or one spouse may have privately decided on divorce and may be seeking to have the therapist validate his or her hopeless view of the marriage.

When the marital conflict is covered by dysfunction such as depression or alcohol abuse or by a problem in a child, the couple will want that symptom addressed in therapy. If the therapist attempts to bypass the symptom in order to bring to light the underlying marital conflict, the couple may well terminate therapy. On the other hand, if the therapist perceives the marital conflict but does not begin to link it up with the symptom, the marriage may be driven into irreversible conflict once the symptom is alleviated.

The stage III treatment plan varies from couple to couple. Some work in each of the three areas—reactivity, triangles, self-focus—is done with every couple in treatment, but the time and effort devoted to any one area differs from case to case, depending on the process in the marriage that is most central to the symptoms and most accessible to intervention, the issues that

are presented, and the availability and motivation of each spouse to work in therapy. In each of the four cases used in this chapter a different area of the treatment protocol was emphasized or was very clearly illustrated.

The Treatment Protocol

Engagement with couples in stage III is made difficult by the intense emotionality that is always present. The efforts of even the most experienced therapists can be sabotaged by stage III couples who hold fast to their blaming stance and thwart the therapist's suggestions. In a successful engagement the therapist will calm both spouses' emotional upset, validate their pain without taking sides or necessarily agreeing with them, and instill hope for their individual emotional survival. This process of connection and validation or engagement must be maintained throughout the course of treatment.

REACTIVITY IN THE MARITAL COUPLE

The marriage, once a refuge from the pressure of the outside world, is now viewed as the source of pressure and pain. The therapy must provide a safe context for both spouses to explore themselves and their vulnerabilities. Therefore, lowering the intensity of reactivity from the very first session is essential to engage these couples successfully in treatment.

Decreasing Reactivity in the Sessions

The emotional climate in a stage III marriage is unsafe and stormy, with dramatic shifts in temperature and turbulence. Icy distance and heated conflict alternate in automatic cycles over which neither spouse seems to have any control. The couple's acute sensitivity to each other leads to volatile reactivity. Over time these cycles erode caring, open up emotional wounds, and create significant emotional damage.

The following case presented problems that required the therapist to create a safe climate in the session. Ellen and John D'Aiello, a couple in their mid-forties, married for sixteen years with four children, came for therapy in overt conflict. The battle began in the initial interview, as soon as the therapist asked each of them to describe the problem. Ellen was in a rage at John and attacked him for the affair he was having and for years of financial irresponsibility. John defended himself by picking on the details of her accusations and rationalizing his own actions as responses to her behavior. Had this process continued, duplicating their interaction at home, their anxiety would have increased and the therapist's effectiveness would have been compromised. The therapist therefore invoked a moratorium on the attacks and defense. He insisted that Ellen and John speak one at a time and direct their comments to the therapist rather than to each other. When one of them interrupted the other, the therapist gently but firmly reminded them that they would not get anywhere if that continued. If they had been unable to adhere in some fashion to this structure, the therapist would have divided the session and seen each of them alone.

When the therapist directed the discussion to the presenting problem, Ellen began to answer questions and describe events with an excess of detail. She wanted the therapist to know the time, date, and place of each atrocity that John had committed. When John got the floor, he

questioned the accuracy of each of these details. To keep the session from filling up with this kind of content, which would have escalated the already high level of anxiety, the therapist elicited just enough detail to get each person's picture of the issue and then moved the discussion to more productive ground by asking process questions developed from the content. This procedure begins to get people thinking rather than just responding reactively. The following transcript demonstrates the technique as well as other methods for changing the emotional climate.

THERAPIST: Now I'd like each of you to give me your view of the problem.

JOHN: I find she's very closed. She thinks I lie.

THERAPIST: You've got a credibility problem with your wife.
[The therapist labels the problem instead of going for details about the lies.]

ELLEN: I don't trust him. He's lied so much in the past.

JOHN: I haven't lied.

THERAPIST: There's a difference of opinion. How do you resolve differences of opinion?

[Again, the therapist is avoiding details and going after a broader process. This is an attempt to get them to start thinking in process terms rather than remaining caught in runaway emotional reactivity.]

ELLEN: I don't know. He just says, "I don't want to discuss it. We'll discuss it when we get to the counselor." And I didn't discuss it until I called the girl. My husband's been seeing another woman who works in his office for a year.

JOHN: No, I haven't been seeing her for a year.

ELLEN: She invited me to have lunch to tell me it wasn't true. My husband has been protecting her. I called her December 21st to tell her to stop seeing my husband. She said it wasn't true. Then she wrote a letter to my husband saying, "How did she find out?" Which he told me.

THERAPIST: You believed him on that. So there are some things you believe and some you don't. How do you know whether to believe the first and third rather than the second and fourth?

[The therapist is again asking questions that bring out process rather than getting bogged down in content. He is also attempting to get Ellen to begin focusing on herself.]

ELLEN: I'm perceptive.

THERAPIST: So it's your insides you rely on?

ELLEN: Yes.

JOHN: I would say she *thinks* she's super-perceptive.

THERAPIST: You think she overvalues her perceptiveness, relies on it too much, and that sometimes it's inaccurate?

[The therapist restates attacks so that they are easier to hear.]

JOHN: You have to be very careful about what you say.

THERAPIST: Let me kind of roll the wheels back. This thing around the other woman has kind of spun things out. There's a lot of anxiety around it.

[The therapist tracks the presenting problem.]

ELLEN: It's not the first time, either.

THERAPIST: When did this one surface?

ELLEN: He started going to Gamblers Anonymous meetings in April. I noticed he started talking about this girl all the time. I thought he was mentioning her too much. I asked him to have her desk moved away from his office. He lied and said the manager refused. Then I called December 21st. He said he wasn't seeing her, which was another lie.

THERAPIST: So back in April you started to talk about it, but you were just noticing that he was talking about her. You were experiencing your husband as missing in action, and you tied this girl to it. You saw him as moving away from you and the kids toward her.

[The therapist has begun to bring out the process around the affair. He puts it in movement terms.]

ELLEN: He had been up in the air because of GA meetings. I was upset by the GA meetings.

THERAPIST: Before going to GA I'd like to try to get a sense of . . . to compartmentalize this piece. Because you've just described something that's maybe a picture of how this relationship works. John, you've got a different picture?

JOHN: We did work together . . . in May . . . job organizing.

[John was giving countless details; Ellen had trouble staying quiet.]

THERAPIST: Ellen, you're in the listening position. [She laughs.] John, I'd like to stop you, because you're giving a lot of details. I'd like to get a sense of where you are. I'm asking you not to defend yourself, even though you feel like you're being attacked. Did you feel like you were available to your family?

[The therapist takes control by stopping the old pattern of interrupting. He attempts to get each of them to do something differently, Ellen to listen and John to stop defending himself.]

JOHN: Not as much as I could. I was in business for myself and tried to keep it going longer than I should. I've been with this new company for a year, and I tried to continue my other business.

[He described great pressure and blamed Ellen for not supporting him enough.]

THERAPIST: You're telling me you've been stressed by work. You don't think Ellen appreciates you. The other thing I hear you saying is that when you're stretched out it's difficult to stay tuned in to her.

[The therapist restates the process in a way that allows John to self-focus. He proposes another reason for the distance and validates both John and Ellen.]

JOHN: That's true. I haven't made plans to do things with her and the kids, the way others might have.

THERAPIST: Is it your style to be an involved father and husband if you weren't so stressed?

JOHN: I haven't been that involved over the years.

[This exchange helps to validate the pain Ellen has experienced without blaming John.]

THERAPIST: So you tend to be a distant guy, and when you get a little more stressed, you get more distant, and Ellen doesn't know what to do about it.

[The therapist sums up the process and avoids being judgmental.]

The therapist in this example was operating from principles that are critical for a successful beginning. First, he kept his own anxiety down and established control of the session in order to create a safe context for treatment. Second, he defined and dissected the process to offer a different perspective to the couple, rather than getting bogged down trying to referee the content. Third, he maintained a systems perspective and avoided taking sides with either spouse.

Another procedure that helps to decrease the intensity of reactivity in the session is to teach the couple about transition times. Stage III couples are usually going through a period of transition when they initiate treatment. Most often the conflict has been going on for a long time, but the added stress that comes from the transitions the family is going through intensifies it and leads

them to seek professional help. The transition times might include the loss of a job, a serious financial reversal, or a physical illness. It might also be a life-cycle crisis like the death of a parent, the birth of a child, the first or last child leaving home, or retirement.

The couple does not usually present these issues as particularly relevant to the current conflict. Their perspective is severely limited; they fall into rigid cause-and-effect thinking and tend to blame life's problems on their marriage and specifically on each other. By documenting the transition times the family has gone through, the therapist begins to introduce the idea that there are other reasons why the marriage is in trouble. The short-range goal is to broaden the couple's perspective and reduce anxiety by teaching them that a significant amount of stress has been building over the years as a result of these transitions and that it has had an impact on their marriage. The long-range goal is to help them to develop skills that will allow them to recognize when their relationship is being stressed by transition times so that they can avoid handling them with the familiar pattern of conflict.

When a transition time is mentioned by either husband or wife as the genogram information is gathered, the therapist takes time to explore the process around it in order to bring out the impact that the event had on the marriage. For example, if the wife mentions the birth of their youngest child, the therapist asks a series of process questions: Who had wanted the child? How had each of them responded to the pregnancy and delivery? What had changed at home after the baby's birth? Had either of them ever thought about the stress involved in adding a new member to the family?

As a number of transition times are mentioned, the therapist comments on the stress they must have produced. "You folks have been through a lot. I'm beginning to understand more about how your relationship got into this trouble." This says to the couple that their conflict is at least in part a result of stress and begins to teach them that marriage is a struggle that requires a great deal from husbands and wives. It also begins to address their secret fears that they are in this position because they are bad people.

Decreasing Reactivity at Home

If the couple is to experience the therapy as helpful, the therapist must begin early to give them suggestions for interacting differently at home. The therapist provides operating guidelines for each spouse that if followed will begin to calm the explosive system. During the evaluation of one stage III couple, Carol and Ed Rutkowski, who were in their early forties and had been married fifteen years, the therapist made two suggestions. First, they had to stop the physical violence in their relationship. Second, they had to take the pressure off the marriage.

Carol and Ed would go for days without talking to each other. Carol would break the silence to argue over one of the many toxic issues in the relationship, such as money, in-laws, or Ed's work. Their arguments frequently got out of control to the point of yelling and door slamming, and periodically they resulted in physical violence. Although Carol usually struck the first blow, she had sustained a number of injuries during their fights; the most severe had been a broken rib.

The first step in changing the climate at home was to address the physical violence. The therapist took a strong position, telling Ed and Carol that violence had to stop because nothing could

change in a climate where people were frightened or worried about their physical safety. The therapist explored the process around the violence and learned that Ed usually knew when Carol was about to cross that line. Ed was advised to distance physically from her when that happened.

For example, in the week prior to their first session Carol had been trying to get Ed to respond to some questions while Ed was reading the paper. The more she asked, the more involved he became in his paper. She pulled the paper out of his hands and started ripping it up. Ed sat staring at her until she attacked him physically; he then slapped her across the face and pushed her into a wall. The therapist used this example to teach them more functional behavior. Ed was coached to move to another room as soon as he realized the intensity of Carol's pursuit. If she followed, then he was to leave the house. Carol was coached to move toward another person or activity when she felt that kind of rage escalating in her. The therapist helped her look for the most positive resources she had to move toward. During the following weeks this behavior was carefully monitored in therapy.

When one spouse is the aggressor in the fighting and the other habitually stays around for the beating, the latter needs to be aware of a number of alternatives. He or she might have to call the police or a hot line for domestic violence or perhaps take legal action. Therapists need to know the law regarding domestic violence in the area where they practice as well as the resources available in the community. Sometimes couples are unable to put a stop to these explosive outbursts, and the therapist may have to advise a temporary separation.

In stage III conflict husband and wife spend a great deal of time and energy focusing on their relationship, generating intense pressure that must be alleviated if the emotional climate is to change. Carol and Ed's marriage was always on the table for dissection; it had become the third leg of a triangle. Whenever they argued, she would threaten to end the marriage, and he would attack her for even thinking about divorce. By the end of the first session the therapist knew that their relationship would have to cool off before they could approach it directly. In other words it would not work to prescribe a weekend alone for this couple or to suggest that they find more time to talk about their marital problems. To decrease the pressure on the marriage, the therapist asked them to refrain from discussing the relationship or any of the toxic issues between them outside of the therapy sessions. They were also asked to stop all talk about therapy. They were told that the marriage was too hot to handle and needed to be put on the back burner temporarily. The therapist specifically stated that in treatment a number of things, like changing the emotional climate, would have to be accomplished before they would be able to address the marriage directly.

This approach raised two questions. First, how would the therapist make therapy relevant to Ed and Carol when they had come in wanting help for the marriage? Second, how were they supposed to deal with each other when almost all of their interaction was devoted to conflict over the toxic issues in the relationship? Ed and Carol agreed that discussing their marriage had been unproductive and exhausting but blamed each other for that fact. The therapist let them know that in our experience with intense marital conflict, attempts to tackle the marriage in a more direct way had repeatedly failed and that the approach we were recommending to them had proved more successful.

This does not mean we promise couples that the marriage will necessarily be saved; if the couple is talking about divorce, the therapist points out that this will always be an option but that it is not a solution and should be approached in a slow, thoughtful way. The therapist is saying that their best chance of turning the marriage into a satisfying or positive relationship, or at least of minimizing the emotional damage to themselves and their children, is to begin by working on themselves rather than on the marriage.

If Ed and Carol were to avoid toxic issues and discussion about the marriage, they needed guidelines for interacting with each other in a different way. The therapist coached them to treat each other decently, the way one might treat a business acquaintance. They did not have to like each other, but they did have to find a way to be civil. The therapist asked them to describe their ideas of being decent and learned that they each had different and unrealistically high expectations about each other's "decency," and these were addressed in the session. A few minutes at the beginning of each of the early sessions were devoted to monitoring their progress on these tasks.

KEY TRIANGLES

Triangles are always numerous and intense in stage III conflict. The following case illustrates our approach to triangles, as well as to lowering the reactivity in the couple and the bitterness in each spouse. The treatment focused on three goals with each triangle: (1) identifying the triangle and revealing the process; (2) shifting each person's part in the triangle so that each could have a close personal relationship with the other two people; and (3) working to lower reactivity in the interlocking triangles.

Bill O'Rourke, an attractive forty-year-old man who operated his own plastics company, had been married to Barbara, who was thirty-five, very pretty and petite, for seventeen years. Both were Irish Catholic. They had four children: Joe, aged sixteen, Tim, fourteen, and twin girls, Kathy and Mary, who were ten. Barbara had called to make the appointment because of the acute conflict in their marriage, which currently revolved around two issues, Barbara's quest for autonomy and problems with their elder son, Joe. During the evaluation sessions the therapist determined that each of these issues involved a very active and intense triangle. In the struggle around Barbara's quest for autonomy, there was a triangle with her social network, and they had been in conflict around their eldest child since the time of his conception.

Work on these two triangles became the major focus of the therapy and took place in forty sessions over sixteen months. Membership varied according to the focus of treatment but usually included husband and wife alone and in sessions together. The therapist considered the child triangle too intense to handle until the spouses were less reactive and so she developed a treatment plan that initially focused on the social network triangle, hoping that if they made some progress there they would be better able to address the child triangle. In order to remain relevant to the family, the therapist addressed the child triangle whenever an issue with the eldest son came up, and there was substantial discussion early in the treatment about the long-term changes each family member would need to make. For the sake of clarity each triangle will be discussed separately, although the work on them was interwoven through the course of therapy.

Five years before coming to therapy, Barbara had started going to Al-Anon during a period when Bill had been drinking heavily. She and six other women from Al-Anon had formed a support group that had continued to meet up to the time she entered treatment. Encouraged by her group, Barbara had begun to explore ways to change her life. By the time therapy began she had been taking courses at a local community college for several years, had started a part-time job, and had begun pressuring Bill to allow her more control of the family finances.

Bill, who had started with practically nothing when they were first married and now owned and directed a very successful company, flew into a rage whenever she broached the subject of money. There was no way he would give her more financial responsibility, he felt, because she could not handle what she already had. Suspicious and negative, he believed that her every move was orchestrated by her "group." He would counter her requests for more financial control with "Whose idea was that one?" and would suggest that the group pay for the taxes incurred by "your ridiculous job that costs me money." Barbara would defend herself and her group, and the pattern would be repeated over and over again. This almost daily sequence was usually triggered by Barbara's absence from home at dinnertime, by a call from one of her group members, or by one of her demands for more financial autonomy.

Early in the therapy the therapist supported Barbara's goal of achieving greater autonomy and maturity. At the same time, she encouraged Barbara to review the three major efforts she was making and evaluate how well they were working. Barbara decided that her return to school was constructive and that she needed to focus her energy on academic goals. She decided to continue her part-time job but to postpone an increase in her hours in order to give the family a chance to adjust. A review of her request for more financial control revealed it to be premature. On the one hand, she was attempting to persuade Bill to put more of their financial holdings in her name and to give her more access to their bank accounts. On the other hand, she frequently wrote checks against insufficient funds and then would appeal to Bill to help her straighten out the mess when the monthly statement arrived. Barbara was demanding more financial autonomy from Bill rather than taking greater responsibility for the money matters already in her control. In therapy Barbara explored the sources of sensitization to this issue in the extended family, worked to objectify her perception of the conflict with Bill, and experimented with her behavior patterns in order to increase her functioning in the financial area.

If a couple is to have a decent chance of surviving a shift like Barbara's move toward autonomy, the spouse who is making the changes needs to be sensitive to the impact those changes have on the family. At first Barbara was defensive when the therapist explored this area. She said she thought her four children were supportive and proud of her and expressed little concern about the change. She labeled her husband a male chauvinist and attributed his angry response to his desire for absolute power and his lack of sensitivity to her needs. Not only did his critical reaction disappoint her expectations for approval, but it also triggered that part of her that was ambivalent about the steps she was taking. Her own fears about the changes surfaced and were explored, and the therapist then worked with her to understand the impact her new direction had already made, to observe the current reactivity of other family members objectively, and to predict what was likely to occur with each new step she took. The goal was to help Barbara stop her defensive behavior and lower her own reactivity while she continued her steps toward personal growth.

The therapist encouraged Barbara to address the way the group from Al-Anon was influencing her thinking and behavior. Clearly she valued their support, but she decided that some of their suggestions had increased her bitterness, which had led to an increase in provocative behavior toward Bill. When she used the group as a sounding board for her rage at Bill, they responded with direct advice that when followed inevitably escalated the conflict. Barbara worried about how the group would see her if she did not "stand up for her rights" with Bill. Coached to explore and experiment, she learned that moving toward individuals in the group for emotional connection and companionship, organized around her own struggle and without the negative discussions about Bill, worked in a much more functional way.

Bill's experience of the triangle was that he had lost influence over his wife. She was listening to someone else, the group. He was encouraged to reach for neutrality and to stop attacking Barbara's group. Bill discovered that part of his emotional discomfort was linked to Barbara's absence when she was not doing what she was "supposed" to be doing. He spoke of his fantasies of finding another woman, one who would appreciate him. As his dependence on Barbara continued to surface, he became more aware of his feelings of loss and their connection to his critical and angry behavior. When Barbara heard him talk about his sense of loss and his fear that if she had more financial independence she would leave him, she was surprised that he could admit his emotional vulnerability. She began to listen in a different way and to modify some of her polarized perceptions of their relationship.

Early in the work on this triangle, the therapist asked that the couple be seen by another therapist in consultation. The following transcript is from that session.

BARBARA: I have experienced things that now have led me into becoming more independent, more self-reliant. I feel more like a partner, and I don't think Bill likes it.

THERAPIST: Do you think he liked you as a victim?

BARBARA: Yes.

THERAPIST: What's your evidence for that?

BARBARA: I think Bill enjoyed that pattern of fighting and making up, and I accepted that for a very long time, and he expressed it monetarily on many occasions. Whether it had to do with his drinking or not is another question.

THERAPIST: You mean he'd make it up to you by giving you more money?

BARBARA: Yeah. You know, like mink coats and stuff like that. And it worked.

THERAPIST: So you've become more independent, and instead of giving you mink coats, Bill's complaining about $250 phone bills. Your independence has cost you a lot.

BARBARA: I know.

THERAPIST: Did your independence cost you anything in the relationship apart from money?

BARBARA: I think that I've been able to become independent very slowly, and that Bill has accepted it very slowly. I feel now he's become very resentful of my new job.

BILL: It interferes with my dinner.

BARBARA: It's interfering now with his life, and I recall him saying last night that he felt that the reason our son was having problems was that I was never home.

THERAPIST: Do you think it's really the absence of dinner, or is it something else?

BARBARA: I don't think I'll ever be able to please him at this time in the way he'd like me to.

THERAPIST: Have you stopped trying?

BARBARA: Yes.

THERAPIST: How long ago did you stop trying?

BARBARA: Not too long ago. I'd say ever since I started school this semester.

THERAPIST: So you're on the track of getting independent, and are you on strike as far as Bill goes?

BARBARA: I'm not on strike. I have to honestly say that the things Bill has asked me to do have been very low priority for me . . . and on the other hand, I try to do everything and be the supermother so I can have time to do things that are important for me.

THERAPIST: But have you lost in that whole process the ability to let Bill know how important he is to you?

BARBARA: I think, maybe he isn't important to me anymore.

THERAPIST: Do you feel bad about that?

BARBARA: I guess I do feel bad about that. I feel our relationship has been clouded by many things: family issues with our children, his health, my going to school, and I do feel—Bill is important to me, and I do love him, but I'm tired of trying to express certain things to him, and I feel very frustrated. It's like I don't want to bother any more.

THERAPIST: How come he doesn't hear you? What's the frustration?

BARBARA: I don't think he does hear me. I think Bill is devastated by my small steps toward independence.

THERAPIST: You mean like if you really loved him you'd stay in place and march to the same tune?

BARBARA: Right.

THERAPIST: And you mean what you'd like is to get a piece for yourself and somehow have him understand that doesn't mean you don't love him?

BARBARA: Exactly.

[In this exchange the therapist spells out the direction of Barbara's movement away from Bill in pursuit of other things. At the same time he attempts to validate her experience of the bind she finds herself in. He then proceeds to explore Barbara's expectations about what response her move for autonomy would evoke.]

THERAPIST: Did you expect your moving out to have fallout with Bill and the kids?

BARBARA: Yes, and I think that's why it's been so delayed.

THERAPIST: That's why you've hesitated for so long?

BARBARA: Yes. I think I've tried and pulled back and tried and pulled back, but I feel like nothing's going to stop me now. I feel better about myself.

THERAPIST: How come that isn't carrying over to everybody feeling better about themselves?

BARBARA: I don't know.

THERAPIST: If Bill ever said to you, "Dammit, Barbara, I never realized how dependent I am on you until you moved out and got all involved." Has he ever said that?

BARBARA: No.

THERAPIST: What would be your response?

BARBARA: I feel like it might put us back on the same ground again.

THERAPIST: Is it hard for Bill to make statements like that, even if he realized it?

BARBARA: I think so, yes.

[In addition to exploring Barbara's expectations, the therapist begins to bring out Bill's dependency and loss, at the same time modeling alternative ways Bill might communicate with Barbara. The focus then turns to Bill to see if he has picked up the message.]

THERAPIST: Bill, how many beers would it take to put that into words?

BILL: I guess I'm a cold person in that respect, and I suppose that's why I give gifts. I supported her college education. I was annoyed when she took the job from 6 P.M. to 9 P.M.; dinner's at 7:30.

THERAPIST: Let me go back. Are you cold inside or outside?

BILL: Probably outside.

THERAPIST: Inside you're not so cold. You have trouble getting it out there? You think that's because you never learned it?

BILL: Probably never learned it.

THERAPIST: Have you made an effort? You think an effort would be worthwhile?

BILL: Could be.

THERAPIST: Do you think Barbara would pick it up, or would it fall on rock?

BILL: I don't think it would make a difference. Now there are new conflicts coming into play. The kids' vacations don't coincide with Barbara's vacation, so Barbara says she'll have to take her own vacation. I don't know how to react to that.

THERAPIST: When you agreed to Barbara's going to school and being out there, did you know it would be as hard as it has been?

BILL: I thought it would be a daytime thing. I never gave a thought to vacations being cancelled.

THERAPIST: So it wasn't going to be on Bill-time; it was going to be on free time, and now it's gone over into Bill-time. Did it have more of an impact on you than you thought it would? Did you feel it?

BILL: I think she's going out faster than she should. My daughters don't like it either, coming home to an empty house.

[At this point the therapist decided he had done what he could to validate Bill, to give him a potential new pathway of perception, and to engage him in the process of therapy. He now turned and attempted to slow down Barbara's movement and modify her reactivity. Finally, he closed by reminding Bill of his dependency.]

THERAPIST: Now what do you think, Barbara, without defending yourself? Have you overcorrected? Have you gone too fast?

BARBARA: No.

THERAPIST: But as you pull out, there's bound to be fallout from it. That's totally predictable. The pace at which you pull out and the way you handle your move out will have more or less fallout depending on how you do it. That's not your responsibility to control all of that. The other folks have to handle their piece of it, but how do you know when you're moving out too fast or too slow, or losing your momentum or whatever? Or haven't you bothered to evaluate that?

[Barbara again becomes very defensive, intermittently crying.]

THERAPIST: It's such a toxic issue for you that it's hard for you to entertain questions about what you're doing without getting defensive and without getting scared of falling back, and that doesn't allow you to see the whole picture and deal with some of the pieces of it. I'd encourage you to do that. Bill, I want to get back to something. When I asked you before whether you could say to Barbara that you never realized how dependent you were on her, if you experienced that, could you tell her?

BILL: I think I have told her. As far as holding down the home fort, and keeping the kids in line.

THERAPIST: How about just your internal feeling of well-being?

BILL: Well, I haven't thought about that.

THERAPIST: If Barbara is going to look at the impact of what she is doing on the family, I think you need to look at your anger and at the internal, deeper feelings that it is covering up.

The couple's reaction to this session was mixed. Bill found it helpful and felt supported by the therapist. Barbara initially felt angry and defensive. She heard the therapist telling her that the steps she was taking toward independence, which she had considered painfully slow, were too ambitious. In the ongoing therapy, the regular therapist supported Barbara's frustration but continued to encourage her to evaluate the impact her change was making on the family. By the time they watched the videotape of the consultation several months later, Barbara's reactivity was significantly lower, and she was able to hear what was being said with much more objectivity.

Bill and Barbara made progress in their work on this triangle, although the process was slow because of the intensity of their conflict. In time Barbara learned to use her group in a more productive way. During one session, when she and the therapist were discussing why she

sometimes felt weak for staying in the marriage (a pattern we have noted with many women today), she was able to connect her feeling with the group's influence. She realized that she was the only one of the seven women who had not left a husband or a lover and felt that there was an underlying theme in the group that a strong woman strikes out on her own. Barbara began to entertain the possibility that it takes a great deal of strength to stay in a marriage and to work on making it better without giving up the goal of autonomy. When Bill fell back into criticism, she was often able to say with sincerity that she was sorry he was having trouble with her movement instead of defending herself. She learned to pace her moves in a way that minimized the impact on the family, and she made progress in taking more responsibility for financial matters. Bill learned to control some of his criticism and began to take risks in exposing to Barbara his vulnerability about his dependence. He also took steps in giving up some of the financial control.

To summarize, the clinical management of the social network triangle involves the following steps:

1. The triangle must be identified and the process brought out. Most commonly the wife is moving toward a woman, a group of women, or a body of feminist literature for support in her struggle for autonomy and away from her husband, whom she labels the enemy. The husband, in reaction to his wife's absence, pursues her with personal criticism and blames the outside influence for her betrayal.

2. Husband and wife need to shift their parts in the triangle. The husband must stop criticizing his wife, give her room to grow, and stop blaming the third party. He needs to identify his dependence on his wife and to explore the feelings of loss he is experiencing. The wife has to look at the way she has been influenced and the way she uses the other women and determine what is productive for her and what is not. She needs to set her own agenda for change, one that is based on a careful assessment of her needs but reflects sensitivity toward the family. When the steps that she takes conflict with her husband's desires, she must avoid being defensive.

3. To reinforce these shifts, both spouses need to focus on the interlocking triangles, which take them back to their families of origin to study the source of their scripting in the social network triangle.

The Child Triangle

Early in therapy the therapist brought to the surface the process in the triangle with Joe. Barbara was concerned about Joe's behavior in school and out. He was failing a number of courses and seemed completely unmotivated. She worried about his use of alcohol and about the group he associated with, and she feared that he might be using drugs. Bill agreed that Joe had problems but attributed them to the fact that his mother had overprotected him. That comment elicited a hostile diatribe from Barbara about the poor example Bill had set for his son. The intensity of conflict around Joe was immediately apparent to the therapist.

In this triangle, Barbara was moving toward Joe to protect him from his father and from the various schools he attended. She had initially felt that Bill was inconsistent and insensitive with Joe, but over the years her perception of his fathering had grown even more negative. By the time they started therapy she felt that Bill had always hated Joe and had wanted to get rid of him. She also considered her husband an alcoholic and blamed him for Joe's use of alcohol. Bill was extremely critical of Barbara's over-protective treatment of Joe, and the two of them were involved in a continuous attack-counterattack pattern.

Joe had felt protective of his mother since he was a very young boy. He remembered standing on his bed with his ear cupped to the wall, listening to his parents' raging fights and wanting to kill his father. When Bill and Barbara began therapy, Joe said his father was always picking on him, and he vowed he would never come in for a session alone with him. A graphic example of the process in the triangle occurred whenever Joe and Bill got into a fight. These fights always happened when Barbara was within hearing range. Bill would tell Joe to do something and then be enraged by Joe's passive or negative response. The interaction would quickly escalate until Bill was challenging Joe to fight "if you're so damned tough." The two of them would go into Joe's room, Bill would lock the door, and they would taunt each other until Bill finally hit Joe. Barbara, who had been listening from the sidelines and demanding that they stop, would run to Joe's room, screaming that she would call the police, and pound on the door until Bill opened it. Days of coldness between them would follow.

Once the triangle is identified and the process understood, work with parents who have lost control over their acting-out adolescent usually proceeds in one of two ways. Depending on the nature of the process, we might coach them to join forces in establishing critical but minimal rules and then to use the leverage they still have with their child in order to enforce them, or we might put one parent in charge of the child and move the other in another direction. In this case the conflict over the son was too intense to begin with either of these approaches. Getting the mother to join forces with the father when she was convinced he would rather see the son dead would only have fueled the conflict. Putting either one in charge and asking the other to move back when they were so hostile and critical about each other's parenting would have had the same effect.

The therapist began by taking a position on the existing level of violence. She said that any physical violence had to stop, because no one would be able to change in that kind of climate and there was a potential for something very serious to happen. Both spouses were encouraged to move away from the situation when they felt themselves losing control over their anger, and the way anger was being expressed was monitored from week to week.

This much was done early in therapy, and the primary focus then shifted to the social network triangle. Once Barbara and Bill made progress there, their capacity to change their thinking and behavior around the child triangle improved. When the therapist began to concentrate on the child triangle, she decided on a plan in which the mother would initially work only to stay out of the interaction between father and son but not back away from her relationship with her son. Meantime, the father would be working on improving his relationship with his son. The son would be encouraged to take more responsibility for himself in school and with the family.

Letting Bill and Joe handle their own disagreements was an extremely difficult task for Barbara. She seemed to know whenever there was a possibility that Bill and Joe would cross paths, and she made sure she was there. When the three of them were together, she always felt very tense and watched carefully for the moment when she would have to rescue Joe.

The first thing the therapist asked her to do was to monitor her own thoughts at those times when Bill and Joe were arguing. She reported a continuous inner dialogue filled with vituperative, blaming thoughts about her husband, which included the rehashing of specific incidents from the past when she felt Bill had been unfair or abusive to Joe. In order to stop monitoring father and son she needed to do something about the bitterness that had built up over the seventeen years of their marriage. The therapist followed the steps we use in working with bitterness, which are explained in detail in the next section of this chapter.

As work on the bitterness progressed, Barbara was coached to change her behavior when Bill and Joe were together. She began by leaving the room when things were calm, which was difficult enough for her because of her fear of the consequences. She viewed her role as Joe's protector in life-and-death terms. Gradually she was able to leave them alone together when stress was reasonably low.

The therapist's initial goals with Bill were to engage him in improving his relationship with his son, to bring out any softness and concern he felt for him, to explore his expectations of Joe, and to get him moving toward Joe in a more positive way. In his sessions alone, Bill expressed a desire for a better relationship with Joe, but in Barbara's presence he was cynical and negative about him. The therapist explored his model for fathering. He had always had a distant and conflictual relationship with his own father but a warm, satisfying relationship with his maternal grandfather. When Bill looked at the way in which his grandfather related to him, he realized that it was fairly close to the way he related to his second son, Tim. He treated Joe more as his father had treated him.

Five months after therapy began, an incident occurred that accelerated the very slow progress they were making on this triangle. Bill had had back surgery and was recuperating at home. Joe came home from a party obviously drunk and demanded the keys to the car. Barbara was out, and Bill told Joe that under no circumstances would he allow Joe to go back out because of the shape he was in. Joe became very aggressive, insisting he was fine, and began to push his way past Bill. Bill grabbed an antique gun from the closet and used it to block Joe's way, knocking him in the nose, which bled profusely. Bill, concerned that Joe's nose was broken, took him to the hospital emergency room for X rays. By the time Barbara came home, father and son were sitting calmly watching television, Joe's nose bruised but not broken. The younger children told her about the fight, including the fact that Bill had used a gun. She flew into a rage, screaming that she had always known Bill wanted Joe dead. She threatened to call the police but called the therapist first.

Once it was clear that both father and son were calm, the therapist encouraged her not to call the police but to bring the family in for a session the next day.

When they came in, Barbara was still raging about Bill's use of the gun. The therapist said she knew Barbara was very upset and could understand how the gun had really scared her. She asked Barbara just to sit and listen while she talked to Bill and Joe about the previous night. Bill summarized the events and defended his use of the gun by saying that he knew the gun, a collector's item, had missing parts and had not worked in years. He said he reached for it because he thought that it might stop Joe, and he knew he could not stop him without help because of his bad back.

The following is a segment from that session.

THERAPIST: What were you thinking about when Joe first came home?

BILL: I thought, "This kid is wasted—he'll kill himself or someone else if he gets behind the wheel of a car."

THERAPIST: So you were worried about him?

BILL: There was no way I was going to let him leave. Yes, I was worried.

THERAPIST: When you saw that he wasn't going to listen to you, did you consider other ways of stopping him?

BILL: I don't think I did such a bad job. I'm sorry about his nose, but it's probably the first time Joe and I have settled a fight. We were fine by the time Barbara got home, and she went completely crazy anyway. She should have stayed out of it. She thinks I should have called the police instead of stopping him myself. I never would have done that.

THERAPIST: What has prevented you from settling fights in the past? Why was this one different?

BILL: Probably because Barbara wasn't home. Usually we end up fighting whenever I'm pissed off at Joe.

THERAPIST: So then it's you against the two of them?

BILL: Yes.

THERAPIST: Joe, what do you think? You think you and your father worked it out?

JOE: Yeah. I think Mom made a big deal of it.

[Note that the process has shifted.]

THERAPIST: Did you know that your father was worried about you?

JOE: I heard him say it.

THERAPIST: Bill, you said Barbara wanted you to call the police and that you would never do that. Sometimes bringing someone in who's completely outside the family can help calm things down. Why do you feel so strongly about it?

HILL: My father once did that to me, and I wound up in jail for three days.

THERAPIST: Joe, has your father ever told you that story?

JOE: No. My mother told me something about jail, but I didn't know the details.

THERAPIST: How much do you know about him when he was your age?

JOE: I know he was wild, but not really too much else.

THERAPIST: Maybe that's something the two of you can do, Bill. Maybe you can fill Joe in about you at his age and about your relationship with your father. I think all three of you could do something different. Barbara, for you I think it goes back to what we've been talking about—taking the risk of letting the two of them work it out. Bill, for you it's working on controlling your anger when you're dealing with Joe, whether Barbara intervenes or not, because that's going to be very hard for her. And it's working on not fighting with her. And Joe, how are you going to stop providing the ammunition for your parents' fights?

JOE: I guess by not getting into trouble.

THERAPIST: What do you think they would do without you to fight over?

JOE: Fight over something else, probably.

THERAPIST: [To Bill and Barbara] Is he right?

BARBARA: We'd come up with something.

THERAPIST: Why don't you try that, Joe? Because it seems to me you keep yourself in a lousy position in the family by giving them so much ammunition.

The rest of the session focused on the couple's need for an issue to fight over and their uncertainty about what the marriage would be like without one.

The next important piece of work with this triangle was done around the choice of a new school for Joe. The advisors at his school, a large public high school, had recommended that he not return because he had not passed the year, and they felt the school could not provide the kind of

individual attention he needed. Both parents agreed that it was not the right place for him, but they were in conflict over an alternative. Most of the choices were boarding schools, which Barbara saw as Bill's way of getting rid of Joe. Bill had gone to boarding school as an adolescent and thought it might be a positive experience for Joe. He also admitted that it would be a relief not to have to deal with him on a daily basis. Joe ultimately chose one of the boarding schools. The therapist took the position that living away from home might be beneficial as long as nobody saw it as a solution to their relationship problems. They would all need to continue working. She also recommended that Joe work with a counselor or therapist at school.

Joe's initial adjustment to school was very positive. Bill went through periods of missing him and would occasionally go to sit in Joe's room— something he had difficulty admitting to Barbara. He also wrote letters to him, and there were phone calls and visits. After Christmas vacation Joe's grades began to deteriorate, and with eight more weeks left in the school year he was suspended for a week after he got into a drunken fight. He came home and wanted to stay there. Bill took the position that he had to finish the year, that coming home was not an option, and for the first time Barbara backed him up. Joe came in for a session with Bill during that week and said he never remembered his mother agreeing with his father on an issue that related to him. All three experienced the process as very different. Joe calmed down and spent the rest of the week painting the basement. He returned to school and did fairly well for the rest of the year, getting reasonably good progress reports from his teachers.

Barbara was able to join with Bill in saying that Joe had to return to school, but she described it as one of the hardest things she had ever done. Her struggle was by no means over. She continued to get caught defending Joe, although not as often, when she failed to make a conscious effort not to. She recognized that her interference only escalated the problems between Bill and Joe, and she developed some confidence that if she left the two of them alone they would eventually work it out.

Bill, too, had more work to do on this triangle. He still sometimes moved toward Barbara with his complaints about Joe, and he easily fell into a harsh critical posture with him. However, there was a softening in his overall approach to his son, and he was able to handle difficult issues in a much more functional way. For example, when Joe came home for the summer, Bill initiated a family meeting to establish house rules, allowing Joe to contribute his ideas and thereby minimizing the potential for heated conflict. Bill's expectations of Joe became much more realistic and flexible. He also became more sensitive to Barbara's difficulty in separating from Joe, and he was often able to keep his reactivity down when she got upset.
Joe began functioning at a higher level, having passed the school year and holding down a full-time summer job. He continued to have difficulty controlling his anger with his father and still moved toward his mother with complaints about him.

To reinforce the progress that each of them had made in shifting their parts in this triangle, the therapist focused on two of the interlocking triangles, one of which involved Bill, Joe, and Tim, the second son, and a second involving Bill, Barbara, and Tim. In the first, Bill and Tim were in a close positive relationship, and Joe was on the outside in conflict with both of them. Joe would criticize Tim for trying to be just like his father, precipitating a fight between them. When Bill intervened, it would be on Tim's side. The process of triangulation with Bill, Barbara, and Tim

was triggered whenever Barbara felt Bill was being unfair or abusive to Joe. She automatically turned on Tim with criticism or some kind of harsh behavior. As Bill went to work on his relationship with Joe, Tim began to act out, throwing tantrums at home and having problems in school. In a session with Bill, Barbara, and Tim, Tim was able to talk about the resentment he felt about all the attention Joe had been getting. Barbara, who had always focused so much on Joe, recognized her reactive behavior with Tim. She began to spend more time with Tim alone and to work on keeping her relationship with Tim separate from her relationship with Bill and Joe. Both parents were able to support Tim through a difficult period he was having in school, and he began to calm down.

The progress on the child triangle is exemplified by two brief anecdotes. On a family trip to Chicago each of the children had a different agenda for the day. Bill encouraged Barbara to go off with Joe, while he took the other three, a clear shift from his old position of raging about any time Barbara and Joe spent together. Second, Bill supported Barbara's desire to visit friends for a long weekend while he stayed with the four children. For the first time she trusted him alone with Joe, and Bill and the children had a very positive weekend, during which Joe assumed some of the responsibility for the younger children.

In summary, the clinical management of this child triangle involved the following steps:

1. The triangle was identified and the process brought to light. The wife was in an overly close position with the eldest son, and the father was in a distant, conflictual relationship with his wife and son.
2. The husband, wife, and son all needed to shift their parts in the triangle. The wife had to give up her role of protecting her son from his father and work on establishing a separate relationship with each of them. The husband had to stop taking his complaints about his son to his wife and work on a more positive relationship with both of them. The son had to stop complaining to his mother about his father and work on taking more responsibility for his own life. The husband and wife had to join forces around the important parenting decisions, and all three of them had to take responsibility for the way in which they expressed anger.
3. To reinforce these shifts, the major interlocking triangles were addressed.

ADDRESSING BITTERNESS

In stage III conflict husband and wife have gone beyond being disappointed and angry that their expectations for marriage have not been met. Bitterness has built up in each of them, and one or both may have turned off the emotional switch that keeps them vulnerable to the pain in the relationship. If the bitterness is not addressed and reduced in therapy, neither will be able to begin taking responsibility for self, which is essential for a resolution of conflict and successful treatment.

When a stage III couple presents for treatment, one spouse, usually the wife, articulates the bitterness first. Alan and Jan Goldman were a good example of the clinical picture we see most frequently. They had been married for seven years, and for the two years prior to therapy they had been in stage III conflict. They married after college, and Jan immediately gave responsibility for handling all important decisions to Alan. He took care of the finances and

decided where they would live, when they would buy a house, take vacations, or buy a car. Jan was initially comfortable with the arrangement, but several years into the marriage she began to resent it. She pursued Alan to change, wanting him to be more supportive and understanding and to encourage her independence. When she attempted to do something on her own, efforts that were fueled by her voracious appetite for consciousness-raising literature, she found him critical, un-supportive, and undermining.

Alan did not respond to her pleas for therapy until she had gone into a deep freeze and talked repeatedly about leaving him. When he did come in, he was much more in touch with his fear about losing her than he was with his own bitterness, which did not surface until the threat of divorce diminished.

The effort to decrease Jan's bitterness included seven steps typical of our approach to bitterness in stage III couples:

1. Bringing out and working on the fantasy solution
2. Identifying and labeling the "bitter bank" and reframing it as self- destructive
3. Tracking bitterness back through the progression from expectation to alienation
4. Researching the bitterness as a generational pattern
5. Changing the perception of Alan as the enemy
6. Working with the emptiness that comes when the bitterness is gone
7. Developing personal goals and working to reach them.

Working on the Fantasy Solution

In stage III conflict at least one of the spouses has a fantasy solution, an idealized answer to the problems of life and marriage: the death of the other spouse by natural or unnatural means, divorce, life with another person, or living alone. The person reactively moves away from the spouse and marriage and toward the fantasy. He or she is usually not doing anything active to reach the solution but is spending a great deal of time thinking or dreaming about it. When people create fantasies that involve life without the spouse, they have given up the hope that life would be better if the spouse changed, because they no longer believe the spouse can change. As long as they are absorbed in this kind of fantasy thinking, their motivation to look at their part in the process and begin work on the accumulation of bitterness will be minimal.

In some cases the fantasy solution spills out in the first session, and in other cases the therapist needs to bring it out. During the first two sessions with Alan and Jan, the therapist asked them what would have to happen for things to improve, and Jan responded that she did not see any way out of the mess they were in. However, when the therapist saw each of them alone during the third week, Jan started her session by saying that, in fact, she did often think about a solution to their situation: for one of them to die. She had no thoughts about committing suicide or murder, but she often thought about Alan's dying. She did not focus on the way he would die but rather on the fact of his being dead. She could picture the funeral and people coming back to the house afterwards. She imagined feeling a mixture of sadness and relief. Her fantasy did not extend into the future except that she was aware of the sense that the slate would be wiped clean

and that the future would at least hold possibilities. The therapist asked how much time was devoted to these thoughts and learned that they occupied her mind at least some portion of every day.

This exploration became a valuable stepping-off point for further treatment. For instance, the fact that Jan had settled on this particular solution rather than looking at other options like separation or divorce or changing the relationship revealed her inability to make active decisions and choices in all aspects of her life. The therapist tracked this powerlessness back into her family of origin, where her father had made all important decisions for her mother, her older sister, and herself. They identified this as a problem she would need to work on.

Once the fantasy had surfaced, the therapist began to test the reality of its central elements. What would life really be like without Alan? Had she thought much about the kinds of decisions she would make? Would there be anything she would miss about Alan? What would she regret about the marriage? The therapist's goal was to get Jan thinking about a more active and functional plan for the resolution of her problems. It is important that the therapist explore the fantasy solution rather than fight it, in order to avoid winding up in a triangle with the creator of the solution. Through these questions the therapist must convey the idea that it is dysfunctional to spend so much time and energy dreaming about life without the other spouse, because that is a way to avoid changing.

Sometimes the person does not give up the fantasy and moves toward playing it out, particularly when it involves leaving the marriage. The therapist must point out that there is a functional way to leave a marriage, which is to do it as non-reactively as possible, without blame, and knowing one's own part in the relationship.

When the fantasy solution is an open issue in the relationship, the other spouse often tries to fight it, and the therapist has to coach that person to pull back. In one case, for example, whenever the wife began talking about her desire to live alone, her husband attacked her. He said she would never be able to do it because she did not know the first thing about supporting herself, and he labeled her immoral for even thinking about leaving her children. The therapist asked him to refrain from this kind of behavior, pointing out that it only intensified his wife's desire to leave.

When the fantasy solution is not open in the relationship and is described in an individual session, the therapist must use clinical judgment about making it known to the other spouse. In a case like Alan and Jan's, where the solution involves the imagined death of one spouse, revealing it is sure to add more fuel to the fire, but themes inherent in the fantasy can be introduced into conjoint sessions. For example, the therapist might bring up with the other spouse present the feeling of powerlessness and futility that are inevitably a part of that kind of wish.

The 'Bitter Bank'

Once the fantasy solution has been explored and the person has in some fashion agreed to do some work before making a decision to leave, the focus of treatment turns to what we call the "bitter bank": the accumulation of bitterness that builds up over time. People in stage III marriages come into therapy so focused on their spouses as the cause of all hostile feelings that they have little awareness of the degree to which bitterness has taken over their own emotional lives.

The "bitter bank" is a useful term for a variety of reasons. People generally respond to it in a positive way and usually take part in embellishing the image with additional banking vocabulary. It creates a tangible image that helps to draw the attention of the bitter person back from the spouse to himself or herself. The therapist labels the complaints one spouse relates about the other as coming from his or her bitter bank. For example, in one of the early sessions Jan began describing the sins Alan had committed through the course of the marriage.

THERAPIST: It sounds like you've been storing up a lot of bad memories for a very long time, and that maybe a kind of bitter bank has built up.

JAN: Yeah, I guess it has.

THERAPIST: Do you have a sense of how often those old tapes play in your head?

JAN: You mean any negative thoughts about Alan? [She laughs.] How many times do these thoughts cross my mind? I guess pretty much of the time. He'll say something, or do something, or something will happen that will just remind me of something that happened in the past.

THERAPIST: You mean something happens that triggers the old tapes, and you'd say that that's a pretty constant kind of thing?

JAN: It's so constant because he keeps doing the same old things. Like he'll say something critical of me in front of other people and then that will remind me of all the times he's totally humiliated me in the past, to the point that I try to avoid going out with other people or having friends home.

THERAPIST: That's really what I mean by a bitter bank. Each time something happens you make a new deposit, and over the years it all collects interest until by now you're really sitting on top of something big.

JAN: Yeah, God, if it were only money, I'd be a very rich lady.

THERAPIST: Have you ever thought about the kind of price you pay for living with so much bitterness? I mean you're telling me you think about it most of the time.

JAN: Sometimes I wake up in the middle of the night with those same tapes playing, or else I can't get to sleep.

THERAPIST: So the feelings affect your sleep. How much do they interfere with your job or with having a good time?

JAN: Who has a good time? I'm okay at work most of the time. Sometimes I can't really shake it at work.

THERAPIST: Where do you think you'd be five years from now if this were all to continue?

JAN: I worry about that because I can see that it's eating me up, but I can't see it getting better as long as I'm with Alan.

THERAPIST: I've seen people end a marriage filled with the same kind of bitterness you've got, and it doesn't automatically go away.

Jan, like other stage III spouses, needed to recognize that living with that bitterness had become a way of life that was more destructive to her than to anyone else. In order to get her to see that, the therapist helped her to identify the bitter bank as something that was hers and to see that the time and energy she devoted to it prevented her from developing more productive aspects of her life. The therapist did not at that point challenge her notion that Alan was a scoundrel—that would have inhibited the engagement process—but rather emphasized that she needed to get her emotional life back under her own control.

Tracking Bitterness Back

Once the person accepts the view that there is something to be gained from working on this bitterness, the therapist begins to guide him or her back through the steps of the expectation-to-alienation progression. Jan was encouraged to study the emotional roller coaster she had been on through the course of her marriage. When she started therapy, she was very clearly on an island of invulnerability. She was reluctant to get out of that position, because it would mean again being vulnerable to the old hurt.

The therapist guessed, and Jan agreed, that since she was probably getting more of a response from Alan than she had in the past, she might be worried that he would go back to his old ways if she ventured off that island. The therapist acknowledged that possibility but emphasized that the purpose of giving up the bitterness is not to get more from Alan but rather to save herself from a dysfunctional and unhappy life.

The research began with the numb phase that Jan was in. The therapist asked her to describe it and to try to pin down when it began. She thought her switch had gone off three or four months before they came to therapy. Alan had described this period as "her deep freeze" in the first session and it was what had gotten him into therapy. The therapist explored what led up to her reactive distance and then got her to look at the stages prior to it.

THERAPIST: If you had been keeping a journal of your thoughts and feelings through the marriage, what would the recent entries say?

JAN: It would sound pathetic probably, so defeated, trapped and defeated. I'm trapped because I've wasted all these years with a man who's incapable of loving. I would write things like "slow death" and "terminal torture" to describe what this marriage has been like. I'm scared about leaving because he's made me so dependent. I know I allowed myself to get that way, but that's the way he wanted it. I don't have the energy to start over; by the time I did it would be too late to have kids so I just feel stuck and defeated.

THERAPIST: Were you saying much to Alan about your thoughts in recent months?

JAN: We've gone through periods of not talking before, but this one has been different. I feel different, and I know exactly when it started. A few months ago an old friend of mine was in town. I hadn't seen her in years; we grew up together. She stayed for a weekend and it was a disaster. Alan was so rude, terrible to her and horrible to me, insulting me, and he kept turning the heat down. It was freezing; we could see our breath. That's something we've been fighting about for years. He thinks the heating bills are too high. He was at his worst, and I just gave up. I fell apart, and I've been shut down ever since. I just don't care anymore.

THERAPIST: So before that, when you cared, how was it different? What would your journal say about that period?

JAN: I was angry all the time, raging; most of the time I wanted to kill him. That's how I was for years, since the time when I started trying to change, to grow up, and he was trying to hold me back every step of the way with his criticism and negativity.

THERAPIST: Tell me what it felt like to be that angry. Try to describe it.

JAN: When it was really bad, it was like acid burning a hole through me. I wouldn't be able to focus on anything else. If I tried to read or do anything, my mind would jump back to whatever he did. Some people talk about seeing red when they're angry; I had a headache. Most of the time I had a headache.

THERAPIST: Do you remember a time when you weren't angry with Alan?

JAN: That would be hard. No, it wouldn't. I wasn't angry before we got married, and for the first few years things were okay. They really weren't okay, but they were quiet. I'd get my feelings hurt a lot, but I wouldn't say anything. I remember being very sensitive and surprised when Alan wouldn't respond to me. He wasn't affectionate after we got married, and he had been before. If I made some tiny attempt to talk to him, he'd clam up or act like I was crazy.

THERAPIST: You had expected that the affection and all that good stuff from your dating days would continue?

JAN: I guess I did. Stupid, huh?

THERAPIST: So if I read this journal, the story of a wife's emotional life, I'd learn about a woman who had certain expectations about the marriage and who spent a few years being disappointed and hurt when those expectations weren't met. Then she got angry about it all and spent a lot of years raging at her husband until she just gave up and got numb to the old hurts. Is that about it?

JAN: Pretty close. I said it was a pathetic story.

THERAPIST: If it ended there, I'd have to agree. It wouldn't be a very cheerful story, but I don't know where you're going to end up: stuck on this island sitting on a mountain of bitterness or back in charge of your own life.

The purpose of tracking the course of each spouse's emotional life through the marriage is to begin to get them focused on themselves rather than each other. By labeling the steps they have gone through, it begins to give shape to the painful and powerful feelings that have controlled their lives. It attempts an answer to the question, "How did I get to this point?" and begins the process of saying "These are your feelings. You have gone through a process that has brought you to this point. You have to take responsibility for changing this course." It also provides an opportunity for the therapist to be supportive by listening to the struggle the individual has been through without fueling the fire by encouraging the unstructured ventilation of feelings.
In the segment just quoted, the therapist took Jan from her island of invulnerability back through the bitterness, rage, hurt, and disappointment to the expectations that were not met in the marriage. This step is taken more than once during treatment, with the purpose of getting the person to describe each of the stages. There is a tendency for stage III people to say, "I was in a rage all the time because he (or she) did this and this to me." Our effort is to help people learn to articulate their own feelings: "I was in a rage, and this is what it felt like."

This is not the time to confront people when they make blaming statements. If a wife says, "I'm bitter because he made me dependent on him," the therapist guides her back to a discussion about her own experience with bitterness rather than asking her what her part in the process is. (That will be addressed when the bitterness is less intense.) The therapist who sees the expectation-to-alienation progression operating in person after person will be able to convey the fact that it is a predictable pattern in people with severe marital conflict. Knowing this helps people to build confidence in the capacity of the therapist to help them through what had felt like a hopeless situation. The exploration of the progression should end up presenting a challenge to the individual: "This is how you got to this point; now what is your next step? Do you stay on the island, or are you ready to begin to move in a new direction?"

The exploration of the progression also provides the therapist with the opportunity to move into the extended family, reinforcing the idea that one had an emotional life before marriage. After the person has described a particular stage, the therapist asks whether those feelings are familiar. This question often triggers memories of a particular period in the past and of a relationship that evoked the same feelings. Jan said she had felt the same kind of hurt she experienced in her marriage with only one other person, her mother. Her mother, who had been hospitalized twice for depression, had never been able to respond positively to anything Jan was pleased about, from school achievements to efforts she had made around the house.

Sometimes the person denies that there is anything to compare these feelings to, holding fast to the story that "I was a happy person until I met him." Rather than fighting this stance, the therapist might simply ask the person to think about it during the week.

We spend a fair amount of time with people focusing on the expectations that began the emotional progression. One of the phenomena about expectations that is particularly interesting and clinically relevant is the way in which people in conflictual marriages have pitched their expectations toward their spouses' greatest weaknesses rather than toward their strengths. For example, one woman complained bitterly about the fact that her husband never verbally expressed affection. He never said he loved her or complimented her on the way she looked. The expectation that this kind of behavior should be a part of any marriage had led to years of bitter disappointment. The reality was that this man had never been good at expressing affection. In his family of origin he had been nicknamed "The Stone" and was seen as a "chip off the old block," his father. Silent men with disappointed wives were scattered throughout the genogram. What this woman was expecting from her husband was probably one of his greatest areas of incompetence. In therapy we point out this incongruity and encourage people to work on identifying the strengths in their spouses and then pitching their expectations in that direction.

Bitterness as a Generational Pattern

The effort to decrease the blame directed at one's spouse and take responsibility for one's bitter feelings can be helped by exploring bitterness in the family of origin. We have found that when there is a great deal of bitterness in one person, there is usually a pattern of bitterness in other family members across the generations. By asking questions such as, "Whom would you describe as bitter in your family?" "Did anyone see himself or herself as a victim?" "How much blaming did you hear as a child?" the therapist enables the person in treatment to see that his or her feelings are not unique in the family.

Jan and her sister often heard their mother's litany against her husband. He had destroyed her life because he was miserly and sour and had prevented her from having friends or doing anything worthwhile. Jan could remember these laments going back to her early childhood. Her maternal grandmother had been abandoned by her husband and forever after lectured her offspring on the injustice men perpetrated against women. As she surveyed her genogram on her maternal side, she realized she had heard only negative stories about men. She believed that her father also lived with a great deal of bitterness, but he had been less verbal about it. His dissatisfaction was expressed around his job and politics.

Jan began to see that bitterness was common in her family and recognized that she would have to struggle to avoid a pattern that was part of her heritage and that was fast becoming a way of life for her. This process further developed the idea that there was more to the making of her emotional state than Alan's behavior. The therapist did not try to convince Jan that bitterness had been passed down through the genes in her family, but rather that there was a possible connection between her own feelings and those of significant members in her family of origin. Perhaps bitterness in previous generations has an effect on the expectations offspring take into

their marriages, making them greater in order to compensate for the disappointment that others have experienced.

Changing the Perception of Enemies and Victims

In stage III conflict each spouse sees the other as the enemy and himself or herself as victim; each believes that the other is motivated by the desire to hurt. Changing this perception so that people begin to understand that they have more power in the relationship than they believe is a critical step in letting go the accumulation of bitterness. We address this problem through a process of behavioral change on the part of the "victim" and by expanding the view that the person has of the spouse. The change in behavior involves three steps: identifying the enemy/victim behavior pattern, changing the behavior, and evaluating the system's response to the change.

To identify the enemy/victim behavior pattern, the therapist working with Jan looked for specific situations in which Jan was clearly operating as a victim. For example, Jan had complained bitterly about Alan's excessive reaction when anything happened to the car. If she got a flat tire, a parking or speeding ticket, or a dent, Alan would fly into a rage.

THERAPIST: What happened when you first saw the dent? What were your first thoughts?

JAN: I was thinking, oh, Christ, he's going to be pissed. He goes nuts about the car.

THERAPIST: So your very first thoughts were about Alan's reaction?

JAN: Yeah. Yes, definitely.

THERAPIST: What did you do when you got home?

JAN: I was really nervous. I didn't say anything at first. I was afraid he'd notice it, but he didn't come in through the garage. Then he had to take the car after dinner, so I knew I had to say something. I guess I just blurted it out, and he started screaming, and I screamed back, so it turned into a major brawl, all over a stupid dent.

THERAPIST: You really had him pegged from the beginning, huh? I'm struck by the amount of fear you felt. You really saw him as the enemy in that situation.

JAN: I know how he reacts to those things, so, yes, I saw him as the enemy.

THERAPIST: It's funny how your own reaction to the dent wasn't even a part of the discussion with Alan. If you were living with a friend, and you came home after seeing that dent, what would you have done?

JAN: I probably would have told her that some jerk ran into my car in the parking lot and didn't even have the decency to identify himself. I'd probably say how frustrated I was.

THERAPIST: Have you ever tried that with Alan? You know, acting as if he were a friend in one of those situations where you expect him to blow up?

During the next session when Alan was present, Alan said that in situations like the dent episode he felt enraged because he never felt as though he had heard the full story. He saw Jan as a sneak, clearly the enemy, and believed she hid things from him in a malicious way. That was a pattern that went on in his parents' marriage. His mother often kept things from his father and confided in Alan; he viewed his father as a weakling for believing her ridiculous stories.

Once the therapist had brought out Jan's pattern of behavior in situations where she saw Alan as the enemy—becoming overly focused on Alan's reaction and in a high state of anxiety withholding information, blurting it out only when it was certain to be discovered—the second step was to change her victim-like behavior. By asking Jan how she would respond in a similar situation with a friend, someone she did not fear or see as all-powerful and larger than life, the therapist helped her identify a more functional behavior. The therapist then coached Jan to introduce that behavior into the relationship with Alan. This was extremely difficult for her to do, as it is for most people. She was being asked to change her part of the process with no guarantee that Alan would change his.

The therapist encouraged Jan to talk about the fear she felt when she even contemplated dealing with Alan in this straight, "friendly" way. They tracked that fear back to her family of origin, where the stakes seemed so high for any infraction that Jan learned to be a perfect little girl who carefully hid anything that might displease her parents. Her automatic response to Alan had its origins in a pattern that began long before she met him.

Jan's attempt to change this pattern occurred in stages. At first she was able to recognize the situations where she was triggered but was unable to change her behavior. Then she would catch herself in midstream and make awkward attempts to correct her part. Finally she was able to exercise enough control to change her behavior before she fell into the old pattern. The therapist predicted these steps and supported her through them.

After the person succeeds in some attempts at changing the victim behavior, the final step is to evaluate the system's response to that change. What does the spouse do in response to the new behavior? The therapist warns that the spouse might be unsettled by it and might try to get it back on familiar ground, even escalating his or her behavior to do so.

In Jan and Alan's case Alan was at times able to step out of his pattern and respond in a calmer way. Jan saw that the old pattern shifted when she changed her behavior, and recognizing that her behavior clearly had an impact on their relationship helped to change her perception of herself as a powerless victim. Her perception of Alan had also been altered through the course of treatment as she learned that he had been as reactive to her as she had been to him. The sources of this reactivity were explored in their sessions together, and Jan began periodically to rekindle some of the sensitivity she had felt toward Alan early in their relationship.

Working with the Emptiness

People who struggle through this work and give up the bitterness that has been consuming a substantial part of their emotional lives are likely to feel depleted and drained. Much of the content and process of their lives have been organized around bitter feelings, and when these are gone, people often experience a profound emptiness. There is nothing to take the place of the internal dialogues replete with blame and anger. People are left without a language to speak or a framework for their thoughts. This is a vulnerable, raw time, which must be handled with sensitivity by the therapist.

Fogarty has written extensively on this aspect of treatment (1976b, 1976c, 1979a), and we rely heavily on his thinking. We teach people to describe the emotions they are experiencing and through that process to develop a new personal language to replace the old bitter dialogues.

Personal Goals

As long as people are consumed with the kind of anger and bitterness that is part of stage III conflict, they typically have little energy for working on personal goals. Once they have stopped blaming their spouses for the disappointments in their lives, there is at least the potential for developing goals and working to achieve them. The therapist can help this process by encouraging the person to evaluate his or her functioning in the areas of productivity, personal relationships, and personal well-being (see chapter 5). For example, in evaluating productivity one would ask about the person's level of satisfaction with and functioning in work and something about the kinds of career dreams he or she has had in the past and present. When the person develops a goal, the therapist helps to identify the strengths and limitations that might either aid in achieving the goal or make it more difficult to reach. The same process is followed in the areas of personal well-being (health, diet, exercise, grooming) and personal relationships (social network, nuclear and extended family)—always with an eye to current functioning.

Jan made progress on developing and achieving personal goals in all three areas. For example, she had been a special education teacher since her college graduation, and after the first few years she had grown to hate the job. She tended to become overly responsible for the students in her class and finished each day physically exhausted and emotionally drained. Once her life was less dominated by the bitterness toward her husband, she was able to focus on getting greater satisfaction from her work. She made an effort to increase her functioning at her teaching job by addressing the issue of overresponsibility, but at the same time she began to explore two fantasies she had had over the years: writing and owning a restaurant.

The process Jan went through to explore her writing ability clearly illustrates the ways in which the marriage can be used to inhibit personal growth. She began taking a creative writing course at night in the city, which quickly became a source of conflict with her husband. Alan would stress the danger in driving at that late hour to a "bad" part of the city. He pointed out that she would have trouble parking, and that weather conditions were likely to be bad during the winter. Jan's automatic reaction was to become defensive and to accuse him of not wanting her to do anything positive for herself. The process between them covered over her own very great fears

about driving to the city and about taking the course, where she would be exposing her writing to the scrutiny and criticism of others.

The therapist worked to shift her attention from her husband's reaction back to herself, to explore her own personal fears. Jan was coached to give up her defensive behavior with her husband, to thank him for his concern, and even to agree with him periodically: "You know, you're probably right; I may be crazy to go out on a night like this."

To reinforce her new effort to get unhooked from Alan's reaction, the therapist helped her to track the issue back to her own extended family. How difficult was it to grow, to take on new challenges in her family of origin? Jan felt that every move out of her family had been frowned upon. She thought her father had a strong need to keep his women at home, and her mother seemed unable to go against his wishes but blamed him bitterly for prohibiting her growth. She never struggled to establish or achieve her own goals. When Jan studied the families each of her parents had come from, their roles began to make more sense.

This process is typical of the way we approach work on personal goals in any of the three areas of productivity, relationships, and personal well-being. First we assess the current level of satisfaction and functioning in a given area. Then we encourage people to define goals for themselves. These goals may come from dreams or ambitions they once had and had given up, or they may simply be the next step in improving their level of functioning in a given area. Next we help people develop a plan for achieving the goal and we focus on the ways in which marital or personal factors may be inhibiting progress. Finally we track those factors back to the family of origin.

Working with the Other Spouse

Husbands and wives rarely go through this individual work on bitterness and its accompanying problems at the same rate. The difference often throws a relationship off balance, with one growing faster than the other. In the ideal situation, both get to the point where they have stopped blaming one another and are taking responsibility for themselves. They are then ready to focus on strengthening their marriage.

Situations like Alan and Jan's are much more typical. One spouse comes in consumed by bitterness, while the other's bitter feelings are less available, concealed because of a long-established pattern of distancing—including distancing from his or her own feelings—or because the fear of losing the relationship takes precedence over bitterness for the time being.

This situation leaves the therapist with the task of working with two spouses who are at very different points. The beginning steps that the bitter spouse is taking through the bitterness protocol are likely to be very difficult for the other spouse to sit through. To detoxify that process for the other spouse, we do much of the initial work on bitterness in sessions alone. We also help the other spouse to understand the necessity of that work and find the personal strength to handle it, perhaps exploring the strengths that got him or her through particularly difficult times in the past. Then we attempt to engage the other spouse in work on one of the key triangles. When the bitter spouse has made progress in minimizing the bitterness and has set to work on personal

goals, the other spouse may be just beginning to experience some of his or her own bitterness. This bitterness can be exacerbated by the belief that the other is moving away. At that point we try to decrease reactivity to the work the other is doing on goals and shift attention back to personal growth.

SECTION II-B: THE CHILD-CENTERED FAMILY

The following paper, which Guerin wrote with the late Edward Gordon, lays out a theory and protocol for the treatment of families who present with the child as a symptom bearer. The authors make the point that the therapist MUST relieve the symptom in the child before he moves on to what might well be the central problem: the parents' marriage.

This paper was first published in 1984 in Models for Family Change, *edited by Charles Fishman and Bernice Rosman (Guilford). It was reprinted by permission in CFL's journal,* the family. *It is the definitive statement of the authors' model for treating symptoms in children.*

Trees, Triangles, and Temperament in the Child-Centered Family

Philip J. Guerin, Jr., M.D. and Edward M. Gordon, Ph.D.

The child-centered family is by definition a family that presents clinically with the child as the symptom-bearer. The child's symptoms may take the form of an emotional dysfunction, a physical dysfunction, or a relationship conflict. The designation "child-centered" is one category in a symptom-based typology of families developed by the authors at the Center for Family Learning. This typology frames the symptom as an expression of the system-wide dysfunction through its most vulnerable member, the symptom-bearer. The purpose of the typology is to help organize and clarify the conceptualization of family process around a particular type of clinical situation. If we can arrive at a standardization of such a typology and a refinement of the conceptual model for it, then, in the authors' view, we shall also have an increasingly effective system for staging clinical interventions and making accurate prognoses. A not less important corollary benefit of this approach is a framework for evaluating clinical results. We examine change from a baseline we call the "premorbid" state of the family, which we discuss later.

As this chapter unfolds, we will attempt to present the current stage of our development in conceptualizing, treating, and evaluating our work with child-centered families. We have chosen to elaborate on child-centered families in recognition of, and out of respect for, the major contribution of Minuchin to this area of family psychiatry.

Family therapy of child-centered families has made great strides in the past decade due mostly to the work of Minuchin and his staff and faculty at the Philadelphia Child Guidance Clinic. To

understand the significance of their contribution, one must remember that in the late 60s and 70s the majority of family therapists, faced with a child-centered family, would have invested considerable energy trying to convert the child problem into one of marital conflict, attempting to sell the family a course of family therapy. This resulted either in the parents' feeling more guilty and responsible than when they entered the therapist's office, or in their departing in anger to find a child therapist who would understand what they were talking about.

The coming together of Minuchin and Haley in Philadelphia was a fortuitous development for the field of family psychiatry. While Minuchin and Haley certainly had their differences in perspective – Minuchin from his early work with Ackerman and then his project at Wiltwyck, and Haley having been influenced by Bateson, Erickson, and Jackson – they shared a fascination for proving the possibility of the impossible. They saw nothing to be gained from blaming families for therapeutic failures by labeling them unmotivated. Their styles and skills complemented each other beautifully – Haley the calculating strategist, Minuchin the consummate clinical artist. If nothing else, their collaboration and parallel presence in Philadelphia stimulated an outpouring of important clinical work from which we have all benefited.

The clinical pitfall of "selling family therapy" to families with symptoms in a child was dealt a damaging blow by the demonstration of structural techniques relevant to the presenting symptom. These techniques were documented by the video training tapes developed at the Philadelphia Child Guidance Clinic. "The boy with the dog phobia" was one of the first such training films. A project of Jay Haley and Mariano Barragan, this tape beautifully demonstrates the clinically induced structural alteration of a child-focused family using the strategy developed from the symptom. The result of the structural alteration was to alleviate the symptoms in the boy; the process shifted and symptoms then emerged in the mother and in the marital relationship. This shift automatically redefined the problem as a family problem rather than a child problem. The central nuclear family triangle of the boy, his father, and his mother was conceptualized as follows: the relationship between the parents was distant but not openly conflictual; the relationship between mother and son was intense and over involved; and the relationship between father and son was extremely distant. Other information of interest, in view of the boy's particular symptom, is that the father was a mailman, and the therapist didn't even think of making an interpretation! Instead, the therapist's strategy combined two elements: 1) a prescription of the symptom, with its paradoxical effects, and 2) the introduction of an object around which to organize the father-son relationship and close off the distance from one another. The actual therapeutic task called for the father to bring a puppy into the session. In order to accomplish this task, the father had to confront and surmount whatever anxiety he himself had about dogs, while at the same time moving toward the boy with an object and activity of potential connection for them. The result, demonstrated on the tape, shows the boy and his father playing with the dog with obvious enjoyment during the therapy session. The perhaps unanticipated side effect is the clearly observable developing depression in the mother. The child's problem has now been redefined as a family problem.

Minuchin's clinical artistry is beautifully demonstrated on video tape in his work with the anorectic "hot dog family." Here he employs two clinical procedures to produce a structural alteration in the family. One of these is *engaging the family's boundary guard*, the father. The second we would call *symmetricalizing*, the process by which the underlying problem is parceled

out to family members other than the symptom-bearer. The basic individually- oriented research on anorexia describes an intense feeling of defeat in the anorectic child. Accepting the validity of that research, Minuchin assumed that that sense of defeat must pervade the family. While symmetricalizing can be done clinically in different ways, Minuchin chose to prod the parents in the "hot dog family" to force-feed their child in a therapy lunch session until they gave up in defeat. This immediately made visible the system-wide problem of feeling defeated. Problems in the parents' marriage surfaced soon thereafter.

A striking example of another systems property of symptoms presenting in the individual – what we call the *child's sensitization to parents' anxiety* – is illustrated in Minuchin et al.'s stress interviews with families of children with uncontrollable diabetes. While the symptomatic child observes from the other side of one-way mirror, the therapist instructs the parents to discuss a problem between them and then carefully escalates the conflict. After a while he brings the child into the therapy room and lets the conflict subside as the parents focus on the child. The dramatic rise in the diabetic child's anxiety level – the result of her sensitization – is vividly documented in graphs of changes in the level of free fatty acids before, during, and after the interviews.

All of the above phenomena automatically take the presenting problem out of the person of the original symptom-bearer and redefine it as a systems, or family, problem. Through such work the "selling-of-family-therapy" pitfall was bypassed. These demonstrations of Minuchin's artistry and his development of systems ideas and clinical techniques for working with child-centered families are contributions of a magnitude that ought never be minimized.

The success of these structural approaches in producing symptomatic relief in child-centered families has been considerable. In recent years, however, these therapeutic maneuvers, in less artistic hands, have at times come to be used in such mechanical and uncreative ways as to diminish some of the early successes. In addition, the mechanistic use of structural techniques can lead to an oversimplification of the complex emotional process involved in any dysfunctional family. Furthermore, it has been the authors' experience that failure to go beyond the initial structural moves and the achievement of symptom relief leads to a predictable recycling of the symptom 6 to 8 months after termination of the therapy. Therefore, we believe that symptom relief in a child-centered family is best conceptualized as stage one in a more comprehensive approach to the multi-generational family process that produced the symptom. This position is taken with the full realization that many families will opt for symptomatic relief and nothing more. Also, this is not to say that the alleviation of symptoms in a child by concentrated work on the central mother-father-child triangle cannot be achieved without the eruption of significant fallout elsewhere in the system. However, the reliability and durability of such results are less than what can be achieved by remaining sensitive to and looking for symptom shifts to other family members or relationships, and dealing with them clinically as a natural succession of interrelated processes. Our work in this direction involves the development of a multigenerational paradigm that provides a broad context for viewing the child's symptoms while at the same time remaining relevant to the presenting problem.

This clinical paradigm, developed by the authors for dealing with child-centered families, consists of the following set of theoretical assumptions: 1) A child is born with certain constitutional assets and limitations, and among the limitations is a propensity for the type and severity of physical and emotional symptoms he or she may develop over the course of a lifetime. 2) Whether and to what degree these vulnerabilities will surface over time depend on a)

the basic functioning level of the family system at the time the child is born, b) how well the child's temperament fits the family and his or her sibling position, and c) the amount of internal and external stress the family must absorb and dissipate over its lifecycle. 3) Symptoms will develop when the amount of unbound or free-floating anxiety in the family has reached a critical level, that is, beyond the relationship system's ability to bind, diffuse, or dissipate it. 4) The driving force for this anxiety level will be the development of “cluster stress," which is the coming together of a series of *transition times* and other family events in a quantity sufficient to shake the emotional equilibrium of the family. A classic example of this is a family that is all at once going through the turmoil of adolescence, mid-life crises, and grandparental aging and death. 5) The most vulnerable member in the family is the most isolated, invalidated family member with the least functional leverage in the system. 6) The symptom serves the function of binding the excess anxiety in the system, allowing the family to maintain its organization, or reorganize and continue functioning.

In summary, the accumulation or clustering of stress within the three-generational family triggers a discharge of free-floating anxiety. This anxiety will be absorbed by the most vulnerable family member and expressed in the form of a symptom. The application of these assumptions and the plan of intervention that develops from them can best be understood from the analysis of a clinical situation. However, prior to presenting a comprehensive clinical case, it is important to emphasize how Trees, Triangles, and Temperament fit into our paradigm.

Trees

In order to organize the wealth of information relevant to this model and to plan the staging of treatment interventions, we begin an evaluation of the family by constructing a genogram during the first interview. This use of a genogram in the study of a family is now as basic a process as obtaining a family's surname. The genogram, first formalized as a clinical tool and named by Guerin, is a structural framework that enables the therapist to diagram the general information – names, ages, sibling positions, dates of nodal events and transition times, physical locations, etc. – and the complex information – quality and intensity of relationships, triangles, repetitive relationship patterns and toxic issues, etc. – about a family in concrete, easily understood terms. It has the advantage of allowing a large variety of facts to be read at a glance. In short, the genogram is a simply but completely organized "roadmap" of the emotional structure and ongoing life of the family across 3 to 4 generations.

Most often symptoms are presented clinically to family therapists as though isolated within the nuclear family. Only after obtaining an overview that offers the opportunity for both locating the potential sources of anxiety and the potential options for movement within the family is it possible to understand how the nuclear family symptoms and conflicts tie into and are fed by the process in the remainder of the system. For example, a local school psychologist referred a family in which the 12-year-old son was symptomatic. His performance in school had dropped far below his potential, and he was clinically depressed. During the previous year the boy's need for glasses had been discovered. The fact that this would prevent his following his father's career was considered an important etiologic factor. Filling in the genogram, the fact of the maternal grandfather's death 14 months prior to the family's initial visit was uncovered. Grandfather was a prominent and successful man. He took a great deal of interest in his family, especially his

daughter and grandson. For this reason he was an important functioning part of this family. His untimely death had been a shock. However, the family quickly accepted it as one of the tragedies of life. They had remained brave and stoic throughout the funeral ritual, shedding only a respectable amount of tears. Grandfather's death left a large empty space in the family. The boy and his mother frequently thought of him. These thoughts inevitably provoked a lot of feelings, but mother wouldn't talk about them "because it's morbid." The son wouldn't talk about his thoughts and feelings "because it would upset mother." As a result mother would find convenient times to cry when no one was around and get it over with, rather than burden anyone with her troubles. Her son found himself unable to concentrate, having difficulty sleeping, and without the energy needed to get involved in his heretofore favorite projects. He often thought of his grandfather, wishing he could talk to him again, wishing he had had a chance to tell him some things before he died. True to the image of the "brave soldier," he kept these thoughts and feelings to himself. The discovery, determining the relevance, and opening up of the issue of grandfather's death in the family session, led to the discussion of these thoughts and feelings and the effects of keeping them closed off. The therapist instructed the mother and son to work on keeping the issue open by purposely discussing grandfather's death whenever thoughts and feelings about him arose. This enabled them to deal with the feelings. As a result, the son's depression lifted and his school performance rose sharply.

We begin to make a genogram in our first contact with the family. Depending on the family's anxiety level as well as its size and complexity, a reasonably detailed and complete picture of three or four generations may require more than one session. During ongoing therapy with the family, their genogram is always available for easy reference, refinement, and further elaboration.

Triangles

Triangulation has long been a central concept of family systems therapy. There is a basic series of key triangles that should be part of the therapist's thinking track in dealing with the child-centered family. The first of the series is the primary parental triangle, involving the mother, father, and symptomatic child. Structurally, this triangle usually presents as an over close relationship between symptomatic child and mother with father in the outside position, distant from both his wife and child. There are at least two standard intervention techniques in this clinical situation. The first attempts to bridge the distance between father and symptomatic child by organizing their relationship around an activity or object of mutual interest, such as in the case of "the boy with the dog phobia" described earlier. As mentioned above, this is the technique developed at the Philadelphia Child Guidance Clinic. The second method, developed at the Center for Family Learning by Fogarty, prescribes a *bilateral* intervention of moving father in to take responsibility for all of the parenting functions of the symptomatic child while instructing the overinvolved mother to retire temporarily from her mothering role, that is, to distance from the symptomatic child and refrain from instructing her husband or making "editorial" comments on his relationship with the child. Both of these methods can be effective in quickly relieving the child's symptoms, and opening access to other dysfunctional processes in the family that are fueling those symptoms.

However, the therapist must remain cognizant of some of the limitations of these methods. First, the symptomatic child is most often sensitized to the level of emotional upset in the mother. The structural rearrangements that these methods prescribe will predictably raise mother's level of

anxiety and internal upset, thereby probably increasing the child's anxiety. While it is true that father's increasing involvement with his son or daughter may better insulate the child from this upset, if the father has significant difficulty carrying out his portion of the task, or mother's anxiety gets raised beyond a critical level, her anxiety may override the insulating effect of father's increased involvement. Also, if the symptomatic child happens to be an adolescent girl, the above prescription is developmentally inappropriate, for it is essential at this time that children establish an effective relationship bridge with the parent of the same sex.

When mother's anxiety threatens to reach a critical level, the problem can be dealt with effectively by working with mother, either alone or in the context of the family sessions, to develop an awareness of how the symptomatic child is sensitized to increased anxiety in her. This can often be brought about by simply asking a few process questions, such as, "Have you ever noticed which of the kids seems most affected by your upsets, even when you're trying hard to keep the upset to yourself? Which of the kids seems sensitized in that way to your husband?" The same questions are addressed to the father. The symptomatic child can then be asked a series of questions: "Can you tell when your mom is upset? How? What does it do to your insides? How do you behave when you're feeling like that?" If these questions are successful, the emotional process that is feeding the anxiety in the family will be opened up, dealt with, and the anxiety decreased. This usually relieves the symptoms and the child and defines the sources of anxiety and the conflictual emotional process elsewhere in the family so they, too, can be dealt with more functionally.

Another complication may be present when the primary parental triangle takes the form of what we call the "target child" triangle. In this situation the symptomatic child is the target of the father's criticism and negativity in reaction to his or her specialness to mother, with father feeling the discomfort of the outside position. This triangle can be dealt with by focusing the therapy process onto how much the symptomatic child's close relationship or behavioral similarity to the other parent is triggering the attacking parent into criticism and negativity.

It should be kept in mind that whatever intervention is chosen, it must be contextually relevant to the family. The more closed the system, the more intense the projection process toward the child and the less cognitively oriented the family is, the more a simple structural maneuver is called for.

In addition to the primary parental triangle, there are several interlocking "auxiliary" triangles that must be defined in order fully to understand the process in a child-centered family and avail the therapist of as many therapeutic options as possible. The first of these triangles is a *mixed sibling-parent triangle*, involving the symptomatic child, a sibling, and one parent. This triangle is potentially present in any family constellation with at least two children but is perhaps most often seen in the single-parent family. Following is a clinical example: Joan, a single-parent mother of three girls, presented her family with a behavior problem in Ginny, her youngest child. Observation and tracking of the process in this family yielded the fact that Joan has a special, over close relationship with Ginny, worries about her a great deal, and spends an inordinate amount of relationship time with her. Ginny is fiercely loyal to her mother and withholds herself emotionally from her non-resident father, Jack. Amy, the oldest sister, is a physical and behavioral "clone" of Jack and negative about her baby sister. Sue, the middle daughter, appears to operate all of the different factions in the family well, and floats fairly free of the overt and covert conflicts.

In the majority of single-parent households headed by a mother, it is necessary for mother to leave home on a daily basis to go to work. Because of this fact a leadership vacuum is created at home, and in most instances the oldest daughter fills the vacuum, taking over the head of household position while mother is at work. This can also be true, of course, in a dual-career, two-parent household, but tends to be less dramatic. Oldest daughter often ends up in a difficult position. She assumes considerable responsibility without any real explicit power and then must vacate the position and go back to being "just" one of the kids when mother returns. When you combine this with the possibility of oldest daughter's specialness to absent father, you have a high degree of potential conflict between mother and oldest daughter. The conflict most often takes the form of increasing criticism of oldest daughter by mother, a double code-of-conduct standard for the oldest daughter and younger siblings, and the oldest daughter's keeping her distance when mother is around, expressing her negativity in passive-aggressive ways toward mother and in openly punitive ways towards her youngest sister, mother's special child.

These families present with the symptom in the youngest, and if family intervention takes the form of increasing mother’s focus on the youngest, her symptoms will get worse. This worsening of symptoms is the result of increasing pressure from oldest daughter to youngest daughter in response to mother's behavior. If, on the other hand, the intervention is focused on surfacing and de-intensifying the conflict between mother and oldest daughter, the sibling pressure will be removed from the youngest and her symptoms will disappear.

In the case of Joan and her family, two interlocking triangles were worked on. In the most active, proximate one involving Joan, her oldest, Amy, and symptomatic youngest, Ginny, the covert conflict between Joan and Amy was surfaced and placed in the context of the triangle with Joan, Ginny, and absent father, Jack. As Joan and Amy dealt with the conflict between them, the pressure between Amy and Ginny diminished, and Ginny became symptom-free. Over the long haul this also opened up the possibility for Ginny to have a more involved relationship with her father.

The second "auxiliary" triangle of clinical importance is the *sibling subsystem triangle*. The sibling subsystem deserves investigation in any child-centered family. One aspect is its *cohesion-fragmentation* index. This index represents the degree to which the siblings are emotionally connected or distant from one another. A simple and productive way of ascertaining this is to ask the children how often they band together behind closed doors to "bad-rap" their parents. Families with a well-functioning, cohesive sibling subsystem will enthusiastically endorse that activity, while those that are fragmented will respond as if the therapist is speaking in a foreign tongue. In our work with child-centered families at The Center for Family Learning, we have found a fragmented sibling subsystem most frequently present in families with anorexia, severe behavior disorders, and psychotic-level process. The symptom-bearing child is invariably the one on the outside of the triangles that exist among the siblings. In these clinical situations parents will often strongly resist the inclusion of the better functioning, symptom-free children in the family therapy sessions. When this happens, the therapist takes the position that the other children must participate and even temporarily isolates the sibling subsystem from the parents by working with the siblings alone in some sessions in an attempt to increase their connectedness with each other and alter the dysfunctional sibling triangles.

Following is a clinical example of this triangular situation. The Sullivan family presented three months after the departure of their oldest son, Joe, for college, with symptoms of progressive

anorexia in their middle daughter, Kathy, age 15 and a sophomore in high school. There was one other child, Helen, age 13, an eighth-grader at a local grade school. The father was a successful businessman, and the mother a part-time foreign language tutor at the local high school. Joe had been a superstar in high school, lettering in three major sports, a straight-A student, active and beloved in the community. He had a special relationship with both of his parents and his baby sister, Helen. His relationship with his symptomatic sister, Kathy, had always been cordial, but Joe often thought that her whiny behavior, moodiness, and clinging were uncalled for. Kathy was born three days after the death of her maternal grandfather, and since early childhood had been the barometer of family upsets, particularly mother's. While she had always admired her big brother, she resented his closeness to Helen and felt on the outside. In family therapy both parents resisted the involvement of the two asymptomatic children, especially the idea of bringing Joe home from college on weekends for special family sessions. The therapist insisted, and Joe's involvement proved crucial on two fronts: first, it surfaced the family's intense reactivity to his departure for college, and second, it established the basis for increased communication and relationship contact between Joe and Kathy, which had an ameliorating effect on the latter's symptoms.

The third type of clinically important "auxiliary" triangle in child-centered families is the *three-generation triangle* existing among the symptomatic child, a parent, and a grandparent. The process in a three-generation triangle may be set in motion at birth or even before, during the gestation period of the symptomatic child. There are two major pathways through which this can occur. The first has to do with what we call the "Battle of the Grandmothers." In the time just before and immediately following the birth of a baby, the family system may go through a series of relationship maneuvers in an attempt to establish the primacy of binding between the new infant and one side of the extended family. The least subtle aspects of this process are enacted in the viewing room of the newborn hospital nursery, when groups of relatives cast their votes for the family member or side of the family the baby most resembles. The geographic proximity of a more cohesive family makes this process much more proximate and viewable. In more disengaged or explosive families, the process may be more remote and take the form of unconscious reactivity on the part of a parent to a child's resemblance to one important but distant family member. A classic example of this phenomenon occurs when a father has intense anxiety and concern for the functioning and emotional health of one of his daughters who physically and behaviorally resembles a dysfunctional sister still at home with their parents and with not much of a life of her own. The father's anxiety may be fed by mother's constantly reminding him of this worry every time the daughter has the smallest bit of difficulty. This phenomenon can also appear in many other forms, including excessive expectations of a child based on genetic similarity to the family superstar, or the acting out of negative process displaced from a parent or sibling to the relationship with the clone-like offspring. A clinical vignette may serve to clarify this process:

This family illustrates the uncovering of a classic case of the "Battle of the Grandmothers" 40 years after it occurred, when a 36-year-old man was being coached in his extended family to reconnect with his half-sister, Carol, whom he hadn't seen in over 15 years. Carol had cut off from the family and moved to the West Coast. She was the only child of their mother's first marriage to her boyhood sweetheart, a World War II fighter pilot killed in action in the Pacific. During the war their mother lived in Kansas City close to both extended families. She worked part time and her mother and mother-in-law rotated babysitting responsibilities. Following her

husband's death, her daughter, Carol, became the only link her mother-in-law had to her dead son, and her already considerable interest in Carol increased exponentially.

The maternal grandmother made some efforts to maintain her standing with Carol but eventually became reactive and negative to what she saw as Carol's choosing her counterpart over her. This is an example of the playing out of the "Battle of the Grandmothers." When Carol was five, her mother moved to Chicago in search of a better job. There she met and married her second husband and started a new family, giving birth to two sons in a five-year period. The oldest of these sons, Jim, was the one who attempted the reconnection with his sister, Carol. Carol, after a stormy relationship with her mother through adolescence, had chosen to go to school in Kansas, where she had spent some of vacations with her paternal grandmother. Through more than four years of college, Carol's conflict with her mother grew to the point of their totally ceasing to communicate. No one in the nuclear family attended Carol's college graduation, and Carol herself failed to attend her brothers' weddings.

Jim's contact with his sister was successful and ignited the process of bridging the relationship between Carol and their mother. Carol's dead father and their mother became the focus of their reconnection. The relevance of this happening in the extended family to the nuclear family problem as it presented was this: Jim's wife was severely depressed, cut off from her extended family, and caught in a conflictual relationship with both Jim's mother and his oldest daughter, Karen. Seeing the process with his mother and sister allowed Jim to view the symptoms in his wife and the triangular conflicts involving himself, his mother, wife, and daughter in a different way, giving him options he had never seen before.

It should be noted that this was a cognitively oriented, affluent family. In families with more chaotic structure, fewer financial resources, and a less cognitively oriented style of being, the direct involvement of extended family members in the family therapy sessions can have equally impressive results in dealing with the process in three-generation triangle.

The second major pathway through which a child may get caught in the process of a three-generation triangle centers around the emotional process that is triggered by the death, most often, of a grandparent (but sometimes of another important member of the extended family). The anxiety and upset surrounding that loss get bound into the relationship between a parent and the particular child that is born, in our experience, in the period approximately 2 years before or after the grandparent's death. Kathy Sullivan, the anorectic girl in the clinical case presented earlier, is an example of this process. We view her involvement in this triangle as a crucial element in the process that set her up to become the most vulnerable child in that family. Mueller and Orfanidis, in one of their studies of schizophrenic families, describe and document the same phenomenon, although their theoretical conceptualization of the emotional process involved in it is somewhat different from ours. We consider the process in both schizophrenic and non-schizophrenic families to be the same and of equal importance, although it is less intense in non-psychotic families.

To elaborate on this phenomenon further, when a child is in gestation or in the early years of development at the time of the death of a significant member of the extended family, particularly a grandparent, the child may in later years appear to be sensitized to periods of increased anxiety and emotional upheaval on that side of the extended family. The mechanism for the transmission of this anxiety is simplest to track when it is a death in the mother's family; mother's emotional

response and its impact on the developing fetus can be postulated as the mechanism behind the sensitization of that child to upset on that side of the extended family. When the phenomenon has been observed to involve the sensitization of a child to the paternal side of the family, two factors appear to be important. One is the extensive involvement of the paternal grandmother in the early years of the child's life, with later developments in the grandmother's life, such as the death of her husband, having a dramatic effect on that particular child. The other factor is the situation in which the child's mother is cut off from her extended family and has adopted her husband's family as her own, in which case the traumatic event or increased anxiety has a profound crossover effect on her. This effect is compounded when the mother, believing she is an "adopted" daughter in her husband's family, is surprised to find herself in the outsider position at the time of upset.

An example from a single-parent family seen recently may help to clarify some ways of maneuvering clinically inside three-generation triangles: This family presented with Sandy, a 14-year-old high school freshman referred by her school for "antisocial behavior." She was brought for the first session by her father and his second wife. Sandy lived with her mother, but her mother, having had eight years of individual therapy following her divorce, was now into Transcendental Meditation with her latest lover and thought therapy of any kind a waste of time. As far as she was concerned, Sandy's behavior was age-appropriate and "she would grow out of it." Father, with his second wife in agreement, framed the problem as inadequate mothering. Sandy defended her mother and said that even though she was somewhat flaky, she hadn't been the one to leave. Her father had, when she was three.

Sandy asked to see the therapist alone. He agreed, and when they met she told him that she had heard from a friend that the therapist was pretty good and understood kids better than most adults. So she wanted to tell him how it really was. She told him her understanding of how her father and mother had married when they were both very young, and she had the misfortune of having been born to them when neither of them knew what he or she really wanted. From her perspective both her parents had found themselves new lives, and she didn't fit into either of them. The therapist asked her who besides her parents had been a "special" adult to her. Sandy became tearful immediately and softly said, "my grandmother." The therapist remembered from the genogram that the paternal grandmother had died six months ago. He asked about grandmother and her death, and Sandy told him tearfully how she could always count on her being there, and now it seemed like there was no one. The therapist asked if she had talked to her father or her mother's mother about her grief. She said no, but agreed to meet in separate sessions with each of them to talk about her grandmother's death and where she saw herself in its aftermath.

Both of those sessions were held. Father got in touch with unresolved grief of his own around his mother, and some of his guilt in relation to his mother and Sandy and his long-term distance from both of them. Paternal grandmother talked of her respect for her departed counterpart and her jealousy of Sandy's special relationship with her. A week after that session Sandy called the therapist to say she felt much better, and that since both her grandmother and her mother were against coming back, she thought it wasn't worth the hassle, especially since she was doing much better. She promised to call if things got worse again. Father came in for one last visit to report on the school's positive reaction to Sandy's improvement and his willingness to continue therapy if the therapist thought it necessary. The therapist told him to just keep in touch and let him know

how things were going, and they could always come back if the problem reappeared. Six months later the father called to say things were continuing to go well. He was spending more relationship time with his daughter. They had been to the cemetery to visit his mother's grave. Paternal grandmother and Sandy were doing very well, and Sandy's mother was still meditating.

Temperament

The concept of childhood temperament is one which we borrow from the much admired work of Stella Chess, Alexander Thomas, and Herbert Birch and their coworkers on the New York Longitudinal Study. Temperament refers to behavioral *style*, the probably constitutional behavioral characteristics of the human organism that describe the *how* of behavior in contrast to the *what* or the *why*. Studying children from the early weeks of life, Chess and her associates inductively identified nine behavior characteristics which showed large but consistent variations over time, within a normal population. These behaviors described the children's characteristic biological rhythm and tempo, mood (positive or negative), intensity of emotional expression irrespective of its positive or negative direction, the distractibility and persistence of attention, the speed of adaptability to change, and the direction – accepting or rejecting – of responses to new experiences. Extremes of these temperamental behaviors, sometimes alone and sometimes in particular combinations, or constellations, as Chess calls them, can have a powerful impact on children's caretakers, whether they be parents or, for example, teachers. In fact, this research clearly demonstrates what mothers have probably always known, that is, that the atypical but quite normal behavioral styles of many children have as much effect on their mothers as their mothers' personalities and behavioral characteristics, or styles of mothering, have on the children.

Three important constellations of temperament that emerged in the New York Longitudinal Study and were predictive of the future development of behavior problems are the *Difficult Child* (slow to adapt to change, rejecting of new experiences, intense and mostly negative in mood, and with an irregular biological rhythm); the *Easy Child* (quick to adapt, accepting of new experiences, mainly positive in mood, mildly to moderately intense, and with a regular rhythm); and the *Slow-to-Warm-Up Child* (like the Difficult Child, except for intensity of emotional expression, which is mild). One of the present authors (Gordon), in association with Chess and Thomas, investigated the effect of kindergarten children's temperament on their teachers' estimates of the children's intelligence. What they discovered was that the teachers significantly underestimated the intelligence of Slow-to-Warm-Up kids and overestimated the intelligence of these children's temperamental opposites, those who plunge eagerly into new experiences.

The mutually affecting, interactional fashion in which temperament – children's *and* parents' – influences the emotional process in families is, interestingly, no more generally accepted a theoretical view than family systems theory, even though the concept of temperament as discussed in the psychological literature goes back at least to the turn of the century. The main reason, of course, is that thinking about child development continues to be linear and embedded in individual theory.

Conceptually, in our view, temperament is analogous to the notion of *operating principles*, a term we use to describe the emotional pursuing and emotional distancing behaviors that occur in all relationships, and that are central to our understanding of the dysfunctional emotional process in the marital relationship.

"Opposites attract," one of those old saws of essential truth, is easily documented in any marriage when one studies the operating principles of spouses. It is oversimplifying a more complex idea to put it this way, but wives tend to be emotional pursuers and husbands to be emotional distancers. In periods of calm in a relationship, this fit is complementary and functional. In periods of stress, when everyone becomes a more intense behavioral version of him- or herself, both emotional pursuit and emotional distance increase, and the formal complementarity of behavioral styles becomes exaggerated and dysfunctional.

This is equally so for the characteristics of children's temperament. However, while spouses choose one another, unerringly so, we would say, parents do not select their children. Thus, any particular parent-child combination of temperaments may be complementary or symmetrical, or something in between. An extension of the magnetism analogy to include the repulsion of likes adds still another dimension to the workings of behavioral style in relationships. Any particular aspect of a child's temperament may be a trigger for a parent's anxiety. There are several forms in which this can occur and set off a dysfunctional emotional process in the family: 1) When a child's temperament resembles a parent's and the parent is negative about that part of him- or herself; 2) When that child's temperament resembles the spouse's and the parent is negative about that aspect of the spouse; and 3) When the child's temperament is similar to that of an extended family member with whom the parent has a negative relationship. The triangles involved in these configurations, which have been discussed in the previous section, are not mutually exclusive. What we are stressing here is that the *formal* aspects of behavior – of which temperament is a prime example – not only fuel dysfunctional emotional process in families but also contribute significantly to the vulnerability quotient of particular children.

We integrate the concept and issues of temperament in our work with child-centered families in a fashion similar to our interventions around operating principles. Several steps are involved: 1) an assessment of atypical temperament in the symptomatic child; 2) a dissection of the parents' sensitization to the child's temperament, including an attempt retrospectively to evaluate the parents' childhood behavioral styles; 3) the tracking of triangling around the child's temperament; 4) the opening up of the issue with parents and the child, calmly teaching them about temperament in general and their own in particular, in an effort to decrease their reactivity to the behaviors involved and to help them structure their handling of temperament issues functionally. As we do in reference to other aspects of family functioning, we may recommend reading material on temperament to parents.

Clinical Example

The Samuels family, Bob and Rita, presented with a problem in the older of their two children and only daughter, eight-year-old Carol. She was described by her parents as having academic, behavioral, and social difficulties with peers. She was a negativistic child, they said, who regularly went into temper tantrums and often had physical complaints, especially stomachaches, usually in the morning before school but also during school and before mealtimes. Her parents thought her excessively shy and anxious, lacking in confidence and performing academically much below her capacity. She had been examined by her pediatrician, who prescribed anxiety-reducing medication, which in practice the parents rarely used. Carol "has always been a difficult child," were her mother's opening words.

Trees

When the genogram was constructed during the first interview with the parents – Carol was not present – the following information emerged: both parents came from intensely child-centered, educationally ambitious families. Bob's career as a teacher was a disappointment to his mother and father, who always pushed their son, an only child, to become a doctor. He had, in fact, been named after his mother's only sibling, a young physician killed in World War II. Bob, who himself had a history of stomach aches dating from about age 12, always fought his parents on this issue, despite doubts and career choice problems in college that drove him into therapy. The issue was still a sensitive one, and his mother regularly bugged him about it. Bob had an over close but reactively distant relationship with his mother and had always been distant from his father who, he said, was in the background as a parent, as he himself was with his own two children.

Rita was the older of two sisters, although, because of their large age difference, they function more as only children. This distance was enhanced because her sister was adopted; their mother could have no more children after Rita due to a hysterectomy. Rita and her sister grew up in a family in which both parents were professionals. While Rita stated that she never was a problem to her parents, Rita’s mother did not agree. In fact Rita was placed in therapy at age 4 because of constipation problems. But her sister was a much more openly difficult child who had a distant but conflictual relationship with their father and was over close to mother. The sister, Julie, was significantly dysfunctional over the years, particularly during adolescence, and went through a paranoid emotional crisis about six months before the Samuels family presented. Carol was reported to resemble Aunt Julie both physically and behaviorally, and their similarities triggered considerable anxiety on Rita's part about the degree and future course of Carol's emotional dysfunction.

The issue of "mental illness" was intensified by the fact of Rita's father's long history of manic depressive illness. He was in and out of the family with several hospitalizations. The toxicity of this same issue in Bob's family came from his mother's case of hysterical paralysis and long-term therapy when Bob was a young boy and around the time of Bob's maternal grandfather's extended illness and death.

Approximately one year before Carol's birth, her parents' first child, a boy with birth defects, died at three months of age. This experience sensitized Rita to Carol's early months of life. By her own admission she was an extremely anxious mother during that time.

The most proximate events that raise this family's anxiety level to the critical point, producing symptoms in its most vulnerable member and bringing them into therapy, were, in addition to Rita's sister's mental breakdown, her father's death (from long-term lung disease) six months after Julie's breakdown and, during the events surrounding his funeral, Bob's father's stroke. The accumulation or clustering of these intense stresses in less than a year was visible to the therapist as soon as the basic genogram was completed. As is most often the case, the family itself made no connections among these events.

Triangles

A number of important triangles were defined in the early therapy sessions with the Samuels:

1. The primary parental triangle of Carol, her mother, and father. Rita was intensely and often conflictually overinvolved with her daughter, anxious and extremely reactive too much of Carol's behavior. Bob was quite distant from both his wife and daughter and very critical of Rita's mothering. He would, from time to time, attempt to discipline Carol, but Rita thought him stern and insensitive to the girl's emotional needs. So she would quickly move in, critically directing his efforts. Bob would immediately withdraw in response to his wife's criticism and be unavailable to both his wife and child. He was somewhat more of a parent to his son, mainly because Eddie was an easy-going kid, much less an object of mother's anxiety and reactivity than was his sister.

2. The second most important triangle in this child centered family was the one involving Rita, Carol, and Aunt Julie. In this configuration Rita is reactively distant from Julie and keeps Carol distant from her as well.

3. The two mixed sibling-parent triangles in Rita's extended family – the one with herself, sister, and mother, the other with herself, sister, and father – had Rita in the outside, more comfortable position vis-à-vis Julie’s intensely over concerned relationship (with mother) and conflictual relationship (with father). Since Rita’s father's death the triangle involving the two sisters and their mother had intensified and altered, so that Rita was finding it difficult not to be drawn into her mother's over concern for the younger, dysfunctional sister.

4. The three-generation triangle involving Carol, her mother, and her maternal grandmother was also important in this family, with grandmother moderately critical of her daughter’s mothering, and Rita reactively distant from her mother.

An examination of the primary parental triangles in this family reveals an essential isomorphism among them. This pattern, from generation to generation, is predictable in child-centered families in our experience, and contributes to the intensification of emotional process and symptomatology over time. Eddie's primary parental triangle was the least intense, and he will probably remain relatively symptom-free over time, other things being equal.

In her early childhood Rita was triangled in her parents' conflicts with one another and became symptomatic enough to be put in therapy. But she was a child who avoided open conflict and for this reason grew up with the illusion that she was not a problem to her parents. Her father's emotional illness and her mother's problems in dealing with it were a much more obvious focus for her. That transition time in her family that was marked by the adoption of her emotionally more volatile, temperamentally more difficult sister when Rita was seven, produced a significant shift in the family's emotional structure. The parents' focus shifted to Julie, who rapidly assumed the most triangled, symptomatic child position. This was due not just to her adoptive status and difficult personality, but also to the intense conflicts that erupted between herself and her father whenever he moved in from his normally distant position to act as a parent toward her. Their personalities or temperaments (there are not enough data to determine which) ignited like a match to gasoline, according to Rita's reporting. Rita happily distanced from this conflagration. The possible future benefits to Rita from her inadvertent removal as the focus of her parents' anxiety were eventually diminished, if not actually nullified, we believe, by the fortuitous physical and temperamental resemblance of Rita's daughter to Rita's sister.

Temperament

In the first session with the Samuels family it was clear that issues of temperament were a significant factor in Carol's functioning and her interaction with her mother. The close questioning of the parents about Carol's first months and years of life revealed the following: from early in life her moods were mainly negative and her emotional responses intense. Furthermore, she always withdrew from new experiences and her adaptation was slow. For example, Carol continually fought the establishment of routines at home, and always had. The introduction of anything new in her life invariably elicited a rejection. Each new school year had her upset about a new teacher and unknown new procedures. And, in fact, Monday itself, the weekly return to a relatively new situation, was her most upsetting time of the week. She was a moderately persistent child, which was a problem when her goals were negative in her parents' eyes and a disadvantage when it came to school work, for she tended to give up too easily in the face of difficulty, which was a major part of the problem in the academic area. The temperamental fit between Carol and Rita was symmetrical and poor, insofar as the therapist could determine from a reconstruction of Rita's childhood behavioral style and an assessment of her current operating principles.

Mother and daughter were too similar in some important ways: Rita herself was emotionally intense, which tended to escalate her daughter's intensity rather than calm it down. And her moods were largely negative, which had the same effect. Rita was also a person who had trouble establishing routines in her life, which added to the difficulty of helping Carol to adapt to routine. She was furthermore an impatient person who could not wait out either her daughter's slow adaptation of style or her husband's personally slower manner when he came to deal with emotionally charged situations, such as parenting the troublesome Carol. Finally, the temperamental fit between mother and daughter was poor in that Rita too was not that comfortable with new experiences, and her daughter was her first child. Rita had been determined to do a better mothering job than her own mother had, especially with Julie, but this determination reached overly corrective proportions and made it even less possible for her to take calm, firm stands with her daughter.

To summarize, Carol was the most vulnerable member of this family for several reasons: 1) the proximity in time of her birth to the death of the family's first child; 2) her extremely difficult temperament, which was viewed by her mother as her own "abnormal" creation, which fed mother's guilt and anxiety about her. Rita’s view of her daughter as abnormal was the basis of Carol's invalidation in the family; 3) the intensification of her difficult and sometimes dysfunctional temperamental behaviors in response to Rita's emotionally programmed itch about Julie’s temperament and personality; and 4) the presence in the family of an easy-to-live-with sibling.

The "cluster stress" in the Samuels family consisted of 1) the paternal grandfather's mental and physical illnesses; 2) the dead baby; 3) mother's sister's emotional breakdown; 4) maternal grandfather's death; and 5) paternal grandfather's stroke. An additional stress not previously mentioned was their move during Carol's preschool years from a low-to-middle to upper middle-to-high socioeconomically speaking community. This relocation strained the family’s finances and left them rather isolated, for Bob was at the lower end of the scale in relation to income and profession comparison with their neighbors. This "inferior" status triggered anxiety about his unresolved career problem, and his mother pumped up this anxiety with regular reminders of his failure to become a doctor.

The Treatment Plan

One of the therapist's first interventions with this family was to educate them about temperament in general and their daughter's in particular. They were given some literature to read and some specific directions about dealing with Carol's intensity, negativity (specifically around new experiences), and her slow adaptability.

While these instructions were given to both parents, mother was not expected to use them immediately, because the next intervention was designed to get her to lessen her involvement with her daughter for an indefinite period and to have father assume the major parenting responsibility. Rita was coached to take the emotional energy she devoted to her mothering and put it into the reactively distant relationships she had with her mother and sister. Moving Rita back from Carol raised her anxiety and depressed her; she required emotional support for this effort and was encouraged to seek it from friends and extended family. Coaching her to open up the issue of parenting with her own mother, which she was reluctant to do, as well as the issue of her father's and sister's illnesses, made these issues less toxic and got her connected to her mother in a new way. For similar reasons Rita was sent to open the same issues with her sister, Julie. This work, over time, had the effect of calming Rita's anxiety about her daughter, circumventing significant depression in her from the loss of her mothering, and making room for Bob to assume a more active parenting role.

Bob was extremely sensitive to Rita's criticism of him, some of which was based on some personality resemblances between him and his father-in-law, and he therefore could not move toward his daughter while his wife occupied that space nor could he focus on their relationship. But Bob had his own parenting difficulties as well, especially with his daughter, whose emotional intensity, much like his mother's, stirred up his insides (in this case his stomach) to the point of pain. In reaction to this discomfort he had either distanced or, forced to deal with his daughter, over-intellectualized and threw reason at her in a way that in fact did make him insensitive to her emotional distress. Bob was very much like his own very distant father. As part of the intervention designed to get him more functionally involved with his daughter, therefore, he was instructed to open up and talk about the issue of parenting with his father. This led over time to Bob's working to de-triangle himself in the relationships with his parents and, in that process, open up and begin to deal with the issue of mental illness in his own family. This detoxified that same concern about himself and his daughter, for he too had some reactivity about Carol's resemblance to her maternal aunt. The mental illness issue existed mostly underground in him, in contrast to the more overt manifestations of it in his wife's family.

The process of moving mother away from, and father in toward, the symptomatic child serves several experimental purposes in our work with child-centered families. First, these movements surface the underlying emotional process in families, for example, mother's depression, marital conflict, etc. Second, we use the intervention to test our hypotheses and prognosis about the family. Their ability to carry out the plan is usually an excellent measure of their future progress in therapy. Finally, the maneuvers serve as "system checks": for example, if mother says she is retired from her mothering and is relieved rather than upset, we are certain that she has not really vacated the parenting space.

As this couple worked to shift their parenting functions around the daughter – which Carol herself often attempted to sabotage or simply resisted because of her intense tie to her mother and in reaction to her father's initially insensitive efforts to reason with her – Carol's behavior improved and her stomach aches diminished. The work in their extended families that Bob and Rita continued over a goodly number of months proceeded with ups and downs. The intensity of emotional process in their families was high, and they had a lot of reactivity to it. Whenever either of them ran into significant difficulty in their work, there was an exacerbation of Carol's symptomatic behavior. The disruptiveness of these periods diminished over time.

The Evaluation of Therapy

There are several areas of family functioning that we examine in evaluating the results of our work with child-centered families. All, however, are viewed from the perspective we have about what we call the "premorbid" state of the family. By this term we mean the level of functioning of the family *prior to the development of the symptoms* that propelled them into therapy. For example, no matter what the characteristic level of anxiety and dysfunction in a family before its presentation – the range is large – there is always some degree of escalation that occurs to push the family "over the brink." We believe it to be a commendable accomplishment to be able to return a family to its pre-existing equilibrium, and, in fact, that may be all that many families want and are willing to hang around in therapy for.

Thus, symptom relief is an initial goal. It is fairly simple to evaluate, and its speedy accomplishment is often the thing that will engage a family for more long-term work that can make them less vulnerable to future stress.

Another obvious sign of progress in therapy is a decrease in the family's level of anxiety.

Third, we look for an increase in the number of "relationship options" in the family. Such options serve as an emotional support system and help to absorb and dissipate anxiety and stress. The most potent support system is family. Thus we work to increase the number of extended family relationships that a mother and father can put their emotional upsets into. Parents of symptomatic children are distant or disconnected from their own parents. It is our observation that those families do best in therapy and over time who increase their emotional connectedness to their extended families. This also applies, but with much less importance, to the family's social network.

Finally, we assess the degree to which a family has been able to de-toxify the sensitive issues in the family. The measure of that is the degree to which the issue can be openly discussed in the family with a minimum of upset. An example of such an issue in the Samuels family was their dead infant. Ten years after the event mother still cried when discussing it. The issue had been covered over many years before in the face of father's own discomfort around it and his inability to deal with his wife's emotional intensity around it.

Summary

The authors believe that the theoretical and clinical paradigm outlined here represents a comprehensive method for tying together the best of conceptualizations, clinical techniques, and treatment options for working with child-centered families over both the short and long term. Further, we are convinced that the potential pitfall of the therapist becoming mired in content in

detail is best avoided by a continuous process of relating what is going on in therapy to our basic assumption about Trees, Triangles, and Temperament and to the treatment goals outlined above.

The following paper, written in collaboration with Donna Gundy, is another example of treating a case that presents as child-centered. Here, the problem of "fit" between the temperament of a symptomatic child and that his or her family is explored: how the lack of fit creates in both child and parents anxiety that produces symptomatic behavior in the child.

Temperament as a Transgenerational Issue: A Case in Point

Philip J Guerin, Jr., M.D. and Donna Dempster Gundy, M.Ed.

Chess, Thomas, and Birch (1963) defined temperament as the basic *style* which characterizes a person's behavior. In their work on the New York Longitudinal Study, they follow the behavioral patterns of infants over a period of years and compiled the differences and similarities of behavior that were consistent patterns of individuality. Nine behavioral characteristics were identified which seemed to remain stable: *level of activity, regularity, approach to or withdrawal from new situations, adaptability to change in routine, level of sensory threshold, positive or negative mood, intensity or energy of response, distractibility, persistence and attention span.* These characteristics describe how behavior is expressed, not what behavior is expressed or why.

Jacqueline Lerner (1985) noted that the Chess and Thomas study suggests that persons whose temperamental characteristics fit with the social and contextual situations in which they find themselves are liable to show more adaptive behavioral functioning than those who do not. She directly measured the "goodness of fit" of peer and teacher contexts for a group of adolescents and found a significant link to positive functioning within those contexts. Furthermore, she found that "perceived" situations were more predictable of successful adaptation than "real." A "major factor governing the behavior of individuals is their unique perception of themselves and the world in which they live and the meaning things have for them." Those persons who find themselves in social contexts where their individual temperaments fit comfortably in either real or perceived situations are more likely to function successfully.

The idea of temperamental individuality and goodness of fit within the family context and how this impacts on family functioning is an important factor in the evaluation of child and adolescent-centered families at the Center for Family Learning. Temperamental mismatching in the family can cause parental anxiety which then sets off parent-child conflict or dysfunction within the child. (Guerin and Gordon, 1984.) This can occur when:

1. A child's temperament resembles the parent's and the parent is negative about that part of himself/herself. For example, a mother who's worked all her life to become more comfortable and competent when faced with new and challenging situations pledges to

herself that her own daughter will not have such a struggle. In the early years of her daughter's life the mother is friendly, engaging, and encouraging to her daughter's developmental tasks. However, as the child enters school the mother is quick to notice her daughter's withdrawal into herself and avoidance of the challenge of this new and important situation. The intensity of mother's reaction is beyond the stimulus, and, lost in its intensity, she loses sight of some of her own problems with the separation. Initially her focus and then her fix becomes behavior in the daughter that awakens her past struggle.

2. A child's temperament resembles the spouse's and the parent is negative about that aspect of the spouse. For example, a father has always been annoyed at his wife's inattention to detail, like what time of day it is and her all-too-easy distractibility. Most of the time he tries to be amused by it but often his aggravation is obvious. When his seven-year-old son is never ready for school on time, and at teacher conferences his absence of sufficient persistence and attention span are reported to the parents, father's response is to increase the pressure on his son to shape up and son's problematic behavior worsens.

3. A child's temperament is similar to that of an extended family member with whom the parent has negative relationship. For example, in a recent session with Diane, a 16-year-old depressed adolescent who was struggling with the loss of her father who died three years earlier, she spoke of her conflict with her only sister two years her junior. The sister was a constant complainer, negative about everything, and although it was worse since her father's death, the same temperamental characteristics had been there since she was very young. Earlier in the family session, when the mother was speaking of her difficulty in dealing with the same parts of younger daughters behavior, she said, "It's like living with my mother all over again." The obvious dyadic and triangular conflicts in this family, plus the issue of father's death, make this case more complicated than just simple reactivity to transgenerational patterns of temperament. However, these very patterns had set up a conflict between the mother and younger sister that was producing immense pressure in the relationship between the sisters.

It is important to note in all these examples a dysynchrony between the expectations of one member of the family and the child's temperament. This sets up reactivity within the family system that may give the child a sense of not belonging. The sense of not belonging further aggravates the problem behavior, and this in turn becomes the organizing focus for system-wide anxiety. The clinical case presentation that follows demonstrates dysynchrony of temperamental fit, transgenerational reactivity to a particular temperament, and how temperament as an issue can be used in the treatment plan.

Case Presentation

The Serrano family came to CFL because of problems they were experiencing with their oldest son, Frank, 14. His parents, Mary, age 39, and Joe, 43, complained that Frank did not spend enough time with the family, and did not have many outside interests. They were concerned that he seemed to prefer to sit in his room and watch TV or play the computer. Mary also felt that Frank did not participate in school activities to the degree that he should. Frank was a bright boy not "living up to his potential," and the parents' views were substantiated by school reports. Since Frank had so much free time, he spent much of it at home picking on his brother, Scott, 8, and

sister, Molly, 5, a situation which was very irritating to Mary, who was with the kids most of the time.

The father owns a produce store in the Bronx. He and Mary grew up there and fulfilled a dream when they moved into a small Westchester town when Frank was 4. The move caused them some emotional and economic distress, but was seen as a positive step. Joe works long hours, including Saturdays, but does take one day off during the week. Mary shoulders the bulk of the responsibility for the children, takes a few courses at a local community college, but makes sure to be home when the kids come home from school. Mary will call Joe frequently during the day to complain about the children and to keep him involved in what is happening at home.

Of all the family members, Mary and son Frank are most similar in looks; they are fair haired, blue-eyed, while the other three are swarthy-complected. Despite her anger with Frank, Mary appears to be closest to him emotionally, which shows in the way she jokes and teases him. She conveys a pride and affection in her conversation with him that she does not show to the rest of the family. Joe seems to be outside the close relationship between mother and son, who often share sophisticated, humorous wisecracks that seem sometimes beyond Joe's comprehension. Mother and son are too quick for him and when they get going with the repartee, Joe looks confused and embarrassed.

Joe and Frank have a very distant relationship. Joe is alternately amused and annoyed with Frank's comments and behavior. He often looks at Frank as if he were some strange creature that he does not understand. On the other hand, Frank seems to be painfully aware of the distance, and also seems hopeless about finding a way to bridge it. There also appears to be a lack of cohesion in the sibling subsystem, with Frank on the outside, and the two younger ones close. The younger siblings seem to be aware that the way to get the parents' attention is to complain about something Frank has done to them.

Joe is the only child of Italian parents. He too was over close with his mother and distant from his father. His father died quite dramatically a few years prior to treatment, during an important family gathering. The pain of that loss is still evident whenever Joe speaks of his father. They had owned and operated the produce store together since Joe's early 20s. Joe's father, Louis, was the glue that held all of his extended family together. Twenty-one years ago, Joe's aunt Rose, his mother's younger sister, left her husband and moved into Joe's family's apartment with her two young sons. This meant that Joe had to sleep on the living room couch, but rather than see this as a usurpation of his privacy, Joe viewed it as another fine example of his father's generosity. The family reunions that were once so frequent when his dad was alive no longer take place, something that saddens Joe great deal.

In contrast to the togetherness of Joe's family, Mary's family is dispersed and cut off from one another. She is the youngest in the family with two older brothers. Her father, who was an alcoholic, had a stroke eight years ago, and Mary was the person responsible for him until his death two years prior to treatment. Mary harbors much bitterness against her brothers for their flagrant disregard of their father in this time of trouble, and feels they had no right to desert him, "no matter how much he hurt us when we were little." Both of her brothers had divorced and remarried since their father's death, and one of them is "somewhere" out West. The whole subject remains so painful to Mary that she would prefer not to discuss it at all.

Transgenerational Sensitivity to Temperament along the Maternal Axis

From the first family session, it was evident that Frank was the focus of everyone's anxiety, frustration, and anger. Everyone present except Frank agreed that he was the "problem" in the family, while Frank protested that they were experiencing the same difficulties that all families experience in getting along together. Mary was especially annoyed with him, presenting a "laundry list" of complaints that range from his not emptying the garbage, to annoying his siblings, to the fact that he just plain" bugged" her by hanging around and not doing anything productive with his time.

The way Frank behaves in response to different situations and experiences sets off anxiety in both of his parents. On the other hand, Frank is unusually at ease and verbally adept in the presence of adults. He calmly answers questions about his behavior, appears not to require social approval, and expresses interests which are different from what both his parents would like him to have. He has unique interests and abilities which his parents deprecate, i.e. computers and collecting comic books. They would like to see him playing sports (like his father and siblings) and going to dances, running out to meet life rather than waiting to see what life brings to him. Frank's style of behavior fails to meet his parents' expectations and has become the focus of their anxiety.

The treatment plan with this family requires an integration of work with the adolescent son, work with the central nuclear family triangle that operates among father, mother, and son, and extended family work along both the maternal and paternal axes.

The first order of business is to make a connection with Frank. This is done in a way that allows the therapist to evaluate the level of emotional distress Frank is experiencing, the sources of that distress, the behavioral patterns that are expressions of that distress, and how those patterns complicate his relationship with his parents and his goals for himself. Frankie is already aware of some of the differences between his "natural" temperament and the expectations of his parents.

The following segment of a session transcript demonstrates the dysynchrony between Mary's expectations of how her son is supposed to behave and Frank's perception of himself. Frank's temperament does not fit the expectations of the family.

Therapist: What are you concerned about in terms of Frank's withdrawal into his room?

Mother: The main thing about this is that Frank is a bright, smart kid and there is more available for him than sitting in his room. I think Joe and I would be happy if Frank were to get into collections and stuff.

Frank: I do! I collect comic books now. That's something I really like. But you think that's not anything. So what I like to do, you say that's not what you should be doing. I should be doing sports and stuff.

Mother: No, Frank I don't say sports anymore. That's not fair.

Therapist: You'd rather he collected friends?

Mother: I don't think it's important to have a slew of friends. It is important to have one really good friend. Not everyone is going to have a ton of friends; I agree. I think it's important to have someone you're close to. Joe and I both feel it's important to see Frank with other interests than the door locked and the TV on.

Therapist: Does he do that all the time? Just Saturday and Sunday?

Mother: Practically!

Therapist: If he weren't here today, would he just be sitting there all day watching the tube?

Frank: (*to parents*) It doesn't bother me, honestly, it bothers you.

Therapist: What you're saying is, you're the kind of guy who likes to spend time alone.

Frank: Yeah, a lot of kids have many friends, but they're not really friendships. It has to be a certain kind of person to be really comfortable with.

Therapist: What kind of person?

Frank: Not so outgoing or so athletic, maybe some quiet interests.

Therapist: Somebody who likes to do computers?

Frank: Yeah, or collect comic books.

Therapist: And you found a few people like that along the way, but not a lot? So you think your parents are worried about something that's not a problem.

This segment marks the beginning of two tracks of intervention. For Frank it opens the issue of "belonging" which can be dealt with both in individual and conjoint sessions with the parents. Belonging is a central theme in many people's lives and within many families; it is especially sensitive in families with dysynchrony of temperament. For Mary, this segment clearly demonstrates the necessity of backing off in her relationship to Frank. The more she applies pressure on him to conform to her expectations, the less he does. To give her a sense of some control, the therapist might suggest that she exercise her parental prerogative to remove the computer and TV from Frank's room to a more populated part of the house and gauge its impact on Frank's isolation. Having made her move, Mary must distance from Frank, decrease her prodding and criticism, and investigate with the therapist where she developed her sensitivity to characters like Frank. This will inevitably take her into her extended family.

The relevancy link between Frank's problems and Mary's extended family centers on "belonging." The issue of belonging is a sensitive one for Mary. Her family, with all the elements of an alcoholic system, was isolated from the outside world, and she found it difficult to make friends or adapt easily to new social situations. Her own unresolved feelings of not belonging are all projected onto Frank when she sees her son's refusal to participate in the things she would've enjoyed. Frank's tendency to keep to himself, stay at home, and sometimes pick on others reminds her of her brother, Carl, from whom she is cut off. Her bitterness against her brother, his ungratefulness and disloyalty to family ties, pre-sensitizes her to Frank's behavior in

the nuclear family, which she also sees as disloyal and irresponsible. The following segment begins the process of linking Frank's temperament to his uncle Carl and Mary's allergy to both.

Therapist: (*to mother*) Is there anyone in the family, Mary, that Frank reminds you of?

Mother: No, I can't say there is.

Therapist: So he's special?

Mother: Maybe. His personality would be like my oldest brother, who stayed in the house by himself and didn't have a lot of friends.

Frank: Personality-wise?

Father: Some of the things that you're doing…

Frank: No, I'm asking because I really don't know him too well.

Mother: I'm trying to think of what he was like as a kid.

Father: You told me that when he was alone in the house he would open up windows and yell down the people in the street.

Mother: He was seven years older than me. My mother told me that when he was younger he would yell out the window, "Hey kid, I could beat you up." That kind of thing. He was the type of kid who would antagonize other kids.

Therapist: Frank, you're being compared to weird Uncle Carl. Mary, is weird Uncle Carl one of your favorite people?

Mother: Well, I don't see my youngest brother at all.

Frank: It's a kind of odd sort of family.

Mother: It will be two years in November that dad was dead. I saw Carl at the funeral. My older brother and I get together from time to time.

Frank: That just started recently.

Having established the linkage between Mary's reactivity to Frank's behavior and her pre-sensitization to it in her relationship with her brother, the therapist can move on, returning to the important issue of belonging.

Therapist: (*to Mary*) The issue of belonging is important to you. Did that get stirred up when your father died?

Mother: Well, when my father was sick, I had to take a lot of responsibility and my brothers just didn't. I wish my relationship with my brothers could be different. When we were kids we were close. As we got older, my brothers took advantage of my parents. I have a lot of bitterness. I have to put that behind me. I don't think we'll ever really be close. I wish things could be different.

Therapist: Are you hopeless about it being different?

Mother: I guess, especially with Carl, but with my youngest brother, I don't even know where he is.

Therapist: Out in Kansas somewhere?

Mother: He's a hopeless case, 1001 jobs, remarried.

Therapist: Do you have a mission to make sure your own sons don't turn out like your brothers?

Mother: I would hope so. We offer the kids different things. We offer them a college education. We live in a different area and like to give kids opportunities. I have expectations for my kids the way I'd like them to be.

Therapist: It's important to you to be connected to each one of your kids. Do those expectations get in the way of connection?

This segment represents the beginning of the work with Mary and the education of Frank as to some of the emotional forces that drive his mother's behavior toward him. While working with mother on these issues, the time is right to execute the second part of the triangular two-step by bringing father in from the sidelines.

Transgenerational Sensitivity to Temperament along the Paternal Axis

The therapeutic focus on the father-son relationship can be directed toward exploring each one's expectations of the other, finding a common ground for them to spend more relationship time together, and through a consideration of the three-generational triangle of father, son, and grandfather as it operates around the family business. The next segment of session transcript sets the stage for work on the father-son relationship.

Therapist: (*to father)* Does Frank like to spend time with you? Are you one of the people that fits the criteria of the kind of person he likes to spend time with?

Frank: No, he's exactly the opposite.

Therapist: So, you two guys don't get together much. There’s a real distance there.

Frank: Sometimes we watch TV together downstairs.

Therapist: (*to father*) Did you play football?

Father: No, I played at the YMCA. I would want Frank to have more than I did at his age.

Therapist: Did you ever let Frank know what you're like at 14?

Father: Yeah, he knows.

Therapist: (*to Frank*) What was he like Frank? Was he a scoundrel?

Frank: I think he was the kind of person who was very into sports and stuff. I think he hung around with a big group of kids. I think he was really close with a lot of his friends. He said he wasn't really the type to stay at home, he would go out and play stickball and stuff. He's the kind of person who wouldn't come in until his mother called.

Therapist: He'd like you to be that way.

Frank: In a sense, I think so.

The state of affairs between father and son is beginning to be spelled out. It is time to resurrect the grandfather. The three-generational triangle with Frank, his father, and paternal grandfather is an interesting one. Despite the affection that Joe felt for his father, the relationship was distant, similar to the one with his own son. In both cases, a difference in temperament is part of the distance between father and son. Joe's father, Louis, had a social ease and quiet assurance of control over the family he ruled, a position that is quite the opposite of Joe's experience with his own nuclear family. Joe is shy, verbally less adept than his father and his son. Frank is socially at ease with adults, with a verbal ability and an ease around strangers that is quite similar to that of his grandfather. In the grandfather's death they have both experienced a loss. The temperamental difference over the three generations and the loss of grandfather are mutual experiences which can start the establishment of a bond between Joe and Frank. In this next segment of transcript, the therapist sets the stage for a relationship experiment with father and son through a consideration of the loss of the grandfather, and father-son relationships over the generations. The relationship experiment that evolves is Joe spending some relationship time with his son at work, much the same way his own father did with him. As the segment begins, the therapist has been asking Joe about the loss of his father.

Father: You have more of a best friend relationship with someone when you work with them. I know Frank took it bad, because there was no wrong that Frank could do as far as my father was concerned.

Therapist: He wouldn't care if he didn't take the garbage out.

Father: Well, he didn't have to do that four years ago.

Therapist: My guess is that if your dad were around today he wouldn't particularly care.

Father: No, I think that he would tell Frank that I had things I had to do around the house.

Therapist: Do you think that your relationship with your dad is the same relationship that Frank has with you?

Father: Well, my father and I got closer when we went to work with each other.

Therapist: How old were you then?

Father: 21.

Therapist: So up till then you weren't that close?

Father: Well, like my wife, we grew up in a rough section and my father wasn't home that much.

Therapist: So he was someone you kind of did know too well.

Father: Not really, he wasn't the type you could just go play ball with. On Sunday the family would do something together. Our relationship, like I said, after we started the business together, that's when we got closer.

Therapist: So maybe you are going to have to wait until Frank joins your business.

Father: No.

Therapist: What would be wrong with waiting? It's only six or seven years.

Father: I would want better for Frank.

At this point, the therapist is able to suggest a relationship experiment between father and son, by suggesting that Frank accompany his dad to work on Saturdays. One possible pitfall to the experiment will be Mary's and (through her) Joe's concern about Frank going into the rough neighborhood where the business is located. The therapist would have to work closely with the parents to evaluate their fears and anxieties and how they may contribute to the distance between father and son.

Summary of Treatment Goals

This case illustrates how transgenerational sensitivity to temperament can be the focus of a system-wide anxiety. The treatment plan focuses on the transgenerational aspects of belonging with its connection to temperament and family expectations. The importance of the therapeutic work for the parents is to desensitize themselves to behaviors in extended family members. It is hoped that as Frank takes more responsibility for his own productivity and learns to deal with his parents' anxiety and pressure in ways that work better for him, Mary's anxiety about it will diminish. As Joe works through his grief over the loss of his father and within the context of his relationship with his son, there will be a decrease in the distance between them. The final goal is an acceptance of Frank's temperament and an opportunity for him to belong with full membership in spite of the difference between the real him and his parents' expectations.

In the following paper Guerin and his colleague describe a consultation Guerin did with the family of an 11-year-old boy with problems at school. The partial transcript is an excellent example of Guerin's clinical skills: his ability to stay free of the family's anxiety, making a connection with each family member, and following a plan in a relaxed but steady manner.

The Theory in Therapy of Families with School Related Problems: Triangles and a Hypothesis Testing Model

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The family with a child experiencing school-related problems is one subtype of what can be classified as a child-centered family. In clinical practice, the child-centered family by definition is a family in which a child is the symptom bearer. The child's symptoms may take the form of emotional dysfunction, physical dysfunction, or a relationship conflict. The designation child-centered is one category in a systems-based typology of families developed by Philip Guerin at the Center for Family Learning, in which the symptom is viewed as an expression of systemwide dysfunction through its most vulnerable member, the symptom bearer. The purpose of the typology is to help organize and clarify the conceptualization of the family process around the particular type of clinical presentation. Symptom relief is the first priority, but it is viewed as the first stage in a more comprehensive approach to the multigenerational family process that produced the symptom.

The assessment of the child-centered family involves obtaining a thorough and precise genogram, determining the synchrony of the symptomatic child's temperament with the family's expectations, and defining the key triangles in the emotional process surrounding the symptom. A family with the school-related problem usually involves one or more of the following five factors:

1. The symptomatic child is emotionally vulnerable in the family system, and this vulnerability is being played out in the child's peer network or in school, rather than within the family.

2. There is an explicit conflict between the symptomatic child and the school authority figure, most commonly the teacher.

3. There is a covert conflict between the child and one or both of the parents that has been displaced into a conflict between the child and the teacher.

4. The symptomatic child has a special relationship with the teacher that makes the child a target of some less favored powerful students within the classroom. This represents the schoolyard version of the classic child triangle.

5. The child is caught up in a triangle based on the conflict between a parent and the teacher. This triangle may be explicit or covert. The child reacts by exhibiting problem behavior, usually of an antisocial or under-functioning academic nature.

RELATIONSHIP TRIANGLES

In family psychiatry, the concept of a relationship triangle is used to describe, study, and experiment with emotional process in a set of three interconnected relationships. A number of clinical investigators over the past 25 or 30 years have stated that the triangle forms the basic structural building block of any relationship system. It is important, for purposes of

understanding, to make a distinction between the triangle as a structure and the process of triangulation.

The triangle is a structure formed from a reactive, emotional process involving three people. The process that goes on within that triangle is the process of triangulation. If the configuration in that structure is altered, the process is altered, and vice versa.

Two basic mechanisms predominate in the initiation of triangulation. In the first, one member of a dyad moves away from the other and connects with the third person in order to calm an internal emotional upset or to gain an ally in a conflict. In the second mechanism, a third person (often a child) who is sensitized either to anxiety in one member of the dyad or to the intense relationship conflict automatically moves in to settle the upset or becomes caught up in the conflictual process.

There are several key triangles that the therapist should consider in dealing with the child-centered family: the primary parental triangle, the parent-sibling triangle, the sibling subsystem triangle, the parent-child-teacher triangle, and the intergenerational triangle. Each of these triangles is pertinent to the family with school-related problems.

Primary Parental Triangle

The father, mother, and symptomatic child comprise the primary parental triangle. Structurally, this triangle usually appears as an overly close relationship between the symptomatic child and the mother, with the father in the outside position distant from both his wife and child. The process and structure, however, may vary. Furthermore, the designation of an overly close relationship between mother and child does not mean a calm emotional connection. Most often, the symptomatic child is sensitized to the level of upset and anxiety in the mother and vice versa. As a mother's anxiety escalates and her state of emotional arousal increases, the emotional tension is transmitted to the symptomatic child. As the child's anxiety increases, it is converted into some form of problem behavior.

Several additional mechanisms may come into play. For example, the child may be sensitized to the father's level of upset, although this is a less frequent pattern and most commonly occurs with father and the oldest daughter. The child may develop symptoms as a result of sensitization to either an overt or an underground conflict in the parents' relationship. The child may become the target of the parent in the outside position, usually the father. This targeting may result from the outsider parent's negativity toward the target child because of the child's specialness to the other parent. The child may also become targeted through the distant father's irritation because the child upsets the mother and leaves the father to deal with an upset wife, which pulls him back from his distant position.

Parent-Sibling Triangle

The symptomatic child, a sibling, and one parent make up the parent-sibling triangle. In this configuration, the symptomatic child is usually the insider child (i.e., the child with the favored relationship with the parent). This child may become the target of an older sibling who feels less valued and manages these feelings by applying relationship pressure to the favored sibling. This type of triangle may occur in any family constellation with at least two children, but it is perhaps most often seen in a single-parent family.

Joan, a single mother of three girls, sought therapy for a school behavior problem in Ginny, her youngest child. Family sessions revealed that Joan had a special relationship with Ginny, one in which she worries about her great deal and spends an inordinate amount of time with her. Ginny is fiercely loyal to her mother and withholds herself emotionally from Jack, her nonresident father. Amy, the oldest sister, is a physical and behavioral "clone" of Jack; she is negative about her baby sister. Sue, the middle daughter, appears to operate fairly well in all of the different factions of the family and floats free of both covert and overt conflicts.

In the majority of single-mother households, the mother must leave home daily to work. This creates a leadership vacuum at home that, in most instances, is filled by the oldest daughter, who takes over the head-of-the-household position while mother is away. (This can also be true, of course, in a dual-career two-parent household, but the phenomenon tends to be less dramatic in these cases.) The oldest daughter, thus, may be in a difficult position. Not only does she assume considerable responsibility without any real power, but also she must vacate the position when mother returns and go back to being "just one of the kids." When the oldest daughter in this position also has a specialness to the absent father, there is a high degree of potential conflict between the mother and the oldest daughter. The conflict most often takes the form of increasing criticism of the oldest daughter by the mother. There is a double standard of conduct, one for the oldest daughter and one for her younger siblings. The oldest daughter keeps her distance from her mother, expressing her negativity in passive-aggressive ways toward her mother and in openly punitive ways toward her younger siblings, especially the mother's favorite child.

Consequently, in these families, symptoms often develop in the youngest child. If family intervention takes the form of increasing the mother's focus on the youngest, the child's symptoms will become worse because pressure from oldest daughter to youngest sibling will increase in response to mother's behavior. If, on the other hand, the intervention is focused on bringing the conflict between mother and oldest daughter to light and de-intensifying it, the sibling pressure will be removed from the youngest and the child's symptoms will disappear.

Sibling Subsystem Triangle

The symptomatic child and two siblings may form a sibling subsystem triangle with the symptomatic child most frequently in the outsider position facing a close relationship between the two other siblings. The sibling subsystem triangle deserves investigation in any child-centered family. One of its most important characteristics is its cohesion-fragmentation index, which indicates the degree to which siblings are emotionally connected or distant from one another. A simple way to assess this index is to ask the children how often they band together behind closed doors to "bad-rap" their parents. Siblings in families with a well-functioning, cohesive sibling subsystem will enthusiastically endorse that activity, while those that are part of a fragmented system will not. A fragmented sibling subsystem is seen most frequently in families with anorexia, severe behavior disorders, and psychotic level process.

The symptom-bearing child is invariably the one in the outside in these triangles among siblings. Parents may strongly resist the inclusion of the better functioning, symptom-free children in the family therapy sessions. When this happens, the therapist must take the position that the other children must participate and may even temporarily isolate the sibling subsystem from the parents by working with the siblings alone in some sessions in order to increase sibling connectedness and alter the dysfunctional sibling triangles.

Parent-Child-Teacher Triangle

In its most common form, the parent-child-teacher triangle is the result of a displacement of a parent-child conflict to the teacher-child relationship. This process is often characterized by a dramatic difference between the child's home and school behaviors. The reactivity of the child to the parent, usually around the issue of control and authority, is exhibited in school. If the involved parent and teacher join forces in "shaping up" the child, the problem behavior escalates. In fact, one way to make this covert triangle explicit is to recommend the joining of parent and teacher, and observe the behavior of the child. This may be done both inside and outside the session. Many teachers are willing to participate in family sessions. After this triangle has been demonstrated to the therapist's satisfaction, the non-triangled parent can be directed to take over the functions of parenting and dealing with the school and teacher; this can have dramatic results. Another technique that is useful in demonstrating the covert parent-child conflict calls for the child to reverse problem school behavior and acceptable home behavior. The therapist does this by suggesting to the child that, as an experiment, she try shifting school behavior to the home and home behavior to the school in a structured way – perhaps on Tuesdays and Thursdays.

There are two other major patterns in the parent-child-teacher triangle. In one variation, the parent has a conflict with the teacher, either because of personality mix or because of educational methods, and the child acts out the parent's feelings towards the teacher. This variation is common when the parent is a professional, especially a teacher. In the other variation, the child's triggers an emotional reaction in the teacher that is programmed from another aspect of the teacher's life. In this situation, if the parent too readily joins the teacher, the teacher's "fix" on the child will be missed and the problem behavior, be it behavioral or academic, will increase. The resolution of this pattern often requires involving the administration of the school to assist the teacher in seeing the emotional triggers and the resultant "fix" on a particular child.

THE MODEL

The hypothesis-testing model is based on the notion of tracking, which has previously been used in clinical research to increase awareness of pattern. The major function of tracking is to assist therapists in the developing ability to detect pattern within the system. Tracking is a method of studying the process of the family and learning the therapy developed by Guerin and Fogarty at the Center for Family Learning. Tracking can be defined as an observational commentary on a consultation or a therapy session in which two processes are monitored and explained: (1) the flow of movement in the family itself and (2) the interaction between the family and the therapist. In the past what each clinician has tracked has been affected by his or her frame of reference, belief system, and theoretical bias. The hypothesis-testing model allows the clinician to track pattern in a more objective manner.

The hypothesis-testing model is a formalization of the process wherein the therapist makes observations, becomes aware of patterns and information in the family, develops hypotheses about what these patterns represent, and formulates relationship experiments and task assignments to test or alter the hypothesis on the basis of the information gathered. The therapist begins by making simple observations and then gradually makes hypotheses. When the therapist judges that a hypothesis is accepted, it can be used to construct an intervention and make a prediction about its outcome. If the prediction is accurate, the hypothesis is strengthened. In any case, new data that form the subject matter for further observation are generated. In one sense,

the therapeutic cycle closes upon itself; in another, it develops spirally as the hypotheses become more and more refined. The therapist continues to learn from an interview because the hypothesis-testing model is a learning model. Although the therapist may be *implicitly* aware of these processes, the model makes the therapist *explicitly* aware of them. A clinical case may serve to clarify application of this model to the triangular processes operating in a child-centered family.

A CASE STUDY

Chris is an 11-year-old with peer problems; he has few friends, is picked on by older children, and spends time with younger ones. Mostly, he is isolated or spends time with adults. He and his mother, Jane, were seen for one and a half years in individual therapy at a local Child Guidance clinic. His father, Adrian, was not involved.

Chris has had a history of school-related problems beginning with the transition to school during which he was described by his mother as "psychosomatic" and "school phobic." This was further complicated by Chris's special needs as a young child; he had previously been physically confined because of a hip deformity. Historically, Jane has been very involved with Chris and his school problems, as well as being primary caregiver when he was in braces to correct his physical handicap. His father has historically been in the distant position.

A series of nodal events coincided to create sufficient stress to activate the triangulation process in several interlocking triangles that have continued to be relatively fixed for the last 12 years. During Chris's first year of life, Jane's father died. Jane and 10-month-old Chris remained in England, while Adrian relocated in the United States, making provisions for his family to join him six months later.

The interlocking primary parental and intergenerational triangles were triggered again when Chris was six years old. Again, the developmental transition of Chris beginning school coincided with Jane's concern about her mother's health. Chris, being sensitized to his mother's upset regarding her extended family, became symptomatic. This also coincided with the covert marital conflict surfacing on the issues of sharing parental responsibility. This pattern has continued to recycle and remains the context for the presenting problem.

The hypothesis-testing model can be applied to the relevant triangles in this child-centered family with the school-related problems; the primary parental triangle, the auxiliary intergenerational triangles, and the triangles in the school context.

The Primary Parental Triangle

The therapist makes observations (gathers data) that form the basis of hypotheses about the flow of movement in the primary parental triangle of the family. Initial interventions either confirm or alter the original hypothesis. Once the hypothesis is confirmed, initial structural interventions are prescribed as tasks.

In the case example, the hypothesis is that Chris is triangled into the primary parental triangle by his sensitization to his mother's anxiety; his father is in the distant position. The process in the primary parental triangle is that the mother shows a great deal of anxiety; the father is at a distance from her; and the child, sensitized to his mother's anxiety, converts that anxiety into his

school problem and his isolation. At any given time, the configuration of the triangle may be (1) mother and son overly close with father in the distant position, or (2) mother and father close with problem son in the outside position.

The observation in the session shows the mother and son are sitting close to each other while the father is on the other side of the room. The description of the amount of relationship time and the character of their connectedness supports the hypothesis that mother and son are overly close and that father is at the outside position.

The relationship experiments (interventions) designed to reverse the flow of movement in this primary parental triangle form the first part of the overall treatment plan. These tasks are to move father and son closer together, and to move mother out to give father and son more time and space to work out a relationship. In the following dialog, Guerin's beginning interventions to test the viability of the father-son relationship can be seen. He gathers information to build a bridge between Chris and his father to begin to close the distance, which increases the stress in the family. Chris triangles in to block Guerin's move with the question "How old is my mother?" The sequence escalates with Chris writing his mother's age on the genogram. Guerin counters this by paying attention to Chris, initially engaging him in a light repartee, then returning to the issue at hand, the over-distant father-son relationship.

Guerin: Do you ever spend any time sharing with your father some 11 year old wisdom to help him out with his day, you know?

Chris: (laughs) No.

Guerin: No?

Chris: He usually shares wisdom with me.

Guerin: He shares his 37-year-old wisdom with you?

Chris: How old is my mother?

Guerin: How old is your mother? They didn't put that up there on the genogram. She made [your therapist] promise not to put it up there.

Chris: (*to mother*) How old are you?

Guerin: (*laughs*) She's not going to tell you. What did I ask you before you interrupted? Did you forget? You’re mad because your mother isn't going to tell you how old she is, right?

Chris: I don't know.

Adrian: You were discussing his school. He mentioned that she dropped it.

Guerin: Well, I was thinking about something, but I forgot now.

Guerin continues to focus on the distant father-son relationship; he is looking for a bridge, an area of shared interest, to lay the groundwork to coach Adrian on ways to build a one-to-one

relationship with his son. Guerin makes direct and indirect interventions to find a connection between the father and son. His strategies include negotiation.

Guerin: What would you like to do with your father, you know, I mean if you were picking it. Do you think his spending more time with you is a burden for him, or do you think he really wants to?

Chris: I think he'd more or less like to do electronics work and work on the car.

Guerin: Are you interested in that?

Chris: No. I'm more interested in doing father-son things like Playland, going skiing, stuff like that.

Guerin: Yeah.

Chris: And he says it's time-consuming and all that stuff, and so we don't go.

Guerin: You don't have any interest in cars and electronics and all that stuff. Do you think if you got more interested in that your father would get more interested in Playland?

(*Systematizing the problem without taking sides*)

Guerin: He's a teacher you know, he could teach you a lot.

Chris: I don't know. When I grow up, I'm going to be a scientist or a psychologist, one of the two.

Guerin: I see. Well, you know the stuff your father does has a connection to science.… You're not so sure.

Chris: More or less a psychologist, I'd like to be.

Guerin: Did he teach you about how a car works?

Chris: I know more or less the basics because I watch him work. He tells me what he does.

Guerin: Does he let you hold the flashlight?

Chris: Yeah, that's basically what I do get to do, hold the flashlight.

Guerin: A "go-fer" and the holder. Do you like that?

Chris: No, but I do it to help.

Guerin: Does he let you put a few screws in every once in a while? Do you like that?

Chris: Yeah.

Guerin: But you're not enthusiastic about it. So you two guys have a problem because you're not enthusiastic about what your dad's really enthusiastic about, and he's not awfully enthusiastic about what you're enthusiastic about.

(*and a reversal*)

Guerin: Maybe you and your father are misfits, you know, as a father and son; you like different things, and you're both kind of loners. Getting you together is going to be a big problem.

The essence of a reversal is humor; it is the nature of a reversal to appear outrageous. Weary after fruitless attempts to counter emotional overinvolvement with rational persuasion, the therapist concocts an entertainment in which the individual's premises are reinforced to the point of absurdity and beyond. The best reversals promote a sudden backlash response from the patient. Guerin uses the reversal here to "twit" the father and son, rather than pushing them directly. Instead of trying to resolve their differences, he amplifies them, saying that the father and son are not likely to become close. Then, he normalizes the distance ("It's something that goes on all over the world.") and anticipates the "recoil."

The First Intergenerational Triangle

In addition to the primary parental triangle, there are several interlocking auxiliary triangles that must be considered. The first of the auxiliary triangles to be applied to Chris and his family is the intergenerational triangle that includes the symptomatic child, parent, and a grandparent. A child may get caught in the process of such a three-generational triangle because of the emotional process that is triggered by a significant death, most often that of a grandparent. The anxiety and upset surrounding such a loss may be bound into the relationship between a parent and a child, particularly a child who was born in the period approximately 2 years before or after the grandparent's death. Furthermore, this child may in later years appear to be sensitized to periods of increased anxiety and emotional upheaval on that side of the extended family.

In tracking the onset of a problem in its intergenerational context, hypotheses are derived by tracking those transitions that coincided with periods during which the problem recurred. Often, these events reinforce each other to form a "cluster stress" in which the problem is embedded; family members may confirm that they themselves felt a shift in the family climate. The organizational structure of the family may shift, and then continue in the same pattern. Each member's options are narrowed, and there is limited movement.

At this point, the therapist transforms the genogram data into usable information by tracking the cluster stress. In Chris's family, there is evidence to support the hypothesis that Chris is caught in the three-generational triangle with his mother and grandmother. There was a shift in the family system in response to the stress associated with the death of Jane’s father. At that time, Adrian moved to the United States, and Jane took Chris, who was then 10 months old, to help care for her mother following her father's death.

The interlocking of the two triangles – primary parental and intergenerational – was fixed at that time with Adrian in the distant position and Jane in a care-giving, over close relationship with her son and her mother. Guerin explores the possibility that this intergenerational triangle continues to be fixed. He questions whether Jane remains involved in the role of her mother's

caregiver by tracking (1) the extent to which the death of James father is a taboo topic; (2) the health of Jane's mother and Chris's reactions to Jane's upsets; (3) Jane's present involvement with her mother.

There is evidence that the death of Jane's father, while not a taboo topic, is a sensitive one that is not freely discussed.

Guerin: How upset do you remember being during the time of your dad's death and Adrian coming over here? And essentially what you had was your dad died and then moving back in with a very upset mother and your husband taking off for the States to set up his new work thing. So was that an upsetting time for you?

Jane: I think it was very upsetting when my father died. I don't think I really got over that when Adrian left. Because even then that was difficult for me to even mention his name or really, it was funny to think about him without becoming upset.

Guerin: Like, right this minute, you mean? Is that an experience for you that's gone over … He's been dead for 11, 12 years.

Jane: Not really; at certain times. Not very often as a matter of fact.

Guerin: Do you on purpose talk about him with your mother, your brother, Adrian?

Jane: Not on purpose, but he will come up maybe in conversation.

Guerin: So you really had an awful lot to deal with while you were trying to deal with your first year of mothering, too. It was during Chris's first year, his first two years of life your dad died, your family kind of got separated off.

Jane: I would say I have a lot of worry as such. I mean, there was a lot of sadness there.

Guerin: Yeah, emotional upheaval or something.

Jane: Yes, yes.

Guerin: Was mothering easy for you?

Jane: Oh, yes.

Guerin: So it was kind of an easy thing for you.

Jane: Oh, yes, to mother Chris was very easy. I enjoyed that. In fact, it may be even having Chris helped me get over losing my father I suppose. I never thought about it, but it does make sense to me.

Interventions for reversing the flow of movement in this intergenerational triangle include coaching Jane to reconnect with her family of origin, particularly around issues of unresolved grief about her father.

The Second Intergenerational Triangle

The second intergenerational triangle apparent in this family is the four-generational pattern of distance between father and son. Chris is triangled into a series of interlocking triangles in his father's family of origin. Adrian and his mother similarly had a special relationship with his father in the distant position. Going back another generation, Adrian's father never lived with his natural father, but was placed in a foster home. The pattern of distance between father and son over several generations is striking. In the following dialog Guerin asks Adrian for his thoughts on this pattern between him and his own father, between his father and grandfather, and between himself and Chris. Guerin attempts to encourage Adrian to develop a relationship with his own father to reverse this pattern.

Guerin: Do you think you and Chris are going to make it? So many fathers and their sons never make it. Did you make it with your father?

Adrian: When you say make it, do you mean work it out, really close?

Guerin: I mean having a solid relationship.

Adrian: I didn't work it out with my father, it's true.

Guerin: So you're one of the ones that didn't work it out with your dad. I mean there's millions of them out there. Fathers and sons seem to have huge problems connecting with one another. Do you think you and Chris are going to make it?

Adrian: Well, with the odds you just put across, it doesn't look as if it might be that way.

Guerin: Are you hopeless about it?

Adrian: No, not at all. Despondent, no.

Guerin: So, you're going to make an effort still, even though the odds are against you.

Guerin: Was there ever a thing wherein your closeness to your mother was an issue for you and your father?

Adrian: Not a major issue.

Guerin: At least it wasn't up on the surface.

Adrian: That's right. Behind the scenes that may have taken place. I can say my mother came to my defense constantly and that, of course, would go against the grain as far as my father would view it.

Guerin: So, that lined the two of you up with him on the outside.

Chris: Sounds like me.

Guerin lays the groundwork for Adrian's relationship experiment: to begin work on developing a one-to-one personal relationship with his father. He "coaches" Adrian on ways to reconnect with his father by encouraging Adrian to:

1. Make predictions about his father's reaction and plan ways to lighten the atmosphere. As Adrian predicts that his father would be "baffled," Guerin comments, "Is it nice to baffle a 60-year-old man?" And "If you started asking questions like that, he'd think the American air got you daft!"

2. Contract for continued coaching with the therapist.

3. Write a letter to his father telling him of the "project" he has begun (that is, connecting with Chris), asking him for advice, and discovering more about his father's relationship with his own father.

Guerin: I just wondered. Would you be bitter about your experience with him?

Adrian: Yes, if you're looking at bitter or not bitter, I'd say bitter, yes.

Guerin: Would the bitterness be entrenched enough to keep you from making an effort to connect with him at this point?

Adrian: No, as I say I feel I have an open mind on that.

Guerin: So, you'd be willing to entertain that as a possibility.

The School Context

In the child-centered family with a school-related problem, it is most important to look at the interlocking triangles embedded in the context of the school system and how it interfaces with the family system. The first of these triangles is the one in which the child's vulnerability in the family system does not show up explicitly within the family, but is played out in the child's peer network. Chris, like his father, sees himself as the rational problem solver; vis-à-vis his peers, he is in a distant, isolated position.

Chris: Well, if somebody is teasing me and I'm really upset, I'll keep to myself and then say, like someone is hurting another kid, I'll step in and say, why are you doing it? And if they were to, oh, they hit me in the head with a snowball, then I think why did he do it and I'd ask him why.

Guerin: So, when you're upset, you like to be by yourself, and you're kind of a reasonable person, and you like things to work smoothly. In those ways, you'd be like your dad.

The hypothesis of a covert alliance between father and son would lead to interventions in which the therapist coaches Adrian to build a more explicit relationship with his son.

The second relevant triangle involves the symptomatic child caught in a conflict with a teacher or other authority figure as a result of an underlying conflict between the parents and/or stress in the extended family. The conflict may be implicit or explicit. In the case of Chris, the conflict is implicit and initially took the form of his refusal to attend school. At the onset of this symptom, multiple factors combined to form a sufficiently stressful context: the intergenerational triangle in which Chris, sensitized as an infant to distress in his mother's family, is triangled with his mother and her concern about her mother's health, and the surfacing of marital conflict around

parenting issues. In the following dialog, Jane outlines some of the problems between her and Adrian at the onset of Chris's symptoms.

Jane: There were problems between Adrian and me in as much as Adrian wouldn't help me with Chris and the braces. He was forever saying you can do this, you can do that, but I didn't get any type of help from him. And Chris was a heavy boy to carry around.

Guerin: So, that was kind of a perennial problem in the thing of Adrian expecting from you that you would handle all of that.

Jane: Yes. I didn't mind handling certain things so much because I knew Adrian was pressured anyway. I think it was more a relationship that bothered me. I don't think we were as close as what we should be. It was a lot of things missing.

Jane's reactivity to Adrian led to yet another triangle, one in which her conflict with the school administration was based in part on Adrian's profession – a schoolteacher. In this context, she increased her focus on Chris, putting more pressure on him and on the school to get more services and to arrange for transfer to another school.

Interventions focus on relevant issues in the marital conflict. In this family, they involve dissecting the pursuit-distance pattern in the marriage, assigning tasks to modify this pattern, and placing it in an intergenerational context.

Conclusion

With the structural alterations in the primary parental triangle, the father's increased involvement with Chris, and the improvement in the father-son relationship, Chris's school behavior problems decreased considerably. There was a marked decrease in his isolation, and improvement in his adjustment to school, and an increase in his play network outside school. Jane began to show signs of a mild-to-moderate depressive reaction, although on an intellectual level she had accomplished her stated goal of bringing together her son and his father. The shift in the triangle put her on the outside and produced her symptoms, which were then linked to unresolved grief and mourning processes resulting from the death of her father and from her worries about her mother's declining health. Focus on these issues, using the interventions of coaching and letter writing, alleviated some of this distress. Intimacy in the couple was somewhat improved. Therapy was interrupted when Adrian was offered an excellent job in England and the family left.

SECTION II-C: TREATMENT OF THE INDIVIDUAL

The third Guerin model is the application of family systems theory to the treatment of adult individuals, particularly those people who come to therapy with a relationship problem, developmental difficulties, or problems that have been refractory to other methods of

intervention. Such problems frequently respond to triangles work, and so, to illustrate the model, we reproduce here Chapter 8 from Working with Relationship Triangles *(Guerin, Fogarty, Fay, and Kautto,, Guilford, 1996). It presents way of helping a well-motivated individual deal with emotional problems at the family system level. Bowen, Guerin, and Fogarty have always taught that family therapy is not question of who is in the therapy room, but rather is a question of widening the lens through which the therapist looks at a problem. This chapter*

Coaching and Direct Intervention with Triangles in Individual Therapy

Philip J. Guerin, Jr., Thomas F. Fogarty, Leo F. Fay, Judith Gilbert Kautto

In the last chapter we established that individual cases are most likely to benefit from triangle therapy when they present in one of three ways – as relationship problems, as developmental difficulties, or as problems refractory to other methods of intervention. We also propose that the clinical interventions used in these cases can be either *coaching* or *direct intervention.* Coaching an individual to do triangle work in his or her family or work system is more effective with people who are functioning at a high level. These people can step somewhat outside the ongoing emotional process, slow down their own emotional reactivity, figure out the structure of a particular relationship set and how the emotional process flows, and form an experimental plan of action. Direct intervention, by which we mean bringing one or more of the triangle's members into therapy and working with the triangle there, is better suited for those who aren't able to detach themselves from the problem sufficiently. They remain reactive and caught up in the emotional process in a way that blinds them to options for dealing with it. It takes direct intervention to depolarize the conflict, decrease the heat, and bring light to bear on the situation.

The cases that follow are meant to give you a fuller sense of how to do triangle therapy with individuals when their problems fit into one of the three categories of relationship problems, developmental difficulties, or problems refractory to other methods of intervention.

Cases that present with relationship problems

1. Jeanne's Problem – Business or Personal?

Jeanne Y. was a 50-year-old investment counselor – attractive, intelligent, and looking 10 years younger than her stated age. She came to therapy following a crisis at work. Until the crisis she had enjoyed a good working relationship with her superiors, her colleagues, and her clients. Economic conditions change, however, and the company's clients were buying fewer of certain derivative products in which she specialized. Trying to recoup some of their losses, Jeanne's boss led an effort to develop and market a new investment product without fully disclosing significant risks inherent in the product. One of Jeanne's best clients discovered this on his own, and brought the matter to Jeanne's attention.

Besides having some ethical concerns about the lack of disclosure, Jeanne felt caught between loyalty to her boss and obligations to her client. Her boss tried to gloss over the problem and minimize the ethical issues. Jeanne demanded full disclosure to the few clients who had already bought the product and a willingness by the company to buy it back from those who wanted out when informed of the risk. Jeanne's ethically-driven behavior allied her with her client. Her boss was in the outsider position, angry but reluctant to dismiss Jeanne or to write off the client. Jeanne's position had been based on her ethical principles, but she was unable to control her anxiety when faced with her boss's accusations of disloyalty. So she came to therapy.

Jeanne's therapist coached her to try to neutralize this triangle by holding her "I-position" based on her ethical principles and be ready to deal with the fallout from both her boss and her client. As she worked on this task, Jeanne began to realize how much she had fostered the client's dependence on her. She had spent excessive amounts of time listening to his personal problems and had made light of his infrequent sexual innuendos, all with the goal of keeping his business. It was as if she didn't have enough confidence in her talents as an investment advisor and needed these other perks to satisfy the client. Her boss's response to the crisis highlighted for Jeanne the many times he had failed to include her in important meetings or to inform her about policies and plans. She realized that her boss valued her charm and sales ability but undervalued her creativity, intelligence, and good judgment.

As Jeanne progressed in therapy and in her work on the business triangle, she felt empowered and no longer trapped at work. She eventually changed jobs and started to reflect on the meaning of all she had been doing for her personal relationships. As she did this, she began to see just how clinging and dependent her husband had become, and how she had fostered that. She even allowed herself to remember how her 80-year-old father had for years used her for investment tips while excluding her from estate-planning meetings with her three brothers. Jeanne defined her relationship with her husband and her father as her next triangular challenge.

2. Lucy – A Single Mother and Her Only Son

Lucy V. Was 36 when she came for therapy. She was concerned about her 19-year-old son, Ben, her only child. He was away at college and would often call her late at night, anxious and worried about his studies. He'd begin by saying that he couldn't sleep and was having fantasies that when he was through with school he wouldn't be able to survive on his own – that he wouldn't find a job, know how to fill out tax returns, find a mechanic for his car. Then he'd say that he had a test the next day and hadn't studied for it.

Lucy was a single parent and was upset about Ben being so anxious. She wanted to find a way to make him go to therapy. Instead, she told him that everything would be fine, and then she'd give him advice about organizing his time so that he could study more effectively. Lucy wondered why she behaved this way with her son and decided it was somehow linked with her guilt about divorcing his father. Ben's father was uninvolved with him except financially, and Lucy also wanted to find a way to convince him to take more interest in their son. This is a description, of course, of an overfunctioner caught in a triangle with her ex-husband and her son. She was trying to fix her son and his relationship with his father, something she'd been doing for years.

The therapist began by trying to get Lucy to experiment with drawing some boundaries – giving less advice to Ben and asking him not to call after 10:30 PM unless it was an emergency. While

conducting the experiment, she was to monitor her emotional state and to observe any changes in her relationship with Ben. She hoped he might call his father to complain about her. To help Lucy distance herself from her son, the therapist linked the therapy process to her extended family by asking her how her life would have been different if, like Ben, she'd been an only child.

Lucy began to focus on the triangle involving herself, her mother, and her older sister, Carla. Mother would call Lucy with complaints about Carla. "Carla never called." "Carla was wasting her money by buying a car that was too expensive." "Carla would never find a man if she didn't stop being so nasty to everyone." Lucy, having her own negative history with her sister, would join her mother in bad-mouthing Carla. Carla was six years older than Lucy, and they had been very close when they were children. Lucy remembered them playing school (Carla always played the teacher) and talking about all kinds of things. All that changed when Carla left for college and escaped from her conflicted relationship with her mother. Lucy felt abandoned. She realized that with her father's recent death and her mother's failing health, Carla was the only family she would have. It made sense to her to do some work on altering her reactivity with her sister and on getting out from between her mother and her sister.

To accomplish that goal, Lucy set up a series of monthly dinner engagements with Carla. She told her sister how lonely she was without Ben at home and how much she now needed the big sister who'd been there when they were little. Carla responded positively, and movement in the triangle began to shift.

Lucy's therapist also focused on the triangles that fed the problems with Ben. If she could help Lucy decrease her anxiety, she'd transmit less of it to Ben, she'd bail him out less, make fewer excuses for him, and his functioning might improve.

Cases with Developmental Problems

1. Joshua – A Young Man Back at Home

Joshua F. was a 26-year-old single man living with his parents. He had moved out after college and had gotten a job as a bank auditor in Virginia. While living in Virginia he had been seriously hurt in an automobile accident, and he had come home to recuperate. He had moved out again but returned after several months. He came for therapy at his parents' insistence. They thought it was time for Joshua to move out permanently and be on his own, and Joshua agreed with them. He felt frustrated and angry with himself that he just couldn't face being on his own again, and he was angry with his parents, especially his father, for pushing him.

This inability to move out after he had recuperated strongly suggested a developmental problem that was complicated by (not caused by) his accident. It was as if Joshua had barely gotten out the first time, and after the accident he got mired in his primary parental triangle. In the aftermath of his accident, Joshua had developed symptoms of depression, seasoned with episodes of intense anxiety. During these episodes, he'd fluctuate back and forth between his fears of leaving home and feeling trapped there forever.

Joshua had always been caught in the middle between his parents. His present situation, the depression and anxiety, and his low functioning were complicated by the accident, his physical pain, and his drawn-out lawsuit seeking financial compensation for his loss of functioning and

suffering. In the background, however, was perhaps the most important factor in this situation, predating his accident – his position in his primary parental triangle. During the therapist's investigation of Joshua's past and present relationship with his parents, she learned that early in Joshua's life his mother had been the beneficiary of a large trust fund from her grandparents. She had given Joshua's father considerable amounts of money to start up several business ventures, all of which had failed. Joshua's most vivid memories of his father were of him leaving to play golf four or five mornings a week. He remembered his father not coming home much, and when he did, he'd drink too much and criticize Joshua on the occasions when he spoke to him. Joshua didn't remember his parents ever discussing any of these issues. Mrs. F. never spoke to her husband about how she felt about his business failures. His parents were quite distant and appeared to live parallel lives. Mrs. F. regularly commiserated with Joshua about his father's criticisms of him, and she managed to convey to Joshua her disrespect for his father's unproductive lifestyle. The therapist suggested to Joshua that it might be useful to include his parents in therapy for a few sessions.

In the conjoint sessions, the therapist began by reviewing the parents' concerns about Joshua – was his pain real, was he getting adequate care from the pain clinic, and was he becoming addicted to pain medication? After listening to their anxieties and discussing them, the therapist then broached the subject of Joshua's living at home and the difficulty he was having in leaving. She asked Mr. and Mrs. F. if they had thought about how they could be supportive of their son without being enabling. This discussion led to suggestions from the therapist aimed at changing the structure of the primary parental triangle.

First, the therapist talked with Mrs. F. about how helpful it would be if she could learn not to pump her anxiety into Joshua. She pointed out that Mrs. F. could instead come in and talk to the therapist about things that were bothering her, or talk to her husband or family or a friend. But she should avoid making Joshua her confidant.

Second, Mrs. F. needed to discuss clearly with Joshua how financially supportive she was willing to be. Her wealth made it possible for her to arrange that Joshua would never have to work again, but that might be more damaging than helpful. The therapist suggested that perhaps Joshua and his mother might negotiate the issue: Joshua could begin by telling her what he needed in the way of financial support, and Mrs. F. could evaluate whether she thought doing that would be supportive or enabling. The therapist offered to help in that negotiation if it turned out to be necessary.

Third, the therapist talked with Mr. F. about his job in this family experiment. He could view Joshua's misfortune as an opportunity to do what he had never done – build a relationship with Joshua. Mr. F's only way of relating to Joshua during his childhood and college years had been to criticize him. Now was his chance to develop a personal connection with his adult son. The therapist suggested that Joshua and his father spend relationship time together, doing something they both enjoyed. She also thought it might be interesting for the two of them to get together and talk about Mr. F's father and in general about the men in the family – how well or poorly they did, and why.

During this work, Joshua, albeit with a substantial apprehension, found an apartment in the same town, moved out of his parents' home, and found a job as a loan officer in the local bank. At this point, the family decided to take a vacation from therapy. In her last session with Joshua, the

therapist asked him if he thought his mother would ever take the therapist up on her offer to come in and talk about what bothered her. That question caused Joshua to raise the issue of his parents' marriage. He told the therapist that during his most recent dinner date with his father, Joshua asked him how he'd evaluate his marriage. Joshua told his father that he'd started thinking about getting married someday, and was curious about how his father viewed marriage in general and his marriage in particular. His father had changed the subject. Clearly, therapy with this family had miles to go.

Compelling circumstances that affect an individual, such as a serious accident, often lead clients and therapists to overlook the family context, as if problems are either in the individual or in the surrounding relationship system. Human beings tend to think in all-or-nothing, either-or terms. Integrating the individual and the system regularly turns out to be harder than it sounds. Although most people accept the importance of integrating nature and nurture, shaping experience and DNA, they still behave as if everything important happens either at the neurosynapse or at the mother's knee.

Joshua's accident and the physical and emotional aftermath adversely affected him and everyone who had a relationship with him. The therapist hoped that the direct intervention with his parents would foster continued efforts to move Joshua and his family toward better functioning and improved connection with one another. His strengths and flaws as an individual, and those of his relationship system, are important in accomplishing these goals.

2. Cynthia – A Middle-Aged Nurse at Work and at Home

Cynthia U. called in an agitated state, explaining that she had been crying, depressed, and without sleep for two days following an intense confrontation with her boss. She felt frightened and out-of-control, and she had asked a physician with whom she was friendly for a referral. Cynthia was a head nurse who had "lost it" with her supervisor when that supervisor informed her that she was reassigning Cynthia to another floor the following month. Cynthia had been happy working in pediatrics, and the supervisor wanted her to move to Ob-Gyn. At 48 and after 26 years with exemplary record of nursing, Cynthia felt abused and said so, loudly. Cynthia was perplexed by her reaction, since refusing an assignment, let alone having a public outburst, was totally uncharacteristic of her. She had been unable to return to the hospital since the incident, and she was having difficulty pulling herself together.

Like most people approaching 50, Cynthia was under considerable pressure. The past year had been particularly stressful. Eight months before the encounter with her supervisor, she had begun hormone replacement therapy and had a hysterectomy, neither of which had resolved her physical problems. She believed that her hormone levels were now even more unbalanced than when she'd started the treatment, contributing to her uncharacteristic emotionality. In addition, Cynthia's older son left for college that fall, and she worried a lot about how he would adjust.

Other pressures were related to both her husband's and her own extended families. Cynthia grew up in an Italian-American family. She was the oldest of three children, having a younger brother and a sister. Her parents, who were retired and sickly, were her major concern. Cynthia's sister had been married to a man whom Cynthia described as crazy. In the latest crisis, Cynthia's sister had called to report that her husband had tried to set fire to their house and that she had called the

police. In the aftermath of that incident, the sister and her three children had moved in with Cynthia's parents.

Cynthia's parents and her brother (who lived out of state) called her daily, sometimes more often, to complain about the situation. She was frantic about her parents' physical and emotional well-being. She was also angry with all her family members because they refused to take her advice.

Cynthia's role in the family had always been that of the over responsible caretaker. She was the one the rest of her family came to to solve problems and express unhappiness about others. She had been the one who behaved, always complying with her parents' wishes even though she felt they ignored her and didn't value her as much as they did her younger siblings. She was never pretty like her sister or brilliant like her brother. She described her relationship with her mother over the years as difficult. Although her mother called her with all her problems, she became angry with Cynthia if Cynthia suggested solutions. Cynthia's dad was a quiet, passive man, reluctant to express his opinion. More recently, with the deterioration of his health, Cynthia feared that the increased stress from having her sister and her sister's children move in would kill him.

In her husband's family, Cynthia found the approval and attention she'd always longed for. Cynthia and her mother-in-law were like sisters and spoke every day, at least on the phone. In the previous year, after an unsuccessful intervention with Cynthia's husband's alcoholic brother, Cynthia's relationship with her mother-in-law changed. It had been a relationship in which Cynthia had felt nurtured, but now Cynthia's mother-in-law began calling Cynthia with her anxiety over the treatment failure of her alcoholic son. This shifted the relationship, and further drained Cynthia's energy – in a place where nurturing and support had been for years. Cynthia couldn't take it and had been trying to avoid her.

Cynthia came to therapy with a litany of symptoms. She had no energy, but although she always felt tired, she had difficulty staying asleep at night, waking up to one more times every night. She looked to herself like her old and haggard mother, instead of the vital woman she used to be. She was irritable and had experienced an increase in the frequency of aches and pains in her head and back. She had been having palpitations. In short, she had a pervasive listlessness and negativity familiar to many of us in our middle years. Feeling this way made it difficult for her to work, a major area of competency for her for years.

By assessing the stressors using a genogram, the therapist could see certain things much more clearly. First, changes that are common in midlife had bombarded Cynthia in the previous year. Illness, the threatened change in her job, her son leaving for school, and the loss of the comfort of her mother-in-law had all contributed to rising anxiety in the family and in Cynthia. Second, Cynthia was an over responsible and serious woman, and her response to stress was to try harder to fix things in everyone's life. When she couldn't, she became angry and felt guilty. She then tried harder and reached a state of burnout. By the time her superior informed her of her job reassignment, she had no emotional reserves left.

Whatever approach a therapist might take to treat Cynthia's emotional turmoil – behavioral, psychodynamic, family systems, cognitive – addressing her behavior in her extended family triangles, especially the primary parental triangle, is crucial in helping Cynthia return to functioning. A return to functioning first meant getting back to work. The therapist addressed

Cynthia's individual functioning by reframing her situation. This involved coaching her on how to make a cognitive shift, altering her overly negative perspective, and acquiring a more positive view to facilitate the kind of changes that were going to be necessary. It also involved helping her see that she had more going on in her life than a job change and the problem with her boss. This shift helped Cynthia to see that in reality she had a long-term, good relationship with her boss, and that his shifting her assignment was a vote of confidence in her abilities rather than a criticism. The therapist normalized Cynthia's difficulty around midlife anxieties and pressures, and the tough situations she was dealing with, by reviewing with her how predictable many of them were and how understandable her response was. This made it easier for Cynthia to develop a rationale for having "lost it" at work: her over responsible and serious nature, the year of physical emotional change, her inability ever to walk away from a problem, and her need to ease up. Speaking to the triangles in her life might also prevent a recycling of this scenario should Cynthia's level of stress increase due to another midlife mishap. As an adult, Cynthia's way of relating to her parents had been to continue her overly responsible role in the family. She was still at her mother's ear, but not her mother's favorite; that was a role reserved for her baby sister. Her relationship with her father, more distant than ever as he developed Parkinson's disease, became increasingly less rewarding. Cindy's position with both parents was one-dimensional, a relationship without options. Cynthia was caught in a pattern of being the problem solver with her entire extended family, not free to operate on a person-to-person basis with any one of them. Being stuck in this place left her without a "real" relationship with her parents at a time in her life when she was surrounded by loss or potential loss. Her contact with her family left her angry, frustrated, and frightened. In a way, the senior nursing supervisor had been a parental figure in her life, one she felt had approved of her until the recent confrontation.

The therapist assessed Cynthia's extended family and in-laws triangles. Cynthia made no secret of the impact that the shift in her previously supportive and close relationship with her mother-in-law had had on her. It was clear to the therapist that the soil had been fertile for Cynthia's connection to her husband's mother, because she was a warm and nurturing woman who was excited about having a "daughter" like Cynthia; this was a sharp contrast with Cynthia's perception of her own mother. Losing her mother-in-law's support and nurturing hurt.

Underpinning her need for her mother-in-law were the difficult relationships Cynthia had in her own extended family. Over the years she had handled her disappointment in her relationships with her mother and father with distance and ritualized contact. She maintained her polite, goody two shoes operating style for all the years until her sister's difficult marital situation caused the change in the way the family operated. Cynthia became the person everyone turned to to resolve what had become an unresolvable situation. She was caught between her own reactivity and her family, and had real anxiety and fears over everyone's safety.

When the therapist discussed with Cynthia her role with her in-laws, it became clear that Cynthia was over functioning in that family, too. Her husband had thrown up his hands when it came to his alcoholic brother. He had no patience for his mother’s infantilizing him. He also felt frustrated that Cynthia had been in the middle between his mother and him, pressuring him to do something so that his mother would not be upset. The therapist coached Cynthia to turn her husband's family problems back over to her husband and just have a woman-to-woman relationship with her mother-in-law. Cynthia liked the idea, although she admitted it would be

difficult work. The therapist made a mental note that the change in this in-law triangle might unearth some conflict between Cynthia and her husband.

Addressing Cynthia's primary parental triangle was crucial to her recovery from her depression. The therapist employed the following strategy to alter Cynthia's position in the triangle with her parents. First, Cynthia was coached to stop trying to resolve her sister's and parents' living situation. This meant teaching Cynthia how to behave in a less parental and more helpless way. She admitted to her mother that she was at a loss. She said that the problem was tough and that it saddened her that she was failing the family, especially her mother. This was a totally new and nondefensive position for Cynthia, and initially it made her quite anxious and worried. However, when she realized that nothing awful happened as a result, she was greatly relieved.

Next, the therapist coached Cynthia to narrow the distance between her sick father and herself. She was to do that by making one- or two-hour, one-on-one visits with him in which she just "hung out" and didn't discuss family problems. If they did talk, Cynthia would ask her father to talk about his past, perhaps about his parents. She was coached to monitor her mother's reaction to this shift and to make sure she brought her mother a little gift when she came to visit or spend some time alone with her. Cynthia planned her visits when her sister wasn't around, as it would have overloaded Cynthia to also have to deal with her sister. That would come later.

The frequency of sessions had been about once a month. The therapist raised with Cynthia the possibility of bringing in her whole family for some direct intervention, but they all had their own their own versions of therapy allergy. Cynthia thought it wouldn't work.

Her position in her primary parental triangle had changed over time. As in all triangles, the relationships and the intensity of the reactivity between people vary from day to day and from issue to issue. When you're addressing a clinical problem that involves a triangle such as Cynthia's, it isn't helpful to focus on the parents' motivation, or even their fault, in the triangle. It's important to remember that everyone in the triangle plays a part. To be successful in coaching a patient to change his or her position, both the therapist's and the patient's reactivity need to be under control. The fact that Cynthia was the unsung hero in her family may have contributed to her feeling victimized and helpless to change her position. The therapist needed to be clear that Cynthia was becoming a hero to herself with the new way she was operating in the key triangles of her life.

Cynthia was a better coaching subject than the therapist had predicted – she was highly motivated to regain some control of her life and these methods made a lot of sense to her. Today she is much less tired out and has even had some decent talks with her mother about missing her son.

Cases of Refractory Anxiety or Depression

1. Denise – A Stubborn Depression with Somatic Complaints

Denise T. loved the juggling act that was her life. She was a mortgage loan officer for a large financial institution, a married mother of two, and 45 years old. All her life she had amazed the people who knew her with her energy and ease of accomplishment. Approximately a year before coming to therapy she began to experience incapacitating headaches, preceded by nausea, photophobia, and other visual symptoms. In the beginning, she had had the headaches only about

once a month, but recently she was losing up to six days a month of work because of them. When the pain came, she had no choice but to retreat to her darkened bedroom, take her pain medicine, and sleep until it was over.

Her internist and a consulting neurologist had tried their best to bring her relief, and when they met with only limited success, they referred Denise to the headache clinic of a major teaching hospital in New York City. At the headache clinic, the doctor in charge created what he called his special individualized headache cocktail, consisting of a combination of anti-inflammatory agents, muscle relaxants, and a tricyclic antidepressant medication. This regimen brought her some relief in the headaches' intensity. The neurologist also recommended psychotherapy for what he saw as her accompanying depression.

When she came for psychotherapy, she hoped that both the intensity and frequency of her headaches would decrease in time. She was less concerned about depression then about her headaches. The initial evaluation in therapy revealed substantial stressors and challenges in Denise's life over the past 18 months: (1) her father had died after a six-month battle with pancreatic cancer; (2) her mother put the family home on the market and moved in with Denise; (3) her husband had taken a new job in the city 200 miles away and was only home on weekends; (4) her youngest child and only son had left for college. The implications of these events with Denise's emotional life were profound. First, she had lost the connection with her father and the emotional support and unconditional approval she had always received from him. Second, she was now subject to constant "constructive criticism" from her mother, which she used to receive only once a week on the telephone. Third, her husband returned home every weekend and gave her his version of constructive criticism. Finally, her son's departure had robbed her of his reassuring presence and had created an emotional void in her life.

Besides all that, her husband's attitude toward her headaches implied that they were psychosomatic (which to him meant a figment of her overactive imagination) and that she was using them to punish him for taking the job in another city. In fact, Denise did think that it was a strange coincidence that Dan's new job opportunity had arisen shortly after her mother had moved in. She acknowledged that she was angry with him, but she knew that her pounding pain was very real. When the therapist asked how she thought her anger at Dan came out, Denise described difficulty sleeping, overeating, and her inability to think about anything else.

Most clinical situations represent a triangle waiting to happen (or, more likely, a triangle that has already happened and is waiting to make an appearance). The symptom bearer often feels victimized or misunderstood by family members or health care professionals. The tightrope the clinician must walk is to provide the necessary validation, empathy, and support without joining in on blaming the family or avoiding contact with them, and without becoming an advocate for the patient with his or her family. Being able to see triangles and manage them is critical to walking this tightrope successfully. Walking the tightrope gives the patient support and calms down the family, enabling them to be less reactive and therefore more supportive themselves.

The theory here is that Denise's losses, combined with the developmental and structural changes in the family, had set off a biological vulnerability to headaches. They had also activated the dysfunctional adult triangle (her mother and her husband both trying to fix her). Denise had distanced herself from the criticism by moving toward neurologists for her headaches and toward psychiatrists for her depression. Introducing myriad physicians had created therapy triangles, as

the physicians had aligned themselves with her against her husband and mother. Having run out of options, and looking for something else to try, one of them had made the referral.

The advantage of seeing triangles in this clinical situation is that it gave the therapist options that hadn't been tried before. First, the therapist assumed that, given Denise's history, there was a potentially significant triangle trap in this therapy, as there had been with Denise's other healthcare providers and her family. The therapist took some specific steps to avoid the triangle therapy trap in which Denise tried to get the therapist on her side against the husband-mother coalition. The therapist called the physician who was treating Denise's headaches and got his view of what was going on with the medical treatment and the psychological overlay. The therapist reviewed with him how she saw the case and told him her plan to work with Denise's mother and husband. This greatly pleased the physician, who was tired of the constant interference and questioning of his treatment of Denise. Bringing Denise's mother and husband into sessions as "consultants" kept the potential reactivity to the therapist in check and calmed them down. Patients like Denise are too caught and powerless to be effectively *coached* on how to work their way out of these kinds of triangles. There's just not enough emotional resilience left after the relationship pressure and the depression have taken their toll. In clinical situations such as this, it is important to include the other two members of the triangle and to engage them in changing their part in the triangle's workings. This also reinforces the therapist's efforts to avoid becoming overly aligned with the patient, and preserves a critical level of objectivity.

The therapist worked to modify the triangle consisting of Denise, her husband, and her mother in sessions with each member. The anxiety that her mother and husband focused on Denise intensified her stress and increased the effectiveness of pharmacological interventions for her headaches. The therapist made the mother's and husband's focus on Denise explicit and highlighted the way that attention aggravated and maintained the symptoms. She got Denise to talk about her experience of their focus on her and how it affected her. The therapist pointed out that, with nothing but good intentions, Denise's husband and mother were giving her what they thought she needed: encouragement, advice, and instruction. The therapist suggested that this wasn't working, and recommended that they take time out to listen to Denise and allow her to tell them what she needs from them, and then try to provide it.

The therapist also asked Denise to listen to what her husband and mother needed from her. What they told her was that sometimes they thought she wasn’t trying – that she wasn't compliant with her treatment and didn't really want to get better. When the therapist asked what gave them that impression, they replied that Denise didn't tell them anything. In fact, it was true that she often withdrew and shut down, probably in response to their instruction and criticism, and didn't tell them about what she was doing and how she was trying. Denise agreed to be more aggressive about communicating with them.

Eight weeks later, the therapist contacted Denise's physician to check on her progress. The physician reported that Denise hadn't had a headache for two weeks and that he was very encouraged. He also expressed his own relief that Denise's husband and mother were no longer on his back.

2. Connie – A Major Depression

Connie B. sought treatment for a symptom profile typical of a major depression. Over a 10-week period before calling for an appointment, she had noticed increasing levels of fatigue. She had spent long periods lying awake in bed, staring at the ceiling and thinking nothing but negative and morbid thoughts. When she began making excuses for not going to work, it had frightened her sufficiently that she decided to seek help. She went to her family physician, who prescribed Prozac. She took it for four weeks with poor results. The family physician then referred her to a psychiatrist, who increased the dosage of medication and talked with her about the current stressors in her life. Suspecting marital problems, the psychiatrist referred her to a systems therapist.

In the evaluation session, Connie reported that this was the third such episode in her life. The first had occurred 16 years before when she was 16 and her next oldest sibling, Dale, had just left for college. That fall Connie had begun having academic difficulty in school, had lost interest in volleyball and dating, and had put on 15 pounds. She remembered vividly the struggles with her mother over her homework and the frustration her father experienced in the face of the constant bickering between them. Connie felt she had never measured up to what her mother wanted in a daughter. She always felt like an outsider in her relationships with her two older sisters, Joanne, now 41, and Dale, now 34.

In fact, Connie never felt she fit in her family at all. As a youngster growing up in Westchester County, she was bigger than most of the young women her age, but she had superior athletic gifts. Besides volleyball, she had also excelled in lacrosse and swimming from an early age. This set her apart from her sisters, who were shorter and slimmer, specialized in looking pretty, and scored more than 1400 on their SATs. Connie remembered longing to be better friends with her older sisters and wishing that her paternal grandmother were her mother. Grandma never criticized and always seemed to understand.

Connie's sisters had both graduated from Ivy League colleges and law schools and had settled in Washington, DC. Both were married and had children and, to Connie, were living happily ever after. She found it ironic that her sisters had moved away and that she had settled in the same town in which she had grown up, since they had been such stars there, and she had been so unhappy. She never traveled very far, going to college at Sarah Lawrence in Westchester County, New York, and getting her master's in physical therapy in Manhattan. As an adolescent, mostly in the aftermath of conflict with her mother, Connie would often fantasize about living in California. That fantasy ended, she guessed, when she met Justin at a New York City singles' bar while she was a graduate student. Justin was an older man, 30 when she met him; he owned his own business and was a "regular, quiet, but fun-loving guy." They courted for two years and after Connie finished her training, married and settled in Westchester. Justin's already thriving advertising and public relations business made California highly unlikely.

Two years after they married, Connie and Justin started thinking about having children but when they stopped taking precautions, nothing happened. Halfway through a prolonged fertility workup, Connie experienced her second episode of major depression. The hormonal rushes and emotional lability the fertility drugs produced in her were bad enough, but the lack of results was devastating. She remembered her grandmother, who had died when Connie was 13, telling her to take comfort in her size and strength because she would make healthy babies someday. She decided to stop trying to get pregnant for a while, and with the help of therapy and Prozac she felt somewhat better within six months.

During this time she recalls having noticed an increasing attachment between Justin and her mother. This pleased Connie greatly because it meant that her mother accepted Justin although he "wasn't Ivy League." Somehow in recent weeks, however, Connie had become increasingly annoyed listening to Justin's encouragement and instructions each evening. It was very close to what felt like criticism from her mother.

Connie's life had been a series of sequential triangles. Born into the third and youngest sibling position in her family, she started out in the outside position in a triangle with her older sisters. Her sisters had been close, and they remained close all their lives – even settling in the same town, 250 miles from home, after law school. Being the outsider, as Connie was, is a vulnerable place to be for a kid who wants to be on the inside. In the triangle with her mother and sister she also occupied the outside position and was her mother's target child. The criticism from her mother was most intense during the period after Dale left for college. Somehow, Connie made it through, depressions and all.

Her present dilemma created the perfect mix for another bout of depression. If she took the fertility drugs, she'd have hormonal problems; if she didn't, she'd probably sacrifice reproductive function. As if that weren't enough, the activation of a triangle with her husband and mother completed the picture. As the systems therapist reviewed Connie’s story, replete with all those triangles, it became clear that some sustained triangle work might improve Connie's response to Prozac, decrease the intensity of her intermittent bouts of depression, and give her the strength to try the fertility treatments again if she wants to.

The Therapy Triangle

The therapy triangle occurs when a therapist becomes reactive to the emotional process either in the therapeutic relationship or in the family, and either take sides or becomes paralyzed and unable to work effectively. Avoiding the therapy triangle when working with troubled marriages or with symptomatic children and their families is difficult enough. It is even more of a challenge in doing therapy with individuals. Having only one person in the room creates a level of empathy and identification that can ally the therapist inappropriately with his patient against the other persons in the patient's life. Closing this chapter with some reflections on this problem seems appropriate.

Dealing with the therapy triangle means dealing with the relationship phenomena among patient, therapist, and significant others from the patient's life. In psychodynamic therapy, these phenomena are treated as transference and countertransference problems. It is relatively simple to shift one's viewpoint and see the phenomena of transference and countertransference as triangular phenomena. The advantage of doing so is that it gives the therapist increased options.

In the classical transference paradigm, the patient struggles with the universal problem of getting emotional needs met. In the process, they're confronted with conflicts between their internalized (intrapsychic) version of an important relationship object (for purposes of discussion, let's say it's their mother) and the reality object that's the mother they experience in everyday life. If the patient has a distorted internalized object – one in which she has over idealized her mother – she may then expect her mother to deliver an abundance of nurturing supplies to her in the present. This leads to disappointment, hurt, and anger again and again. As the patient's dependency intensifies in the therapy relationship, the internalized version of mother gets externalized into

the therapeutic relationship. The corresponding expectation of nurturing supplies from the therapist gets activated and once again is frustrated. The conflict between patient and mother is thereby transferred to the therapist. If we forget for a moment about the unconscious, we can see that this phenomenon represents the displacement of needs and expectations from the mother to the therapist.

Displacement is one major mechanism of triangle activation. In systems psychotherapy, however, instead of encouraging the dependence of the patient on the therapist and thereby fostering the transference, we work to minimize the intensity of dependence within the therapeutic relationship and thereby tried to minimize the transference. We achieve this by being active, real participants in the treatment relationship, by limiting the frequency of sessions, and by keeping the treatment focused on the patient's real-life relationships rather than on the relationship with the therapist. We also try to educate the patient about how a person's expectations are often not aligned with what the other person can realistically be expected to deliver. Finally, we send the patient back to work on the relationship with the significant other, or we bring the other into the therapy sessions.

It is not news that therapists are vulnerable to becoming emotionally reactive as they sort through a patient's situation and try to come up with a treatment plan that is effective and satisfactory to the patient. Most of us have spent time, energy, and money in our own therapy, in therapist’s own family (TOF) work, or in supervision, finding a way to handle our personal issues so that they don't compromise the treatment we provide. We've all been in situations in our clinical practice in which our own emotions, needs, biases, and assumptions blind us. Even in family and couple therapy, we get angry with one or more people in the treatment room for being difficult or resistant. We get caught in power struggles with some patients. Out of exasperation, we reactively and inappropriately label one patient as borderline and another narcissistic because we are unable to find a way around our lack of empathy. At other times, we are sometimes too empathetic with and protective of a patient. Our anxiety makes us overly responsible for patients' decisions and well-being. We work too hard and worry too much, unable to steer a clear path through our own reactivity, often paralyzing the patient in the process.

Usually when we look at these situations, we find countertransference issues. When we do, we can be confident that there are one or more therapy triangles we need to address. The therapist has a responsibility to search out countertransference reactions by actively attempting to understand them in the context of the therapist's own family. This is best done by getting supervision, clinical consultation, or coaching from a colleague, consultant, or therapist. However, many of the more minor countertransference reactions, if looked at as triangles, can be worked out by therapists themselves – locating their own triggers, calming their own reactivity, eliminating reactively driven behavior, and detriangling by putting the problem back into the context of the patient's life and helping the patient deal with it there.

One therapist requested a consultation for Eleanor, a 39-year-old divorced woman who'd been seeing him in weekly psychotherapy for 10 months. Eleanor was talking in most sessions about her attraction to the therapist, her fantasies about him, and her lack of interest in meeting any other men. This woman had been utterly dependent on her husband, a thoroughly controlling man who had left her. The therapist had seen them both initially, and the husband left therapy almost immediately. The therapist was left with the devastated wife, who became increasingly dependent on the therapist and then eroticized the dependency. The therapist was anxious about

the eroticized material, and his reactivity began because he didn't know what to do about it. He kept trying to convince the woman that she didn't feel this way, or that if she did, she shouldn't. The therapist's behavior was caused by his anxiety and his reactivity to the patient's displaced erotic feelings from her husband to him.

The consultant saw almost immediately that Eleanor's feelings for her therapist were displacement of internal issues. She directly and without anxiety explored Eleanor's sexual fantasies about the therapist and with pointed questions linked them to unresolved issues concerning her husband. The consultant coached the therapist to stop running away from the patient and to start talking with her about it and what it meant in a way that made it safe for Eleanor to explore the feelings with the knowledge that at least one of them was in control. This advice was based on keeping the triangle in the consultant's consciousness. With ex-husband in the distant position, the wife was moving to the therapist, and the therapist was distancing from the wife rather than standing still in dealing with her about her dependence on her husband. By seeing this as a triangular issue, and keeping the triangle in mind, the therapist was able to understand the emotional process, detoxify it, and encourage the patient to move on with her life and find new love objects, instead of focusing on a relationship in which her fantasies would never be realized.

The issue here isn't whether it's truth or fiction that we fall prey to in our role as healers, but rather, how we handle the emotional pressures that swirl around us in therapy and distort our vision. Here, the idea of the potential for the therapy triangle is invaluable in helping us keep our balance and therapeutic perspective. Moreover, understanding the manner in which the therapist can keep free of therapy triangles is critical to engaging the patient and to moving the therapy along. What is crucial is that by keeping out of triangles with your patients and their worlds, you become a person who is credible and safe for your patients.

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PART III: MENTORING

Throughout his career, and especially at CFL, Guerin has always sought to bring along people whom he was training. In this sense he was a true mentor. The papers below, as well as eight of the papers in the parts above, are examples of helping people get published. He did the same thing by offering workshops at national meetings, in which people he was mentoring participated in the presentations.

The following paper Guerin wrote with his wife, Katherine B. Guerin.

Theoretical Aspects and Clinical Relevance of the Multigenerational Model of Family Therapy

Philip J. Guerin, Jr., M.D. and Katherine B. Guerin, M.A.

By using a three- to four-generational model, it is possible to remain relevant to a family's presenting symptom, and at the same time go beyond it to the underlying patterns of the multigenerational system.

Families can present in many ways. One way is with the symptoms in the child, either a physical symptom like asthma, or an emotional symptom like depression. On the other hand, a family may present with a marital focus—open conflict on the verge of divorce, or just a communicational breakdown. A family may present with emotional or physical symptoms in one or the other spouse. In rare instances a family will present with an extended family problem. And in these days of having to deal with aging and death perhaps more often than in the past, we also see families whose major concern is with an aging parent and whether or not to institutionalize.

Most of the time, however, the symptoms are presented to family therapists clinically as isolated to the nuclear family. Only after tracking and uncovering, and elaborating on the boundaries of the system is it possible to understand how the nuclear family conflicts tie into the remainder of the system. Most frequently the place that the symptom presents in the family is where it seems to be safest for a symptom to reside. For instance, in some families in which symptoms present in the child, it is evident in the first interview that it isn't safe for that family to have a problem in the marriage.

There is a lot of anxiety that if the therapist looks too closely at the marriage, it is going to rupture or break apart in some way. Other families come in with a marital problem, yet symptoms are obviously leaking down a generation to the kids, and if you begin to investigate the parenting function, they get very skittish about that. Every family has safe and unsafe areas, and very often there is one generational level the family finds it difficult to let the therapist in on. Research and clinical experience seem to indicate that most often this is in the extended family Many families don't see the clinical relevance of the grandparent generation to their specific problem, and it's up to the art of the therapist to make the three- to four-generational model relevant.

The family we shall discuss here started out originally as a child-focused family. They have three adopted children, two boys and one girl. The parents are both in their late thirties. The problem presented originally in the daughter. The parents were concerned about her social behavior, considering it sometimes inappropriate. They also worried about whether or not she had a learning disability. The parents were seen by themselves; with just their daughter; and with all the kids together. The parents are both Catholic and originally from New York City. The husband is of Slavic origin; the wife is Irish. The husband, a very effective and successful businessman, was clearly an object-oriented overfunctioner. His wife, on the other hand, was a relationship-oriented emotional overfunctioner. She was tied into and anxious about the kids and their functioning, and about her mothering. He was the distant critical expert, especially in relation to the job she was doing with the children. He was very much into his own business and projects around the house, whereas she was underfunctioning and really distant from a lot of the

family busy work. There was some activity with the kids on his part, more with the boys than with his daughter.

In a child-focused family it is important not to fall into the trap of trying to sell the parents the idea that what they really have is a family problem or a marital problem. Any such attempt will only trigger already primed feelings of parental guilt and responsibility, and the result will be an increase in the family's anxiety level, and a reinforcement of denial and projection.

Whenever I see a child-focused family, I automatically assume a set of four potential triangles: the central nuclear family triangle of mother, father, and symptomatic child; two auxiliary nuclear family triangles, one involving a parent, the symptomatic child, and an asymptomatic sibling, the other an intersibling triangle among three of the children; and finally, a triangle over three generations involving a grandparent, a parent, and the symptomatic child. There are many other possibilities, but these are the most frequently encountered clinically. As I evaluate the family, I try to search for the active existence of any one or more of this set of potential triangles. Once I locate the existence and spell out the process, I am ready to intervene. In this family the initial intervention was a two-stage process. The central nuclear family triangle of father, mother, and symptomatic child was clearly spelled out. The father was in the distant critical position, the mother emotionally overinvolved with her daughter and reactively distant from her husband. Since the daughter was exquisitely sensitive to her father's criticism of her, and especially tuned in to her mother's anxiety level, an increase in either one predictably exacerbated the daughter's symptomatic behavior.

In order to set the stage for structurally shifting the process in this triangle and thus shifting the symptom, a detoxification of father's critical expert position had to take place. Therefore, stage one was to instruct father to increase his coaching of mother until she gets it right and daughter shapes up. This was meant to exacerbate the problem to the point where father had to concede this method of proceeding was useless—after which the stage was set for move two.

The second intervention was to encourage mother to move out of her present position and become more interested in some extrafamilial things. She was also instructed to decrease her degree of responsibility for daughter's functioning and well-being. The father was instructed to move into the space vacated by mother. If these steps are carried out by the family, they are engaged, and a shift in the process usually occurs. In this particular family, mother moved out, father moved in, and father began to question whether his distance wasn't something that was affecting the family. As his wife moved out, he began to find that he had a lot of difficulty dealing with her being outside his radar. As long as she was where she was supposed to be when she was supposed to be there, he could go off and do his thing around the house or elsewhere and be calm about it. As soon as she was out somewhere doing something, and her bleep wasn't appearing on his radar screen, he began to get anxious. He developed some somatic symptoms and became somewhat depressed and concerned about himself. The little girl in the middle of this process responded to the attention from her daddy and the decrease in pressure from her mother by showing marked improvement in her functioning. The primary shift had thus occurred. The process had shifted, and the problem been redefined and systematized with the relocation of the symptom in the marriage.

As the marriage is worked on, and the marital fusion unfolds, the process inevitably involves a tie into the extended family. The interlocking character of the three generations comes into view. Pieces from all three of those generations must be worked on at different times, depending on what's going on in the present time frame with the family. Success and progress don't mean that the symptoms and the dysfunction just disappear; instead symptoms will reappear over time in all three generational levels of the family. For instance, as you get close to the core of the difficulty in the marital fusion a child may pop up symptomatic again in response to the rising anxiety level. In sorting out the nuclear family process, grandmother's part in it may move the focus to the extended family. Working with a family over a long period of time reinforces the view that there is a transgenerational flow, and that isolating an emotional problem inside the nuclear family makes no more sense than isolating it inside an individual's head. The whole three-generational structure of the system, with all of its interconnections, becomes ever clearer. Change is measured in terms of a decrease in the intensity and duration of the reoccurring predictable dysfunction as the process inevitably recycles itself.

Not all families embark on a long term course. Some fail to engage at all, and sabotage interventions with "I can't," or "I won't do that," or some version of "You've got it all wrong, Doc," or "You wouldn't suggest that." Other families will buy the initial intervention; with symptomatic relief, they then gratefully withdraw lest the therapist in his zeal for further change mess it up all over again.

The term *fusion,* in a systems-relationship framework, indicates a blurring of self boundaries. This blurring of boundaries carries with it a constantly fluctuating, momentarily changeable reactive state in the relationship. On one end of the spectrum is the time-limited comfort of relationship refuge. On the other end is the discomfort of the furnace-refrigerator phenomenon of active and open conflict. Every married couple I have studied exhibits complementary operating principles and reciprocal functioning. That is to say, people with opposite operating principles marry each other, and these differences in their operating principles provide an attraction and a balancing stability to the relationship. As their interdependence grows, each relies on the other for emotional balance, so that reciprocity of function evolves. The husband, let us say, is the objective overfunctioner, and the wife is the emotional overfunctioner; these characteristics form a complementary bond which operates like a seesaw: if one spouse's functioning is up, the other's must be down.

In this marriage, for instance, the husband is the reasonable, object-oriented emotional distancer. He responds to upset and crisis with rational thought; emotionally he operates on an even keel, only blowing up after long build ups. He keeps active and busy, deplores small talk, and likes to spend his relationship time discussing important impersonal issues, or participating in some invigorating activity like tennis, handball, or sex. His wife, on the other hand, is the relationship-oriented emotional pursuer. She reacts intensely to upset and crisis; her facial expression is a mirror of her inner thoughts and feelings. She deposits the byproducts of her inner turmoil into a relationship with anyone who will listen. She explodes easily, but then the fire and smoke dissipate quickly. She likes activity, but likes just sitting and talking best of all, especially when it involves small talk and juicy gossip. Both spouses are competent adults. His distant, reasonable reserve provides a balance for her in the same way that her talkative emotional tolerance for people provides a balance for him. So how come they don't live happily ever after? Well, a lot of funny things happen in human relationships. One of them is that people become more like themselves when stress hits a relationship. Distancers reason at feeling; and when this

fails, they seek refuge in non-talking-back objects. Pursuers express their feelings from the soul and seek refuge in togetherness; then they wonder why everyone is moving away from them. The balance becomes the itch. So if you ask someone what he or she likes best and what least about the spouse, the answers could be the same, depending on the emotional climate of the moment.

The buildup of dependence on the operational attributes of one's spouse atrophies the development of those same parts of one's self. In time of crisis, if a call is made to that part of the self, there will then be nothing there to respond; and the dependence on other to fill that void becomes further intensified. This increasing interdependence builds to the point of producing reciprocity of functioning, so that when one spouse functions well, the other functions poorly. This may move back and forth like a seesaw, or it may become relatively fixed. The fixed states produce the most emotional symptoms.

A clear definition of the relationship reciprocity is therapeutically important because it educates people to the process they are caught up in, and produces a hope for change. Establishing the way reciprocal functioning swings back and forth over time can validate the emotional experience of the present underfunctioner, and perhaps serve to motivate an attempt at change on his or her part. It should be kept in mind, however, that it is the one in the overfunctioning state at the time they are seen clinically who will have the easiest time changing his or her part in the process.

The issue of self-boundary—how people define themselves and their personal space in relation to others—is another aspect of marital fusion. Emotional pursuers are boundary invaders, always moving into another's personal space. They want to know what everybody else is thinking, and feeling; they also want to take responsibility for helping others. The emotional pursuer's own boundaries usually tend to be nonselective, that is he tends to invite almost anyone in, and lets them know about rather personal matters. This nonselective boundary may foster a state of chaos in which the emotional pursuer feels quite at home. The emotional distancer tends to invade only on object-oriented issues; only rarely does he ask anybody into his own personal space. Even when he seems to want to, his tightly-drawn boundaries make it difficult. Order and quiet, and a mildly cool emotional climate are preferred.

Taking responsibility for others is also central to the emotional marital fusion. In this family, for example, both spouses monitored each other's public image. The husband was extremely tuned in to how his wife appeared in social groups, and whether she was making a fool of herself or not. Responsibility for changing the other is something that all of us get into. We get uptight in a situation; our insides put the problem outside of our-selves into the other; and the automatic programmed response is to change the other. A close look at the situation shows each spouse is doing a fine job of being critical of the other's areas of responsibility while not doing his or her own jobs well or at all. Furthermore, each spouse assumes that his or her own behavior can't be helped, but that the other's behavior is on purpose.

This transcript is from the fifth session of therapy with this family. The beginning of the shift in the central nuclear family triangle has already happened. I am trying here to dissect the elements in the marital process and to relabel them, and also trying to define the positions of each of the spouses in reference to listening and hearing, with subsequent directives to get into one position or the other. The central issues in this first segment, for the husband, are productivity,

organization and public image. For the wife the issues are their relationship, togetherness, and obtaining approval. Some of the component parts of the marital fusion are elicited.

[Parents at session without children have just reported that their daughter is much improved. I take that opportunity to broaden the focus of the therapy to include the marriage.]

Dr. G.: Suppose the kids were perfect? Then life would be—

Ann: Oh, hell, we had six years of that with no children around, and it wasn't—

Jim: It wasn't what?

Ann: We had six years, and we didn't have a peaceful relationship.

Jim: What do you expect?

Ann: Then the animal has to come out, all the nastiness, all the—everybody is human.

Jim: You mean you have some statements about the first six years? You can look back and say they weren't a good six years?

[The husband shows his reluctance to view the marriage as anything but normal and good.]

Ann: I'm not saying that they weren't a good six years.

Jim: They were a six years that had a few problems.

Ann: What I am saying is your disposition hasn't changed, it was rotten then and it still is.

Jim: What? What? What? *(laughter)*

Ann: He was a lousy. . . .

Dr. G.: Was he born like that or did his mother give it to him?

[Therapist participates in the banter, without getting caught up into trying to mediate.]

Ann: Well, not any more but I think she was very difficult when she was young, according to his sister.

Dr. G.: All you gotta do is wait it out. He'll mellow as he gets older.

[Therapist continues banter]

Ann: Well, I am not waiting until he is eighty-four years old, though.

Dr. G.: You're going to change him now?

[Therapist labels efforts at changing other; wife shows evidence of assuming her husband's motivation. His toxic behavior is on purpose; hers, she can't help.]

Ann: Yeah, absolutely, I am not going to change him. But he is too intelligent, he is not a dummy, there is no reason, because I think a lot of it is his will, you know, I think he—

Dr. G.: You think he could be nicer if he really wanted to be?

[Therapist picks wife up on her assumption of his motivation.]

Ann: Absolutely, I am really convinced of that, I really am, I really feel that.

Dr. G.: Well, if he didn't have the kids to get bugged at you about, what would he get bugged about?

[Therapist attempts to focus the conflictual process around issues, to get away from the attack-defense pattern and sharpen the focus on the relationship process.]

Ann: He can't pick on my weight any more, or my eating habits, because they're together.

Dr. G.: You changed all that for him?

Ann: No.

Dr. G.: You just changed it for you, and he happened to like it?

Ann: Yeah, and he happened to like it. I am not very good at changing things just for him, because he is not pleased even when I do it.

Dr. G.: No matter how you do it, he is not pleased?

Jim: Oh, that's—come on, come on.

Ann: Bullshit, then you try something else. You are going to give me a two-week reprieve here, until you start with the cigarettes, and then you are going to start on that.

Dr. G.: Two main complaints about Jim here would be his criticalness of you and the kids, and your being unable to get underneath his expertise to the real him.

[Therapist tries a process hypothesis, focusing on the husband's tendency to criticize his wife's mothering, and the way her reactiveness to his critical expert makes it difficult to bypass it and get to the real him behind it.]

Ann: Number one is right. Number two, you might be right, but I haven't ever really given it much thought.

Dr. G.: Well, you're talking about his moving around on the table the stuff you put out there, instead of putting out his own stuff.

[Therapist pushes hypothesis.]

Ann: Yes, I would sense you are very right on the second one, but I never really thought about it. There was a thought that went through my mind last week about how I rely on Jim and his expertise, and how much I need his strength. You know, I need his approval of things I do, there's no question about it.

[Wife responds by talking about herself for the first time, describing the other side of the marital fusion—the degree to which she depends upon the parts of him that at other times she labels as toxic and willfully destructive to the relationship.]

Jim: Expertise in what? By the way, that's not true. You have really shown over the last couple of years that you handle the most difficult situations with great expertise, even better than I.

[Husband continues to counter wife's position even in this.]

Dr. G.: Now, when things get wound up between the two of you, both of you have trouble assuming the listening position. You sort of get into buttal, rebuttal.

[Therapist moves to stay in control of the flow of the therapy session.]

Jim: Yeah, there's a lot of that.

[Husband's first validation of marital conflict.]

Dr. G.: How responsible do you think Jim feels for your happiness?

[Moving quickly back to wife and her reactivity, therapist asks a question aimed at the marital fusion—responsibility for other's feelings—in an attempt to detoxify wife's anxiety, and to get her to on to a new thinking track.]

Ann: That's a question to ask me tonight. I would say not too much.

Dr. G.: You don't think it bugs him when you look unhappy?

Ann: He claims it does. I would say that would be a difference in the past few weeks. For the first time in fourteen years I have had a feeling that he might care whether I am happy or not.

[Wife proceeds to describe beautifully the movement in their relationship which has led to a fixed distance between them. The husband, in response to thoughts developed in an earlier session about his distancing behavior, has attempted to move toward his wife. The resulting

process is one in which the wife, from her position of reactive distance, mistrusts her husband's moves toward her, and gets caught in a fixed expectation that once he attempts a change he'll never fall back into old ways.

Dr. G.: What would give you that impression?

Ann: Telephone calls from the office.

Dr. G.: He calls to see how you are?

Ann: Yeah, tells me he is sorry, how much he loves me but he can't do it in person.

Dr. G.: He is moving towards you, and you are complaining about the way he does it. He calls you on the telephone and makes contact with you, and you say he can't do it in person.

[Therapist labels this process in both instances.]

Ann: But then he walks in the house and has a complaint, and I can't see why he bothered calling me.

Dr. G.: You expect that when things get a little better between you, they are going to remain better? You don't expect him to become his old self again?

[Therapist labels fixed expectation.]

One of the things brought out in this segment is that the husband has made an effort to change things, to which the wife has responded from her position of reactive distance with the resentment built up over time and stored in her bitter bank. He attempts to move toward his wife in an effort to connect with her; she criticizes him for the way that he does it. That's the kind of thing that happens all the time, and is a significant roadblock to change. The emotional pursuer has pulled back in frustration to a position of reactive distance; the distancer, sensing the empty space, moves in and runs into some version of, "You weren't there when I was looking for you, so buzz off." It's seen as too little too late. The distancer usually then pulls back with a confused, "What can I do, I tried?" and a fixed distance sets into the relationship, which is then set up for triangulation.

Another point of importance is that the therapist validated what's important to different family members, and the differences in what's important to each of them. The wife talks about her social network. True, she is sidestepping the issue of closeness. However, the husband is also invalidating its importance by putting down her interest in the social network. It is more comforting to his insides if he can isolate her and have her orbit around him, and function as she is supposed to in the house. But that also indicates how her network functions for her: it helps to keep her insides calm in the presence of his distance. Also touched on is the issue of safeness — that is, whether it is safe to put your insides out into the relationship and what will happen if you do.

What about the issue of the therapist taking sides? Have I been triangulated into the relationship in any way? Some may consider that I am obviously on her side and seeing things her way,

because I spend so much time talking to her to the exclusion of him. Being triangulated means being emotionally locked into the process in the family in such a way that you see a victim and a villain. It means that the issues being raised by the family trigger something in you so that you behave vis-a-vis the family or one member of the family in a way that demonstrates you are reactive to their toxic behaviors. As far as the process in this particular session, the husband was more reluctant about being in therapy and about attempting to redefine the problem as a family problem. He is more the distancer; you never chase a distancer, but rather engage him while leaving him a lot of room. The therapist has to watch lest he get reactive to the wife's blatant attacks, or become infatuated with her amusing descriptions; at the same time, he has to assist her providing information.

If the therapist can stay detriangulated, the family is then going to have an experience different from what usually happens to it, for whenever this couple would sit with anyone else, or whenever one of them would move unilaterally toward someone else, that person would quickly lose neutrality and choose sides. In addition to staying detriangulated, the therapist has to label the dysfunctions present in the relationship, and challenge the patterns. This is done by pointing out the pattern and asking individual family members what they can do to change it. Or, what would it take to change it? Challenging the pattern gives the family at least a hint that the therapist expects change, and a hope that change is possible. Then the therapist can try to guide them as they form a plan for trying to change things.

How can the therapist deal with his or her personal triggers so as to avoid being triangulated? I stay tuned into my own reactivity by observing what the triggers are for me with a particular family Is it someone talking too much? Not talking at all? Contradicting everyone in sight? Or invalidating what I think is going on? Having isolated the triggers that tend to activate emotional response in me and set me off on a punitive or reactive course toward the family, I try to pick them up and feed them back into the family. If I pick up something that the husband does that bugs me— let's say, being vague—then I feed that back into the system by asking her, "What do you do when faced with your husband's vagueness?" or, "How does your husband's slipperiness affect you?" That is a very effective way of freeing myself from being pulled into reactivity to that behavior. I assume that if the behavior is bugging me there's a good possibility it also bugs some family members. One good indication that you have been caught in the system is that you notice you don't have any more questions, or any more thoughts, or any sense of where you want to move with the family. Then you know you are incorporated into it somehow, and you are effectively paralyzed.

This next segment begins with my turning to Jim. While I was spending a lot of time talking with Ann, I told Jim to assume the listening position; therefore I had to return to him and ask him what he heard, what was going on with him while he was listening.

Jim begins to concur with the relabeling—that is, he agrees that there appear to be some problems in this marriage. I challenge the pattern by asking what it would take for him to decrease his criticism and get out of his predictable ways of behaving toward his wife. That begins to register with him; then the wife interrupts, and he quickly jumps back to the kids. His jump is a result of her incendiary remark and my having challenged his pattern and tickled him to change. This is a frequent pattern in therapy; as progress is being made in sensitive areas, the anxiety level rises sufficiently to retrigger the presenting complaint. Ann doesn't want to go back to the child focus, and offers evidence that there really are other problems in the family apart

from the ones around the kids. At the end of the segment the issue of control in the relationship and how it is exercised comes into view.

Dr. G.: Have you been listening, Jim? What are your thoughts about it?

Jim: I am sad. I guess that there is a problem between us.

Dr. G.: What has you sad?

Jim: I don't know. I am sad because I guess over the last fourteen years or so we have had our share of arguments and fights and all, but I relate, I always relate to a feeling that I have towards Ann. There isn't an altercation that we've had, nor that we ever will have that will change my opinion of her.

[Husband describes his hurt at being criticized, and describes his persistence in caring for his wife.]

Dr. G.: So you care for her, and there are a lot of things about her that you think are A number one.

[Therapist recognizes and reinforces positive factors, and then moves to process and asks how often they are communicated to wife.]

Jim: Yeah, something like that.

Dr. G.: How often would you communicate those things?

Jim: Occasionally, not a lot.

Dr. G.: So a larger percentage of your communication would be of the shape up kind.

Jim: Yes, I guess the sexual part of it is the time that I reveal this, or talk about this, or just convey the feeling.

[Husband validates his difficulty in communicating tenderness and positive responses, except in conjunction with sex.]

Dr. G.: So when you are making love you let her know about the positive things about her?

Jim: I think so, I try.

Dr. G.: Is that hard for you to do?

Jim: For me? No, it's not hard.

Dr. G.: Is it hard for you to do when you are not making love to her, just come up to her when she is slopping around the kitchen or something?

[Therapist presses for an expansion of the positive feedback to other nonsexual times.]

Jim: Hard, no. Maybe I have been neglectful of it. I wouldn't find it hard, no.

Dr. G.: What would it take for you to be less critical?

[The press continues.]

Jim: Work.

Dr. G.: What kind of work?

Jim: Hard work.

Dr. G.: You mean you would really have to sit on it?

Jim: Yeah, I would really have to work on it. I would have to have a reminder, I would have to have a string around my finger.

Ann: I could get you some flash cards.

[Wife tosses in a provocative barb.]

Dr. G.: Isn't Ann enough of a reminder when she starts bristling at your criticism? Or is that a red flag to bring the bull on?

[Therapist labels it as red flag.]

Jim: It's funny, but most of these situations occur when the children are involved. I would say that most of it, I disagree—

[Husband reacts, and takes problem focus back to the children.]

Ann: Oh, Jim.

Jim: I am telling you right here and now.

Ann: What about when we go out to dinner?

Jim: Those are situations that occur earlier, they are not the situation at dinner time.

Ann: I am talking about times when we are away from the children when they occur.

Dr. G.: Ann says she senses you are being critical even when the kids aren't involved.

Ann: When we are out with people.

[The pattern has been defined and established as repetitive, and successfully kept within confines of marital fusion.]

Jim: Under certain circumstances, yeah, if you tend to monopolize the discussion or get on the religious situation.

Ann: You're always telling me something that I shouldn't do.

Dr. G.: Could you get less responsible for the way she behaves, and let her be responsible for herself?

[Therapist challenges the pattern by questioning the husband on his ability to change his predictable part in the process.]

Jim: Well, it depends on the circumstances. There are certain people that might be interested in whatever she has to say, and others that are definitely not interested.

Dr. G.: Next time your wife is making an ass of herself in your opinion, why don't you leave her responsible for herself?

Jim: Regardless? Yeah, I'd need work on that.

[After several times around the bush, the husband agrees to give it a try.]

Dr. G.: Otherwise you end up responsible for her. Then she ends up feeling responsible for you as a critical husband who makes negative statements about his wife in public. Suppose she, suppose you left her out there to catch her own left hooks?

Jim: I would really have to work at that.

Dr. G.: Would she take her own lumps?

Jim: I think she would take her own lumps.

Dr. G.: Why don't you try letting her take her own lumps and see what happens?

[Therapist pins down the prescribed change.]

Jim: O.K. Then she is going to take her own lumps.

Throughout most of the next segment the issue of control is the focus as it relates to the marriage itself; eventually the issue of control is tied into the process of the therapy. In relation to the marriage the issue of control is there in every relationship. We all know that people control by different kinds of behavioral variants. At one extreme, being controlled can be a controlling behavior. In most relationships both people are struggling for some semblance of control, and going about it according to their own operating styles. Each sees his or her own behavior from the "I can't help it" position, but assumes the other's actions are on purpose. The issue of control in this particular family was not being verbally expressed. The therapist's thinking-system and feeling-system radar has to remain active to pick up the toxic and invisible issues that are not being talked about, so that he can introduce them into the discussion of family process in such a way that they can perhaps be heard and detoxified. In the process of bringing the issue of control to the surface, Ann and Jim get into a chaotic dance, bouncing off each other and interrupting each other's statements. Since I believe the therapist must not get locked into a position of being the referee, I give them a brief reverse communication—"Could they continue this chaos, and escalate it for the rest of the week?"—they agree they can, and the tension and bickering dissipate. That maneuver on my part is an effort to retain control of the session.

Dr. G.: Would it be important to you to be in control of what is going on around you?

Jim: In control? Not completely, no. I think I have relinquished a lot of control in Ann's area.

Dr. G.: Control has been an issue then. It's gotten better, but it is an issue in the relationship?

[Issue re-emphasized.]

Ann: Never a voiced one.

[Invisibility of issue validated.]

Dr. G.: Would you get anxious inside if you sensed yourself losing control of the situation?

Jim: Out of personal control of the situation, yeah, I guess so.

Dr. G.: You are comfortable when you know what's coming. If things get unpredictable you would start spinning around inside?

Jim: Yeah, but that doesn't happen very often. When it does happen I do get upset but I think my reaction is pretty sound.

Ann: You made a comment that you don't have as much control over me as you used to, what do you mean by that?

[Control and oppression are triggers for the wife, and now that they are visible, she zeroes in.]

Jim: No, no, we are not talking about control over you—

Ann: No, before didn't you say something about that?

[A tiny bit of chaos gets in.]

Jim: Control over you?

Dr. G.: I believe you said you relinquished a lot of control in Ann's area; she wants to know what you mean?

[Therapist clarifies.]

Jim: I meant from the standpoint of functioning as a married couple with a family, with a house, with this and that.

[Husband normalizes.]

Dr. G.: You mean telling her how she had to live her life, that kind of stuff?

[Therapist escalates.]

Jim: No, no.

Ann: That's a feeling I have that we get into this every once in a while and never get down to the core. But you ask me, what are you complaining about? What are you talking about? You do what you want, and I don't stop you in any way, you have all the freedom that you want, you finally reached it.

[Wife opens up the issue more widely.]

Jim: All the freedom, no, no. Why do you always say all, everything has to be all.

[Husband complains about wife's all-or-none positions.]

Ann: O.K. most of the freedom. You have relinquished control with regard to me. When we first got married you would come home and tell me what was expected of me.

Jim: You came from a family with a very hip-shooting attitude towards spending of money and—

[The issue around which control is exercised by the husband surfaces.]

Ann: There is something tied up with this money and my attitude and feelings about money?

Jim: Of course.

Ann: You said that money is no problem.

Jim: Ann, if we had urinated our money away, instead of pissed away, we wouldn't have had certain things that we have today and maybe these things aren't important, I don't know, I don't want to get into that.

[A flurry of reactive process emerges around money, control, and who dictates how proper behavior is defined.]

Dr. G.: What's the difference between urinating it away and pissing it away?

[Therapist playfully encourages flurry to run its course.]

Jim: She would punch your fucking heart out and I would just—

[Husband and wife continue banter.]

Ann: That's awful to say that. You fucked yourself around the whole house yesterday, you used that word every two seconds, but that's all right. Jim, I am going to say punch out your fucking heart. I am not vindictive and I don't like to expend energy in getting even, but I am going to say it, I enjoy saying it, I don't feel there is anything wrong with it and I am not going to stop saying it because you tell me it's a dirty word, when you use it all the time yourself.

Jim: No, no, I don't use it all the time, in fact I don't use it much at all.

Ann: You use it towards me.

Dr. G.: Can the two of you continue this kind of thing for the rest of the night, if you really try?

[Therapist moves to regain modular control of session.]

Ann: If we really try, yeah.

Dr. G.: I think you ought to practice ping-ponging it back and forth with one another.

Jim: I think she's ready, I think she really has her guns out.

[Wife proceeds to make a clear statement of her feeling state. She protests her helplessness to control it, while holding husband responsible for doing his toxic numbers on purpose.]

Ann: I told you before it's not something I work at, it is something that takes place within me that disturbs me, and I get very hurt and very upset and I don't get over it easily. I never used to be this way. It gets worse and worse all the time, and it's not something I'm in complete control of. I

got up this morning and I decided, it's not going to bother me. Before a quarter to nine, the kids were out of the house. You know, even before they left at ten after eight I was all stirred up inside, and then after they left, I said it's not going to bother me. By a quarter to nine I had all this to face, and boy, if you were there I would have told you it was on my mind. I couldn't get it off my mind. I had a pit in my stomach all day, I felt shitty all day, you know, it's something I have no control over. I can't turn it on and off like you do.

Dr. G.: Do you think his criticism is more on purpose than your being upset the way that you are now?

[Therapist attempts to refocus with a balancing question, giving wife responsibility for her own behavior.]

The eventual goal here is to work toward the development of one-to-one personal relationships with as many people in the family as possible, in the hope of being able to provide the individual members of the family a degree of emotional freedom from their reactive triggers. That way they won't continually be in a responsive position, caught up in the reactive flow of the family process and behaving like predictable robots; instead, they will have some initiative to move in many different ways within the context of the relationship system.

Ann and Jim did a fine job of getting self-focus and beginning to define themselves in relation to one another. Ann got a sense of the way she operated, the triggers that pulled her into performing her toxic behaviors, and the reflexive character of her blaming those behaviors on Jim so that she held him responsible for her unhappiness. Jim became much less critical; he developed a sense of his tendency to distance from feeling, and saw how much his attempts to control Ann's movements were tied into his internal comfort. They both began to change their own behaviors, and found ways to remain in charge of themselves when their anxiety rose.

The process of defining marital fusion eventually goes back to the family of origin. A focus will develop on each spouse's primary parental triangle. Marriages of grandparents and siblings will be compared. Sometimes there is a very proximate and obvious connection between nuclear and extended family processes so that the transition to extended family focus becomes automatic. Other times something in the extended family will affect the nuclear family, and thus bring the third generation's part in the process into sharp focus. A mother-in-law's input, or a wife's special relationship with her brother will be perceived as increasing the uptightness in the nuclear family; it may be coming out in the marriage, or even have moved down another generational step to the children. A child's functioning must be viewed not only in relation to parents, but also in relation to the extended family. Very often a grandmother and a mother and child are involved in a fairly intense triangle which demonstrates itself by dysfunction in the child.

The last segment of transcript occurs after six months of work. The wife is beginning to give some serious consideration to her relationship with her mother. I am trying here to get Ann to focus on extended family relationships. The tracking process starts with the demonstration of triangulation over three generations as related to the issue of the favorite child, and brings out the ambivalent feelings that Ann has for her mother. Sometimes extended family exploration

produces a totally bastardized version of a parent. "You wouldn't even ask me to get into that if you knew my mother." Or it may produce an over-idealized whitewashed version—"They were great folks"—but without any detail. Asking a family member to paint a family landscape may help to bypass some of the denial. If denial persists, and layers of semigloss continue to hide the view, then an artful dissection and elaboration by the use of a set of questions developed from clinical experience and theory is most helpful.

Nodal events in this family's life cycle—Ann's sister's marriage, and her stepfather's heart attack—are discussed. Ann talks about her relationship with her mother, and how it shifted so that she became her mother's mother. Questioning her about that experience pinpoints the nodal events around which it happened. Focusing in on these nodal events allows other pieces in the historical process to fall into place so that other occurrences over the years that relate to that particular nodal event begin to make more sense, and the past comes into perspective in relation to the present.

Dr. G.: You said your mother works hard on keeping it impersonal and general with you?

Ann: Hmmmm, yes, especially with Bill around. When Bill's around she has to create this intellectual type of climate.

[This emphasizes the importance of getting each parent alone if anything is going to develop. Otherwise the field is contaminated, and the other people present are easy ways to detour working on the relationship.]

Dr. G.: So she is out to impress Bill?

Ann: Yes.

Dr. G.: And when he is not around, what?

Ann: Oh, well, then she is more herself I guess. She is more on a personal level.

Dr. G.: What would be in the content of the communication then?

Ann: Well, she'll ask how the children are, and I'll start to tell her. Then she gets to talk about things like she tells me how Richie is her favorite, and that she really can't help it, and then I ask her to please try and keep that to herself and not show it to the other two children. I don't think it's a good idea to have a favorite grandchild when you have three, and she knows that I definitely disapprove of something like that.

[Ann begins to develop one aspect of the three-generational triangulation in this family.]

Dr. G.: Do you have some kind of principle that your kids should be equal in the eyes of their grandmother?

[Therapist challenges Ann's position.]

Ann: But, you don't realize, it's not practical.

Dr. G.: Are you trying to protect your kids from not being the favorite or from being the favorite?

Ann: Well, because I was the favorite in my house over my sister, and then I was faced with the same problem myself with the boys and Susan, and I kind of feel it's not a good thing.

[The generational repeat surfaces.]

Dr. G.: How is she going to go around pretending that Richard is not her favorite?

[Therapist continues to challenge.]

Ann: Well, she said it Saturday night in front of him. I kind of appreciated it as something she has been feeling for a long time; and usually she sneaks it in without directly saying it. So Saturday night when she said it, I said, "Why?" She wants to take Richie to the ballet for Christmas, and she doesn't want to take the other two anyplace, and I won't let her do that because I don't feel it's fair. She hasn't taken any of them any place in eight years, and I know that they would really be hurt. So I suggested if you take one someplace that you take the other two too, not necessarily to the same thing, but that you follow up with Eddie and Susan some place. Then she takes Eddie into it and completely leaves Susan out. Then I go through the same thing nicely, you know, I really think it's better to take all three, some time at least. It doesn't have to be all the time.

Dr. G.: What would happen if she took Richard, the kids would start complaining?

[Therapist moves to concretize the process.]

Ann: Yes.

Dr. G.: Eddie and Susan would start complaining that Richard is going on a trip with Grandmother, and she likes Richie better?

Ann: She told Richie that.

Dr. G.: If they complain, tell them to go to your mother. Would they like that?

[Therapist suggests surfacing the process in the family.]

Ann: Susan would.

Dr. G.: What would your mother say if one of them said, hey I hear you like Richie better?

Ann: And she'd say, "Now Ann, you know I didn't mean that. I just felt that Richie is more sensitive, and I can't help that I relate to him a little bit more. He was the first in the family, you know," and all that.

Dr. G.: You tell her, tell Susan that?

Ann: But she really doesn't see him very often. That would really be something; I would really like to see that.

Dr. G.: How are the kids going to get a relationship with their grandmother if you are in the middle directing traffic? Maybe it makes you anxious to get out of the middle, and out of the directors' position?

Ann. I don't know, I'm so confused, I really don't know. After the past couple of weeks, I even thought, how much do I really like my mother? It's the first time No it's not the first time I ever thought about it, I've thought about it for the past five or seven years. I really don't know how I feel about my mother.

[Ann moves off the kids and into the process between her mother and herself.]

Dr. G.: How much time do you spend just you and her?

Ann: None.

[Therapist concretizes time and space aspects of Ann's relationship with her mother.]

Dr. G.: So there is always somebody else around. How would you work it just to get the two of you alone?

Ann: Well, I'd go out to dinner with her.

Dr. G.: What would that be like?

[Reinforces the idea.]

Ann: I really don't know, I haven't done it, I haven't been alone with my mother I guess for fourteen years.

[More information on distance between Ann and her mother.]

Dr. G.: That's a long time. Is that about how long you've been her mother too functionally?

[The dissection process continues.]

Ann: No.

Dr. G.: How long have you been functionally her mother?

Ann: Five years, six years, maybe something like that.

Dr. G.: How are you going to switch that back?

Ann: I know that's what I started to think about.

Dr. G.: Why did you pick this time to start to think about it?

Ann: I came up with the idea of just how I feel about my mother, and like do I really have deep feeling for her? Do I really? Maybe not. Am I clouded by the last six years or so, if I am being too caring at times and guilty because I don't care enough, don't put myself out enough.

Dr. G.: So it brought in a whole flood of feelings and thoughts and questions.

Ann: Uh huh.

Dr. G.: Have you got the last five or so years put together as to what's going into the thing where you ended up her advisor and counselor and taker-care-of? What's that all about?

Ann: Well, I think it really happened when my father had his first heart attack. Maybe it could even be seven years. It could also be around the time my sister got married and she left. My mother didn't have Jane around once Jane was married. She battles with her all the time, but she didn't have her around as much. She didn't have Jane depending on her as much, maybe it could be that.

[The nodal events surface, and are connected by Ann to the relationship process with her mother.]

Dr. G.: So you would connect it to your stepfather's coronary, and your sister's getting married?

Ann: Yes, I think I could.

Dr. G.: Which happened first?

Ann: Jane's getting married.

Dr. G.: How long after that did your stepfather have his coronary?

Ann: Do you remember, Jim?

Jim: No, I'm very bad about dates and things like that.

Dr. G.: You never connected those two events?

Ann: No.

Dr. G.: Does your stepfather have trouble dealing with your mother when she gets upset?

Ann: I really don't know.

Dr. G.: How would you find out if you wanted to?

[The challenge to continue on the track.]

Now that Ann's thoughts have moved from her children, to her mother's relationship with her children, on to her relationship with her mother, it is time for her to begin to define a self in relation to her family of origin. The goal for the work in the extended family is the same as for the nuclear family—a sense of emotional freedom from her own and her family's automatic emotional responses. To do this Ann must set out to get a one-to-one relationship with each important family member. In her family Ann is the older of two girls. Her mother and father were divorced five years after they were married, when she was five and Jane was four. Her mother then married Bill, and since that time Ann hasn't seen her father. Her mother is the younger of twin girls, followed by a younger sister and then a brother.

First, of course, she had to define what the problems were, and where she and her sister fit into them. How did her mother relate to her and to her sister? Were they adopted by Bill? Did they take his name? What was their relationship with mother and biological father? I found that he had been an alcoholic. I asked Ann what would happen if she looked him up after thirty years. She said that first of all she couldn't do it, because of all the negative stuff. Secondly, it would be disloyal; she wouldn't be able to handle the responses by mother or aunts or sister, and especially by stepfather because of his poor heart. It took several months before she was willing to consider the possibility of connecting with her biological father.

One of the effective questions I asked was, how was she going to get her mother to be her mother again? How could they have an adult-to-adult relationship unless she did manage to get to where her mother was her mother again? I coached her to go to see her stepfather directly when her mother wasn't there, talk about the issue of her biological father, and tell him she was upset about being seen by him as disloyal and ungrateful for all that he had done for her. She did it. Bill said, "I told your mother she hasn't been responsible in not making sure that you knew your father better. So, I think it's a great idea. But expect trouble from your mother and her siblings." Now, the easiest thing in the world when somebody asks you for permission is to say "It's okay with me, but watch out for those other guys." But at least Ann had made meeting her father an open issue.

Then she finally got to the point where she was able to call her father and make a date with him for lunch. They met in a restaurant in midtown Manhattan. Who showed up in the restaurant while they were there? Her mother. Nobody had told her about the meeting. She didn't know Ann was there. She works in Manhattan, but not in the same area. She came into the restaurant,

looked around, saw there was a long waiting line, and while Ann sat with her heart in her mouth, then walked out. If you study enough families, you begin to appreciate the power of emotional systems. Crazy things like this happen all the time.

Ann thus had connected with her father; he is a reformed alcoholic who's been married three times. The biggest complication, however, is that he's rich. How was he going to make it up to his two kids?

The response to Ann's contact was negative all around. Furthermore, she learned from her father that her parents had had a clandestine relationship off and on over the thirty years. By connecting with her father, she'd blown this clandestine relationship out into the open. The whole family began to relate to the long-absent father, who became especially close to the younger sister. So Ann, after having done all the work, ended up on the outside. But her mother began to treat Ann as she had when Ann was an adolescent: lots of criticism, lots of shape up. So Ann is definitely no longer her mother's mother.

The issue of sex in their relationship was a problem that Jim defined as Ann's problem, and that Ann defined as her problem. I touched on it off and on, but she wasn't ready to tie into it and grab hold. When she wouldn't take a direct symptomatic approach to the sexual issue, I tried to get her into the programmatic approach, asking her where her programming came from about sex, and how it tied into her sexuality in her marriage. She said she didn't know, since her mother was a swinger, still a beautiful woman at 58, who still sees herself as desirable, and who is still active sexually. So it wasn't a hang up from mother. Then she began to wonder if it had to do with grandmother and grandfather. Well, grandfather was called the Colonel, and was a compulsive gambler, which led to the premise that her mother was the counter-positioner to her grandmother's strict position about sex. In fact, grandmother even counter-positioned her as an adolescent into marrying Ann's father. Since Ann had lived in the home with the grandparents, she supposed she had picked up and complied with her grandmother's position about sex.

The older of the twins, Aunt Margaret, had in many ways been the functional mother in Ann's family. She was the responsible older twin; Ann's mother was one who flitted around. She lived off in the Midwest, married to a man with a couple of kids from a former marriage. She married only after the grandmother had died, and everybody else in the family was settled except one sister who never married.

Aunt Margaret had been a heavy smoker all her life; she had chronic lung disease, and had also had pneumonia many times. She got sick again and it became clear that her lungs had run their course, and she was dying. Ann went to the Midwest and connected with her aunt. She opened up these issues of her father and her relationship with her mother; she also tried to get some information about her grandmother and how that might tie into the sexual thing she was struggling with in her marriage. Margaret got a little bit better, and Ann came home, but a few months later Margaret again ended up in intensive care, and the doctor said that it was probably for the last time. Ann went to see her again, this time with other members of her family. She connected with Margaret in the intensive care unit, and began after that visit to remember how important Margaret had been to her when she was a kid, how when her mother was off having a

good time Margaret was always there. Margaret and she were the only ones in the family who open talked about the fact that Margaret was going to die, and they re-viewed her life together. Ann went through a difficult time with the other members of her family because of her aunt's obvious response to her as somebody special. Margaret died. Ann came home.

After she was back, she felt different. She felt sexually freer, but she didn't quite understand what it was. Two weeks later, she dreamed she was involved in homosexual activity with a beautiful friend of hers; in the middle of the dream, the friend changed into Aunt Margaret. She woke up in a fright and a cold sweat. In the next three days there was a breakthrough in her sexual relationship with Jim. It was fantastic. He came into the next session with a big smile on his face, and when I said "What's the matter?" he replied, "Wait till we tell you."

What Ann's story has to teach us is how important it is to connect with those who matter to us. However, the people who are moving in have to be in control of their own anxiety, and know what they are doing. If not, they'll raise the anxiety level of the whole system so high there will be a blow up, with all kinds of ensuing havoc. They must have a carefully thought out plan; otherwise the family system will chew them up and spit them back out in the automatic, predictable response to anyone who behaves in a different way, crosses a family boundary line, or breaks some family taboo. As soon as one family member is able to begin to change, it opens up new sets of pathways and new options for the whole system of relationships. Again, any change will be resisted by the system, which will try to push the changing member back into his old position. If you're an overfunctioner, and you begin to underfunction on purpose, the reaction you'll get will be that there's something wrong with you; you don't understand the way things really are, and you had better change back or else. If you're a distancer and begin to move in, you'll be invalidated. If you're an emotional pursuer and you move back and stop your demands, you'll be accused of making those demands anyway, even though you know positively you aren't. That's the way emotional systems operate. And if you can get people to understand their own responsiveness to the system some way, then you make it possible for them to change.

The following paper Guerin wrote with Eileen G. Pendagast. The first sentence makes the case for its significance. People come to therapy with a report of symptoms and an often mistaken theory about their cause. Careful analysis is crucial. Guerin took Bowen's "family system diagram," refined and structured it, and renamed it the genogram. It has become an indispensable tool for evaluation, diagnosis, and treatment planning. The carefully done genogram shows the location of problems, makes connections between those problems and the history of the multigenerational family, and suggests interventions that might never have suggested themselves.

Evaluation of Family System and Genogram

Philip J. Guerin, Jr., M.D. and Eileen G. Pendagast, M.A., M.Ed.

A family rarely enters therapy with a clear-cut idea of exactly where its problems lie. The therapist's major job in the first interview is to elucidate and organize the facts and characteristics of the family, and dissect the emotional process in a way that pinpoints the trouble spots in the relationship system. It is to the advantage of both the therapist and the family that this process be simple, and accomplished in a relatively short period of time.

The choice of a particular method for evaluating a family depends upon the ideology of the therapist and the state of the family when it enters therapy. A family that comes to the initial session in an agitated state may need to be allowed the beginning of the session to talk about their view of the crisis. While they are doing this, the therapist can attempt to cool down the affective overload in the system before proceeding with more structured information gathering. If the family is not in crisis the therapist is able to move quickly on to the structure of his particular method.

The first contact is usually by telephone, and at that point, membership issues involving the first session will be decided. Most family therapists have their own set of guidelines for these issues, which to some degree depend on the therapist's definition of the clinical unit "family." If family is defined as the household, all members of that particular household will be brought in. Therapists who emphasize family as a conceptual base, rather than a natural group, consistently see only the spouses, or, at times, just one motivated family member. Another factor that must be considered at this point is the family's view of the problem. If they define the problem as a marital crisis, the husband and wife may wish to be seen without the children; a child-centered family will most often want the children included.

We believe therapists should maintain a flexible response so that their options will be open to serve multigenerational families or one family member, depending on the circumstances.

If one family member is seen alone as the initial contact, the issue of confidentiality should be dealt with at the beginning. The most functional position is one in which the therapist refuses to make secret pacts, and thus establishes his freedom to introduce into the larger family system information received from one family member, if clinical judgment warrants such disclosures.

Many kinds of information can be looked for in the initial session. Some therapists choose to combine observation of nonverbal behavior and kinesic communication with an elaboration of the family's view of the problem. Others always proceed using a regularly structured format. There are pros and cons to both positions. In the end it comes down to a matter of clinical judgment, and to the short and long range goals formulated from the therapist's own particular theoretical position.

We start off by telling the family that we will ask a few background questions that are important to an overview of the situation. We then use the structure of the genogram to spell out the physical and emotional boundaries, the characteristics of the membership, the nodal events, toxic

issues, emotional cutoffs, the general openness/closedness index, and the multiplicity or paucity of available relationship options. Ideally, by the end of the first session we should have a reasonably clear definition of the membership and boundaries of the system, and some beginning definition of the emotional process surrounding the presenting symptom. At the same time, we try to make what we are doing relevant to the family's view of the problem, and to assist the engagement process by saving enough time to give the family some feedback before the end of the session.

In our experience, the evaluation time can be used most efficiently if a therapist has a well-defined structure and method for gathering necessary information about the family. We will therefore elaborate our particular method for evaluating a family, starting with the overview and genogram, and going on to engage the family to define their view of the problem.

There are some general contextual questions that should be part of the overview. Cultural, ethnic, and religious affiliations of a family should be explored, as should also its cultural heritage, socioeconomic level, the way the family relates to the community, and the social network in which it lives. If a family lives in a very affluent section of Westchester County, and yet makes only $10,000 a year, the chances are good that it is in dysynchrony with its affluent surroundings. This can lead to isolation of the family unit within that community. Also, the therapist has to wonder how much financial backing is coming from the extended family. The real problems of poverty-level families must be recognized and validated, without making them feel patronized. Income level and placement within the community affect not only personal options and expectations, but also relationships with other families in the area. What is the extent of the social network of a family? How isolated is this particular nuclear family unit? It is important to document social and familial isolation because it can create an emotional cocoon that intensifies emotional processes in the nuclear family, and significantly limits the relationships available to dissipate anxiety and emotional distress.

In moving from the general contextual issues to more specific issues of boundary, membership, and process the genogram is our most useful tool. A genogram is a structural diagram of a family's three-generational relationship system. It uses symbols to illustrate these relationships.

These symbols, together with other pertinent factual data, are used to show the relationships and positions for each family member. This diagram is a roadmap of the family relationship system. Once the names, the age of each person, the dates of marriages, deaths, divorces, and of births are filled in, other pertinent facts about the relationship process can be gathered, including the family's physical location, frequency and type of contact, emotional cutoffs, toxic issues, nodal events, and open/closed relationship index. Each of these facts will help the therapist to form a picture of the family's characteristics.

Physical location of the family is important for tracing the physical boundaries of the system. Mapping gives information about the degree to which physical distance is used to solve relationship problems, and how much of a support network is present for a particular nuclear family segment. Families can be classified as either explosive or cohesive, depending on how close they have stayed to their original location. For example, in the Italian-American section of New Haven, Connecticut, there are many families who live within walking distance of most of the members of their extended families, and they have never lived anywhere else. The late

governor, Ella Grasso, for instance, lived in such a section in her hometown. She has said that her work in politics and her eventual rise to the governorship of Connecticut depended on the fact that when her children were growing up she was never afraid to leave them at home, as everyone for blocks around was either a family member or a close friend. On the other hand, some people would find such cohesion a source of potential apoplexy and emotional paralysis. Often a member of an explosive family marries into a cohesive family and tries to make it his own.

Another important piece of information is who calls, visits, writes to whom, and with what frequency? Is there one person who serves as the family communications switchboard? Grandmothers and oldest siblings frequently occupy this position. It is not uncommon to find an explosive family that remained cohesive until the switchboard person died and no one moved into the vacated slot. Ritualized family visiting, territoriality, and telephone addiction are all phenomena to be recognized. Ritualized visiting accompanies the use of physical distance as a solution to emotional problems—that is, a totally predictable timetable of visits, involving an equally predictable repertoire of behavior while there.

Most frequently territoriality is shown by whose house everyone congregates at on the important holidays. Are grandparents willing to visit, eat, and stay over at their children's homes, as well as vice versa? Telephone contact also reveals a lot about the family process. Who calls whom and with what frequency? Who answers the phone? When the grandparental home is called, does the father answer and immediately hand the phone over to mother? Is it impossible to get to talk to one person alone? Who are the members of family who prime the anxiety pump or calm their own insides by an addictive use of the telephone?

As the patterns of closeness, distance, and conflict emerge from elucidating the family system boundaries and characteristics, the toxic issues around which the family process gets played out will be defined. There are some almost universal issues—money, sex, parenting, and children. How is the money handled in a marriage? who makes it, controls it, doles it out? Which side of the family has the most, and how is it passed on from generation to generation? His, hers, ours, and theirs are categories that are simultaneously toxic, amusing, and revealing. Often there are specific toxic issues—for instance, alcohol abuse, death, religion, and education level— that are worth tracking.

The open-closed index of a family system can be estimated by studying toxic issues and the relationship process around them. Examples would be the death of a central family member, the premature death of a young parent or child, onset of serious physical illness, an oldest child's leaving for college, a youngest child's getting married, an only son's being killed in war. Are individual family members able to deal openly with toxic issues in some relationships and not in others? or is there a more generalized conspiracy of silence? The presence or absence of emotional cutoffs is another indication of the open-closed ratio. Emotional cutoffs can be brought about by the use of physical distance, but can also be present in relationships with considerable proximity.

Nodal events are those crossroads times and events in the family lifecycle that shape the future form and structure of the relationship process. Normative crises and catastrophic events fit into this category.

PORTIONS OF AN EVALUATION INTERVIEW: THE FLYNNS

Tom Flynn is 49 years old; his wife Mary is 41. From previous marriages they have between them a total of seven children. Mary called and asked if she and Tom could come in for consultation around the effect on the family of Tom's being out of work. In the initial phase of the evaluation interview, the genogram was employed, and the basic facts were gathered. One of the facts that surfaced early in tracking the genogram with this family was that both Tom and Mary have lost mates: Tom's first wife and Mary's first husband both died in 1964.

In this first interview, it is important to strike a balance between hearing the family members out and not getting totally distracted from the goal of obtaining an overview. The following segment illustrates the way this kind of questioning is done:

Dr. Guerin: You're how old, Tom?
Tom: Forty-nine.
Dr. Guerin: And you, Mary?
Mary: Forty-one.
Dr. Guerin: You were married when?
Mary: It will be eight years this June.
Dr. Guerin: That was in June, 1968? Is it an only marriage for both of you?
Mary: No, it's a second marriage for both of us.
Dr. Guerin: You were married to your first husband when, Mary?
Mary: 1957.
Dr. Guerin: His name?
Mary: Bill.
Dr. Guerin: He is how old?
Mary: He is no longer living.
Dr. Guerin: When did he die?
Mary: In 1964.
Dr. Guerin: Of what?
Mary: He took his own life.
Dr. Guerin: Was that a surprise? Had he been depressed? Ill? Or was it a sudden kind of thing?
Mary: No, it was a complete surprise.
Dr. Guerin: Have you spent any time trying to sort that out? Were you in any kind of therapy? I know you spent a lot of time trying to sort it out, but did you use professional assistance to try to sort it out?
Mary: Only the family doctor.
Dr. Guerin: Did you have any kids with Bill?
Mary: Yes, two.
Dr. Guerin: And they are?
Mary: A boy and a girl.
Dr. Guerin: Oldest?
Mary: She will be sixteen next Monday.
Dr. Guerin: Her name is?
Mary: Nancy, and there's John who is fourteen.

Dr. Guerin: Both of them doing okay?
Mary: Both of them are doing okay, but I worry about Nancy's moodiness.
Dr. Guerin: Do you have any children from this marriage?
Mary: No.
Dr. Guerin: Your first marriage was when, Tom?
Tom: 1951.
Dr. Guerin: What was her name?
Tom: Katherine Kelly—she died in 1964 also, the same year as Bill. In 1964, in childbirth.
Dr. Guerin: In childbirth? That's kind of unusual these days.
Tom: Yes, it is.
Dr. Guerin: Did the baby live?
Tom: No.
Dr. Guerin: Hemorrhage? Or what?
Tom: A long labor, something to do with the membranes.
Dr. Guerin: Then no delivery until the next day?
Tom: No delivery. We had five children, that was our sixth.
Dr. Guerin: So you both have the symmetrical experience of losing the first spouse to death?
Tom: It was at about the same time, too.
Dr. Guerin: Your five kids are joined with Mary's to make seven, is that the way it has worked?
Tom: Yes, but my one son was killed two years ago—accident during the summer. The rest of mine are all girls.

As this segment illustrates, a routine manner of questioning about dates of deaths and marriages quickly elicits the facts about the structural characteristics, membership, nodal events, and toxic issues in a family This line of questioning has established that there has been a symmetrical emotional experience for these two marital partners. Mary lost her husband through suicide; the therapist files away for some appropriate time a series of questions about how responsible Mary felt for her husband's suicide. If she did, then how did she deal with that? Who can she talk to most openly about it? Later on, the therapist learns that his suicide is a major secret being kept from her children. Tom's wife died in childbirth, an unusual happening in this day and age. The fact that she died *giving* birth to a sixth child, which today may be viewed as contributing to overpopulation, leads to speculation about the degree of responsibility Tom felt for his wife's death. This family has sustained a number of losses in a very short period of time.

One of the major benefits of taking this kind of family history is that important things are learned about right away that otherwise might not come out until much later. One of the goals of each session is to locate toxic issues and open up communication around them which hopefully will detoxify them and open multiple relationship options. As the therapist proceeds, he will focus on pinning down the process and emotional reactions to some of the factual happenings.

As the genogram is filled in and the family process is spelled out the therapist organizes the information around these significant areas: the family's operating principles; its operating principles in times of stress; the function of time in these relationships; generational and personal

boundaries; the conflictual issues—sex, money, in-laws, kids; triangles; personal closeness, tenderness, and honesty; and the extended family's relevance to the stated problem.

Once having done this, the therapist and family can go on to thoroughly investigate the family's view of the problem. This is important to the process of engagement between the therapist and the family, which depends on many factors. The therapist must make a personal connection with each family member present. How he does this will depend on his style. In making this connection the therapist must remain alert to the family's boundary guard. Frequently the boundary guard is the father, and successful initial contact with him will implicitly open the remainder of the system to contact with the therapist. It is also important that he communicate an understanding of each family member's position vis-a-vis the presenting problem. The evaluation session then becomes an emotionally validating experience for the family, and as such fosters the process of engagement.

The therapist turns to Mary first for her view of the problem. She states that she has been feeling better just since making the appointment to come in. The fact that her mother has been visiting for the previous week is offered as the most recent disorganizing experience. The therapist decides to be untracked for a moment, and find out just what position Mary's mother occupies in the present family structure. Mother is described as anxious, critical, and easily upset. The therapist probes the openness of that relationship by inquiring if Mary told her mother she was coming in for consultation. Mary replies that her mother couldn't handle that sort of information. The therapist, referring to his genogram, sees that Mary is an only child, and investigates the impact of that fact on the intensity of their relationship. Going further, he looks for three-generational triangulation, and asks, "Which of your kids is Grandma's favorite?" The answer is Nancy, who just happens to be the daughter Mary is most concerned about.

A number of things come together at this point. Earlier in the interview Mary has remarked on how much Nancy reminds her of her father, Mary’s first husband, Bill. One of her worries about Nancy, Mary reveals, is that Nancy might repeat her father's suicide. This revelation, combined with the therapist's observation that while this line of questioning is going on with Mary, Tom is relieved to the point of being pleased, causes the therapist to take a series of steps. He frames his move by first recalling Mary's concern for Nancy's possible suicide; then he gradually moves to open the issue of potential suicide in the marriage.

The first target of the therapist's questioning is Mary's feeling of responsibility for her first husband's death, and to what extent that ties in to her present worry about her daughter. Next the therapist checks on Mary herself. "With all of this trouble that you have been having recently with the children, and Tom's lack of work, have you ever thought of cashing in your own chips as a solution?" Mary replies that while she frequently feels that the entire household would improve greatly if she packed a bag and left, she does not see suicide as the answer to her problems.

The therapist then moves to cover the primary target, and asks a reverse question. "You'd never find yourself worrying about Tom becoming so despondent about his own career that he would take his own life?" Mary's answer requires no period of deep thought. She says immediately, "Definitely. Quite often." This is then opened up with Tom and checked out with him. Tom does a disclaimer, stating that suicide is not his style; but he does admit being bugged at not being able to reassure Mary. Much of the presenting problem as it appears from Mary's vantage point

has been spelled out. She has never come to terms with her feelings of responsibility for her first husband's death. She is determined to prevent a recurrence in her daughter. She has virtually no one that she can talk to about her deepest worries in this regard. When she does let them out into the relationship with her husband Tom, he reasons at her intense feelings. Her mother, too, lost a husband prematurely. But the intensity of that relationship can't contain Mary's emotions. In her isolation Mary is constantly taking Tom's emotional temperature, trying to deal with his children as well as her own, and feeling supported by no one.

The therapist has heard the problem from Mary's viewpoint. Tom has also been connected with about his views on the issue of suicide. Tom relates his central concern to be no job and an upset wife. The therapist asks, "Are you ever aware that Mary is sitting there worrying that you will become so depressed about your lack of a job that you might resort to suicide as a way out?" This question has a dual purpose: it allows the therapist to move toward the areas of Tom's concern, and it also sets the stage for questions about how the Mary/Tom relationship works on an operational level—that is, how aware of Mary's concern is Tom, how much is he tuned in to her and the way she thinks?

Tom appears to be a calm reasonable man who takes most things in his stride. He even appears to have the present state of affairs under control, and describes his situation with a half-smile and a gentle joking manner The therapist observes this, and puts it together with the fact that Tom is an Irishman, and perhaps therefore has inherited some of the cultural patterns of his forefathers. How much is his calm, jocular exterior related to the Irish manner of holding in feelings of rage? Pride is often the napkin that covers everything else in the Irish picnic basket.

Here is a man who is used to making $50,000 a year in an important job. Now his wife supports the family on considerably less. How low has his pride index fallen? The therapist's questioning follows this train of thought. He asks, "What are some of the problems you personally face around your present work difficulties?" "Frustration, mostly," is Tom's reply, "I mean, I never get violent or anything." The therapist remarks, "The Irish are famous for their underground rage." Tom laughs and confides that he does experience a significant degree of rage, and that most of the time he just does not know where to put that feeling. He tries hard to control it. He does doubt himself and his abilities. "Supposing I really am not all that good. . . . then what?" He worries about this daily, and sometimes feels that this constant internal battle will result in a loss of confidence in himself, so that when he does go to an interview, his embarrassment and lack of belief in himself will show, and work against the impression that he makes.

The therapist asks, "Do you have the freedom to put these kinds of thoughts and upsets into your relationship with Mary?" Tom confides that he really is holding most of this in, because he does not want to complain and burden everyone, especially Mary, with a situation that he can do nothing about. The therapist points out that talking about it to Mary might validate her thoughts and feelings, and be a relief to her. If she knew he was suffering, she would be less upset and he would have less to contend with. Also, she wouldn't have to fill the vacuum with thoughts of his suicide.

A good deal of time in this part of the interview is spent discussing the practical difficulties in job hunting, over-qualification, lack of readily available jobs due to the economic crunch, and so on. The therapist questions Tom about the possibilities of relocating to another more prosperous

area. Tom says that of late he has been considering it. The therapist also remarks that Tom is being interviewed by men who are less qualified to do the jobs they are doing than Tom himself is; Tom states that he has learned to write his resume to fit the description of the job for which he is applying. This tells the therapist that Tom is not sitting around the house waiting for a job to come to him, and is in fact doing everything that he can for himself.

The operating principles that each of this marital pair uses to govern his or her own individual action and reactions have been evident throughout the interview. The therapist knows, for instance, that Mary is a distancer when it comes to her mother, but a pursuer of her husband and children. She is the self-appointed protector of her charges who tries to keep them from all harm. She oversees everything from the laundry to her daughter's and her husband's depression index. Tom, on the other hand, distances from everything but his work. He used his work as a source of refuge when his first wife and baby died, and also later on, after the untimely death of his son. Here is a man whose major prop—the work in which he took pride—has been removed. In his own words, "Pride gets in my way and sometimes it colors my judgment about things. Sometimes I think that now it is my pride that I protect the most."

The problems that this couple have with their two middle daughters (one each from their former marriages), who strongly resemble their respective dead parents, point up the need to deal with the ghosts of these former spouses, so that the children do not indeed become pushed into repeating those parts of the family script. At the end of this interview Mary and Tom were asked to bring in the children for the next visit. In addition, they discussed the possible advantages of having a session that included Tom's two oldest daughters, both in their twenties and living away from home.

We usually set aside an initial period of two hours, followed by two one-hour sessions, for a family evaluation, but the many complex problems in this family made another two-hour session including the children necessary. Ideally, the next step might be a home visit with the whole family, perhaps at dinner, but this is usually not possible with most families.

In the last evaluation session, the therapist presents the things he has learned about the family and charts a general course of action to be followed in subsequent meetings. This interview often includes specific assignments for each partner, which will be checked on in the next meeting.

A great deal of information is gathered in an evaluation interview, which has to be synthesized and recorded. To facilitate this process we have developed a form, which we offer as a model.

PRESENTING PROBLEM: Tom has been out of work for 2 1/2 years. He is a graduate of Fordham with a B.S. in Business Administration and an M.A. in Engineering. His salary when last employed was $50,000. He was a consultant to a major engineering firm. Mary is currently employed in administration at a Mental Health Clinic at a salary of $11,500.

The couple cites a variety of emotional adjustments they have found difficult to make as a result of the loss in income; father's being a housewife with scant business prospects; and behavior problems in Mary's daughter.

REFERRAL SOURCE: Jane Thorndike, M.S.W., Director of Rehabilitation Services at North Park Mental Health Clinic.

EXTENDED FAMILY RELATIONSHIPS: *Mary's Family.* Mary is the only child of a father killed in an automobile when she was three years old. Mother (73) is still living in Florida. They have little contact except for yearly "duty visits," from Mother, "to see my grandchildren." Mary's distance from Mother has been in existence since adolescence. Mother objected strongly to both of Mary's marriages, and wished her to remain at home. Mary is very close to first husband's sisters, sees them frequently, calls them every other week on the phone.

Tom's Family. Both parents died within six months of one another. He rarely sees either of his sisters or their families. He has remained in contact with first wife's sisters. He had very little contact with parents after leaving for college.

N.B. Neither spouse has developed close friends in their social network. Friends appear to be for good times only.

NUCLEAR FAMILY: Mary is a pursuer and accumulator, easily upset. She is overinvolved with all kids, and while working still tries to monitor husband/kids/house. She feels responsible for her first husband's death, just as Tom feels responsible for his first wife's death. One of her kids and one of his get caught up in this.

Tom—is a distancer, into objects and books. He is very depressed, since he is a man who distanced into his work and survived his losses through death by immersing himself in work. There is no support for the nuclear family from the extended family.

Mary is allergic to Tom's housewifing and he to her role as provider. She worries about his depression and fears it might lead to suicide. She also worries about this in her own daughter.

DIAGNOSIS OF PROBLEMS & PLAN FOR TREATMENT

1. Detoxify the issues of death, suicide, and father's job loss by lowering the anxiety level and opening the relationship around these issues.
2. Dissect the relationship process and dysfunctional patterns that orbit around all of the issues listed above.
3. Challenge dysfunctional patterns by offering alternative options and tasks that will reverse the direction of movement in the present process.
4. Make known and then structurally alter triangles involving Tom and Mary and both of their dead spouses. Do the same with all other triangles, especially those involving the children and dead parents.
5. Attempt to open up the extended family on both sides.

PROGNOSIS

The tenderness/caring index in this particular family is quite high, which is a positive prognostic sign. But this first session demonstrates that there is a significant amount of closed communication in the family system. There are cutoffs from the extended family, and these signs tend to make the prognosis somewhat guarded. From the initial evaluation time, Tom and

Mary appear (with the therapist's help) to be able to label the areas of dysfunction. However, how they take to tasks aimed at intervention in the ongoing process, and how well they sustain a focus on the thread of movement toward change, remains to be seen.

The willingness of Tom and Mary to re-enter their respective extended family fields will be an important indicator as to whether the family will settle for some form of symptomatic relief, or move into an ongoing process of long term change.

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The following is chapter 14 in The Book of Family Therapy *(Science House, 1972). Studying one's own family was a keystone in Guerin's design for training marriage and family therapists. Both Guerin and Fogarty believed that it was as important for such therapists as personal analysis was for psychoanalysts. The also thought psychotherapists had no business sending their patients back into their families unless they had done that work themselves.*

In this paper, Guerin reveals some of his own therapist's-own-family ("TOF") work. Written in 1972, at the beginning of a forty-year project of studying his nuclear and extended family, it describes early work on his relationship with his wife and children. It is illustrative of the self-revelation he practiced with people whom he was training, and his reluctance to ask of them what he would not do himself. Fogarty decided to describe his coaching of a trainee in the importance of studying his family. This is illustrative, among other things, of a difference between two long-time, very close friends.

Study Your Own Family

Philip Guerin and Thomas Fogarty

Once upon a time, an all-together-now asked two lone wolves if they would put together a series of "we" statements in the form of a chapter for the all-together-now's book. In the spirit of camaraderie and friendship the two lone wolves tried. But try as they might they just could not make "we" statements. It was almost as if it were against their "religion." As a result, the chapter to follow was divided into two sections, one by each of the authors.

P. G.

Part I, by Philip Guerin

The inevitable has come to pass. Family therapists, having established a beachhead in psychological circles, are now turning their attention to working on their own families. But what does "working" on one's own family mean and what place does it have in training family

therapists? What it means depends to a great extent on how the trainee and supervisor view family therapy.

To some therapists family therapy is a technique to be tried when all else fails or when individual therapy is not feasible. Others see "family" as a new approach to emotional problems. To them psychological problems are products of dysfunctional relationships. Each of the dyadic relationships in the family is interconnected, forming a relationship system. How this relationship system works is of primary importance. "Why" explanations, though plausible, are of secondary importance. Those who see "family" in this way make working on one's own family an important part of their personal and professional life.

Murray Bowen has been a major proponent of this view, and has stressed the importance of the trainee's working on his own family. In practice he has carried this to the extent of presenting the "work" he has done on his own family at a workshop presentation and later in print (1971).

While under Bowen's supervision as a psychiatric resident at Georgetown, I began "working" on my own family. For the past three years I have continued this work and at present see it as a lifetime project. Now, in my position as a "family" supervisor, I liberally use examples from this work to seed the idea with trainees.

Stories about one's own family have a certain shock value and are usually listened to intently. The various ways the message behind the stories is heard, however, are always of interest to me. It is often heard as "Go visit your grandmother," or "Go back home and tell the old lady off," or "Go back home and make everybody happy." In supervision I usually field such responses by agreeing that it can be fun to see grandma, triumphant to tell the old lady off, or gratifying to promote togetherness, but that I don't see any of them as accomplishing anything in themselves. At any rate, none of these are what I mean by working on one's own family. The best way to define what I mean is by describing what I do in the context of my own family. When a problem arises in my family, I try to examine my own behavior (i.e., how I am thinking, feeling, and operating). For instance, if my wife appears depressed or one of my daughters becomes whiny and irritable, I will look to my behavior in my relationship with my wife, the troubled child, each of the other children, my parents, etc. The purpose of this is based on the idea that if my wife's depression or my child's behavior is an expression of a family problem, I have a responsibility for my part in the process. I believe that the only one I can change is myself, and therefore if I hope to exact change in the family process there must be a change on my part. I remember an instance during this past year in which I was aware of being moderately depressed and somewhat irritable. At dinner I noticed that my oldest daughter was engaged in one of her sporadic bouts of thumb sucking. I dropped some sardonic comment. My daughter replied, "Daddy, if you don't stop picking at me, I'm going to suck my thumb for the rest of my life." We all laughed. After dinner in the relative isolation of my office, I was able to figure out the following seemingly connected series of events. Early in the week the emotional tone in the extended family had been especially tight. In response to this extended family difficulty, my wife predictably pulled back, establishing distance between her and other family members. Sensing this pulling back, I, according to form, began crowding in on her by repetitive questioning and expert but unsolicited supervision on household projects. This method of crowding usually results in increased distance on the part of my wife, and I begin taking this distance personally – thereby further intensifying the situation. When things get to this point between my wife and me, our oldest daughter's feeling barometer picks up the rising level of tension. As her own anxiety level rises in response

to this, she begins making frequent mistakes or appearing confused and helpless. Watching this, I will become irritable and begin to press her.

If sufficient pressure is applied, pacification by oral gratification becomes apparent. All of these observations may or may not be true, but using them as a basis for a hypothesis on how the present situation evolved, I could then begin an attempt to change my own part in the process. Actually my daughter's comment on the possible perpetuation of her thumb sucking had succeeded in decreasing some of the emotional intensity. This decrease had enabled me to begin thinking about the situation. Once I attempted to bring about some change in my part of this process, I would then be able to validate or invalidate part or even my entire hypothesis.

The plan of action I decided upon called for me to cease questioning or commenting on either my wife's or my daughter's behavior. In place of this I would make comments in my wife's presence like, "It sure is peaceful to live with someone who doesn't burden me with personal thoughts and feelings," or "I can't stand people who are always talking about their troubles." Immediately after a comment like this I would make a quick exit, instead of waiting for or even expecting a response from my wife.

Where my daughter's performance was concerned, instead of a barrage of irritable corrections, I would say, "Can you do that wrong once more honey? I think it's good for kids to practice doing things wrong," or "After you have finished practicing I want you to spend the next half hour sucking your thumb." I would then leave the room.

Moves such as these served several purposes. I was able to check my anxiety and decrease the crowding of my wife and daughter, while still letting them know that I was aware of what was going on. Handling things in this way made it possible for me to view their behavior as less of a personal affront. Given enough room, my wife was able to move toward me and open up the issues which were bothering her. Once the anxiety level of the whole family had decreased we were then able to deal with the problems in the extended family in a more meaningful and successful way.

Obviously the outcome of the story was satisfactory or I wouldn't have used it as an example. But more important to me than the success of this individual operation was the fact that I had learned something. One of the recurring, automatic behavior programs in my family had been spelled out and an attempt had been made to change it.

The trainee's response to "hero" stories such as these is often[1], "Sounds interesting, but how does one go about it?" The first step is to obtain a minimal groundwork of theoretical ideas. The best published source of these at present is Bowen's article on "The Use of Family Theory in Clinical Practice" (1966). The next step is to take out a pencil and a large piece of paper and draw out a schematic diagram of your own three generational family relationship system. This schematic diagram is called a genogram. I shall attempt to illustrate by using my own family system.

The genogram provides a guide for following the action. It's like the program at a football game or perhaps even more like the coach’s blackboard at halftime. It names and numbers each of the family members and their relationships to one another. You start the genogram with the central

[1] In my experience, fifty percent of trainees express interest. Of this fifty percent only one-half actually do anything with the idea.

and primary relationship in the nuclear family – that between the spouses. Squares are drawn to represent men, circles to represent women, with no offense intended to the men. You then insert the ages of the individuals inside their respective square or circle. On the line connecting the square and circle you place the date of marriage. I am 33, my wife is 30, and we were married in 1963. Next comes the completion of the nuclear family by adding the children. My wife and I have three girls ages six, four, and one.

At this point the functioning of the nuclear family can be considered. The presence or absence of work productivity, socialization, isolation, emotional and physical symptoms are reviewed. Then the state of the various relationships is scanned, with an eye toward how emotional issues are handled. The relationships that appear to work well and those with the most difficulty are pinpointed. An attempt is made to define the shifting patterns of alliance and how they operate. The effect the functioning level of one family member appears to have on the functioning level of the other family member is defined. These matters having been considered, you expand the genogram to exclude the extended family – each spouse's family of origin.

My wife's side of the extended family consists of her mother, age 60, and two younger siblings. Both siblings are married; one living in New York City, the other in Washington, DC. Her brother has two daughters. My wife's father died in December, 1969. In constructing a genogram the dates of important events such as deaths, births, marriages, retirements, etc., are always worth investigating. Events such as these have a profound emotional impact on families. Like adolescence and old age, they are normative crises. If the family relationship system is flexible and open, there are open lines of communication. Through these lines emotional issues get dealt with, rather than closed off and buried. As a result, the impact of such events on the family system will be absorbed and dissipated.

If the opposite is true and family behavior patterns are more fixed, channels of communication get closed off and feeling-laden issues are buried. Apprehension over controlling one's own feelings or dealing with the emotional response of others prevents the open airing of issues such as the death of a family member. In this type of "closed-system" situation, emotional or physical symptoms will often appear in one or more family members. A local school psychologist referred a family in which the 12-year-old son was symptomatic. His performance in school had dropped far below his potential and he was clinically depressed. During the previous year the boy's need for glasses had been discovered. The fact that this would prevent his following his father's career was considered an important etiologic factor. Filling in the genogram, the fact of the maternal grandfather's death 14 months prior to the family's initial visit was uncovered. Grandfather was a prominent and successful man. He took a great deal of interest in his family, especially his daughter and grandson. For this reason he was an important functioning part of this family. His untimely death had been a shock. However, the family quickly accepted it as one of the tragedies of life. They have remained brave and stoic throughout the funeral ritual, shedding only the respectable amount of tears. Grandfather's death left a large empty space in the family. The boy and his mother frequently thought of him. These thoughts inevitably provoked a lot of feelings, but mother wouldn't talk about it "because it's morbid." The son wouldn't talk about his thoughts and feelings "because it would upset mother." As a result mother would find convenient times when no one was around to cry and get it over with, rather than burden anyone with her troubles. Her son found himself unable to concentrate, having difficulty sleeping and without the energy needed to get involved with his heretofore favorite projects. He often thought of his

grandfather, wishing he could talk to him again, wishing he had had a chance to tell them some things before he died. True to the image of the "brave soldier" he kept these thoughts and feelings to himself. The opening up of the issue of grandfather's death in the family session led to the discussion of these thoughts and feelings, and the effects of keeping them closed off. The therapist instructed the mother and son to work consciously on keeping the issue open by purposely discussing grandfather's death whenever thoughts and feelings about him arose. This enabled them to deal with the feelings. As a result the son’s depression lifted and his school performance rose sharply.

To return to my own genogram, both of my parents are living and age 63. I have one sister, who is married. My sister and her husband have one daughter. My parents and my sister both live in Fairfield, Connecticut, within 5 minutes traveling time of each other.

The physical location of the various parts of the family system is another area to investigate. In some families cohesiveness appears evident. When this is present, you will find multiple members of the family all living within walking distance of one another. There is frequent visiting back and forth. In other families, there is an explosive quality. When this is present, you will find family members spread to all corners of the globe. The frequency of contact is minimal at best. It often happens that a person from an explosive family will marry someone from a cohesive family and become absorbed into the cohesive family structure of the spouse. In my family this doesn't appear to be the case, as strong elements of cohesion are present in both parts of the extended family.

The issue of physical proximity and distance within the family has another facet. People tend to deal with emotional conflict by either becoming over-distant or over-involved with the problem. For instance, one person may respond to family problems by telephoning one or more family members daily. On the other hand, another person may move 3000 miles away and reduce contact with family members to a minimum. In order to deal with emotional conflict, a certain degree of physical distance seems necessary. Moving one's self outside of the range of the family's emotional bombardment is necessary to facilitate a relatively objective view of what is going on.

I now live within 50 miles of my extended family. Until two years ago, I lived 300 miles away, so the tension input from my extended family was much less intense than at present. It took much less energy on my part to deal with the relationship problems as they arose. On trips to visit the extended family I would often get caught up in the conflictual part of the family emotional process. I could feel myself tightening up inside and the ability to observe and think about what was going on would become markedly impaired. It would take up to a week following my return from the visit before I could begin to think again. Since moving to within 50 miles of my extended family, the emotional input has greatly increased, as has the amount of energy necessary to keep myself loose emotionally. On one occasion during this past year, I found myself caught up in attempting to deal with the conflictual process in my extended family. I made several attempts at thinking about it but drew a blank. The absence of the flow of ideas about a particular problem is a good index of the degree to which one is emotionally caught up in a feeling process. While struggling with this, a professional trip to Boston happened along. On the day of my departure I made another attempt at sorting out the difficulty by visiting my parents. The visit was at best unproductive. It was not until I had been in Boston for 24 hours that a flow of ideas about the situation began. As a result I was able to sort out my part in the

process. On my return trip, I made a reentry into my extended family. This time I was emotionally loose and had a plan of action. I was able to reverse my part in the process and as a result, the conflict was eventually resolved.

Instances like this point to the importance of physical distance. On the other hand, people tend to equate maturity with an avoidance of contact with extended family members, particularly parents. Being 3000 miles away and not having had contact with one's parents is seen as independence. In my experience, rather than independence, it represents a reactive distance to unresolved conflict in an extremely important relationship. *Planned* distance to enable thought and planning for reentry is essential. *Reactive* distance leaves the problem unresolved and attempts to close off the feelings connected to the conflictual relationship. Unfortunately these closed feelings will out, most often in a camouflaged form in one's nuclear family.

The names and numbers, physical location, and frequency of contact of family members have been filled in on the genogram. Important happenings such as deaths have been investigated. The next step is to define the triangular sets within the relationship system of the family. The emotional process in the family system appears to move in such a way that interlocking triangular building blocks are formed. The concept of the triangle is one of the primary ones in family systems thinking. It is based on the idea that the emotional process between two people is unstable and thus moves to stabilize itself by triangle and in a third person or object. This triangulation may take place by the active movement of one or both parties to triangle a third or by the third party's being caught up by the anxiety in the tottering dyad and being pulled into the emotional process as a stabilizer.

In any people triangle, there are three points (representing the individuals), and three legs (representing the relationships). The process works so that at any given time two points and the leg connecting them are cozy and pulled together. Simultaneously, the other two legs are distant and the point connecting them is in the odd-man-out position. For instance, referring back to my genogram, let's look at the triangle concerning my mother, my sister, and myself. My mother and sister are together and my mother begins to talk about her displeasure with me. The emotional process between my mother and me is being run at my sister. If my sister reacts to this communication by agreeing with mother she and mother form the cozy or pulled-together leg of the triangle, and I am in the one-man-out position. On the other hand, if my sister reacts to mother's communication by defending me, she makes the leg of the triangle between us the cozy one and mother is in the out position. My sister might further solidify the pulling together by telephoning me to complain about mother. And so the process goes on.

The dysfunctional or undesirable aspect of this process is that it prevents the emotional process between two people from ever being worked out. In this way, personal, one-to-one, open relationships, in which there is a mutual sharing of personal thoughts and feelings, cannot develop. De-triangulation of oneself and the development of a one-to-one personal relationship with each family member is the pot of gold at the end of the rainbow in the project of working on one's own family. In order to accomplish this, it is therefore necessary to do the work of spelling out the triangles that exist in one's family. The process of de-triangulating one's self is complex. Basically, it entails a definition of the process and the plan of action whereby self ceases to participate in it. For example, in the triangle just discussed, if we flip that around so that my mother is communicating to me her displeasure with my sister, I can attempt to de-triangle myself in the following way. If I do not react on a feeling level to my mother's communication, I

can take her hypothesis, "your sister has faults," and run it into the ground by finding so many things wrong with my sister that mother, in a predictable fashion will begin to defend her. In addition I can phone my sister and indicate to her that she should find a better way to relate to my mother. By this series of moves I have given them back to one another to work out the problem. Maybe they will or maybe they won't. But I have fulfilled my responsibility by not participating in a triangulation of the conflict.

Realizing that the number of triangles multiplies with the number of people, it is easy to appreciate the complexity of the family process. Faced with this real complexity, one can only begin to spell out the triangles and deal with them as they become active. In the beginning it is especially wise to try to pick out a few of the more dormant triangles and try your hand at those. That is preferable to waiting for one to become active and hit you over the head. In this regard, I found it was initially much easier to work on my relationships with my wife's half of the extended family. This was the area in which I was first successful. These successes spurred me on to the greater challenge of my own nuclear family and my half of the extended family.

The most difficult work for me has been in attempting to establish a one-to-one personal relationship with each of my parents. The trainees I have supervised who have tried this project also found this to be so. When an attempt is made to exact a change in a relationship with one parent, there is usually a pulling together of both parents into a position of "we-ness." Parents are experts at the lateral pass. For instance, if I open up the conflictual issue with my mother, she will invariably pass the ball laterally to my father with a "What do you think about that?" This is usually followed by a statement like "We've always thought . . ." Therefore it is impossible to accomplish any work on a one-to-one relationship while both parents are physically present. In attempting to do this work, arrange to have a time and place where it is possible to be alone together.

Despite this difficulty, working on my own family has enabled me to see my parents as real people. At this point I don't believe I over-value or under-value either of them. Although on the one hand I am perhaps more aware of their shortcomings, I believe that each one of them is more knowable to me now and that I am closer to each of them than at any other time in my life. One thing is certain: I don't view them as the malignant cause of my shortcomings.

There are many reasons for sharing this work with trainees. First of all, it demonstrates to the trainees that you really mean what you say, and furthermore that you do what you say. You don't propose that others – patients and trainees – work on their families while you do something else, or nothing at all. It also demonstrates your willingness to be open about yourself, and personalizes the work. In turn it makes clear to the trainee that you are interested in his own family as well as those families he is seeing professionally. In addition, the presentation to the trainee of your work on your own family gives him a frame of reference from which he can launch his own work.

Of the 25% of trainees who, in my experience, take on the project of working on their own family, all have found it to be helpful personally and professionally. The part they find most difficult is thinking out a plan of action and doing something different once the process has been spelled out. Doing something to change your behavior in the context of your relationships with spouse, children, parents, etc., is the route to differentiation of self from other. It is this planning and doing which is the most difficult emotionally and separates the successes from failures.

Another important aspect of the work a trainee does on his own family is the relationship between the trainee and his family supervisor. This is dealt with extensively in part two of this chapter.

Part II, by Thomas F Fogarty

> George walked into the office and we introduced ourselves. In direct response to questions, he told me about his position in the training program, what he planned to do when he finished, what his orientation toward emotional problems was, and some other pertinent data. Then I told him about my own training, experience, practice, etc. Again, in response to questions, he told me that he was married, had one son, and a little about his parents. Then, I sat back and asked what he would like to do with the rest of the hour.

It would be hard to tell, out of context, if the above paragraph described either a training hour or a treatment hour. Much the same thing occurs in both. There is a focus on gathering of pertinent data, and then a gradual clarification of the "I" position of the trainee. Initially his "I" position is spread out to include his profession, his family, and his particular position in time. From the start, the context of supervision is set to include the total self of the supervisee – profession, inner self, family, viewpoint, and future. This is followed by the supervisor's doing precisely the same thing. I tell people of my own family, orientation, training, viewpoints, practice – a necessarily general but inclusive definition of me and my context. This is designed to set the scene. I hope it will lead to each of us seeing himself as part of a continuum and to the development of a personal relationship.

> George starts to tell me about families. I sighed with relief. At least he is seeing some families. In the worst of supervision, the trainee lapses into individual dynamic thinking and ponders about seeing a family sometime in the future. The future is now. It is difficult to follow George because he keeps giving me historical data full of holes, liberally laced with gratuitous explanations and interpretations about what is going on inside these people he is talking about. I long to have them there so that I can ask them what they are thinking and feeling. But I persist, trying to show interest. I find myself really wishing that he would talk about his own family.

When I was in supervision, I would either try to impress the "big man" with how much I knew or look to him for wise answers. I would be generally relieved when the whole thing was done with. I assume he was too. My supervisors would refer to me as if I were an impersonal machine, and I don't really believe they knew what they were talking about. Heaven forbid that I should ever get to know them. Supervision, like all human contact, tends to start with two people talking about a third – the patient. This is to be expected and endured. Fools rush in where wise men fear to tread. Distance between self and other is narrowed gradually. There is a routine, a ritual, a format which leads into the possibility of a relationship going further. It is not so troublesome that this ritual exists, but that it so often gets stuck there. To unstick, the supervisor must be alert, like a half back going around an end, for an opening.

> George is telling me about a family. The husband lives alternately with his wife and a mistress. George thinks that the husband is a homosexual and is full of explanations about the man. I noticed that George seems to document every viewpoint by "I feel this and I feel that." I wonder what a homosexual is. It seems to me that this family is in a triangle. I try to explain this to George. He looks confused. I search for a piece of paper and draw a diagram of a triangle. Then I illustrate with examples from my own family. "It's like this, George. If my wife is doing something with my son that I believe is absolutely wrong, then I have a tendency to jump in and give her the truth, which only I possess. If I jump in, then she and I get into a fight and while we argue, son goes out the back door on his way. My wife retreats to her room and I sit down and ponder how I am going to straighten out all the other members of my family. The result of my jumping in is to increase the emotional intensity of anger, to prevent discussion, to allow my son to parlay the triangle, and simply to repeat things that haven't worked in the past and won't work in the future." As I talk, I can see old George's eyes light up with this; he even begins to chuckle. I wonder if he has had some of the same experiences. This is what you call an opening.

In the process of supervision of families more often than not I find golden opportunities for the development of a struggle. My own experience in my family and in my practice has convinced me that this kind of development is useless and often destructive. I try hard to listen to what the other fellow has to say; then I try to get my ideas across. I try to take an "I" position. With George, he saw homosexuality and I saw triangle. I generally start with some kind of an abstract explanation of what a triangle is and this, as often as not, simply does not work. Yet, it forms a baseline. Then I draw pictures and tried to demonstrate it visually. This helps. It always helps. Seeing something will sooner or later help to clarify an idea. Then I move it into the concrete and the personal. It was concrete because I gave an example of a specific situation in a specific family. It was personal because it referred to me and my own family. The results are almost inevitable. They are not inevitable (nor should they be) in terms of agreement. They are inevitable in terms of the beginning of openness. We now have the beginning of a context wherein George can take a stand and I can too. We can be honest with each other. Furthermore the first teaching experience of families, "What is a triangle?," has been put on the table. It has been put there in a personal way. I did it first with my own family. I ain't caught a fish yet but I can see them biting. What's more, they don't even know they're biting. Now I'm starting to get into business.

> The next meeting, George doesn't show up. He is attending some important meeting on the "Importance of transference-counter-transference in the development of the female carrot" at the New York Psychoanalytic Association. Without further comment, this is a most discouraging development. But I persevere. After all, they pay me, and the other parts of the job ain't so bad. There are some people there that I actually enjoy. The next week, George is back. He tells me about the meeting and I'm sure glad he went to it. What the hell? George deserves such a fate. I think he is hopeless. Something wakes me from my sleep. George is talking about his family. How about that? He found a triangle. He knows they exist. This is a phenomenal development in view of the fact that every family has about 5 million of them. George is alive. The trouble is that George doesn't even know if he is alive. But hope springs eternal within the human breast. George found a triangle. We are back in business. George starts to talk about himself and his wife. It

> seems that he has a mother-in-law that he has no trouble with. The only trouble is that he can't stand her and that he stays away from her. Of course, this isn't a real problem. He is taking care of this in his analysis. He can explain it now. It's just that he hasn't spoken to her in 10 years. Of course, someone might consider it a problem because, every time the subject comes up, he and his wife fight. Well, they don't really fight; they just don't talk to each other for one week.

The teaching of family therapy or family theory is a most discouraging prospect. It is like swimming against the tide. Yet there is an audience, a group of people who really want to know. George jumped out toward it and then took a massive retreat. Yet, the next time he jumped he landed smack in the middle of his own family triangle. Now I know that he is gettable, he is reachable. Now he has to live with it. He can no longer run. He has a triangle in his own family. If what I have to say is really useful, then I should be able to document it. The context has been set. The continuum has been set. The rewards of good deeds earlier done may now be reaped. We have taken the pains to set the context in the continuum wherein his family, profession, and other interests now meet with my family, profession, and interests. He doesn't move in a straight line, but what does? He has opened his mind so that he can see. That is all I ask. There is something personal for him to deal with in his own family. Now he can begin to see what I mean. My family is my system. That is where my most intense involvement lies. I care more about my family than any person that I supervise. I will tell George that. He'd better understand it. I think that now he can understand. He begins to find out that he really must deal with his mother-in-law. Staying away from her is no solution. He is beginning to find out that distance is a useful tool to "think," but that distance never solves problems. Explanations are great until one has a problem in one's own family. Then, one wants results. But, "What is the price?"

> George tells me about something that he tried. He asked his mother-in-law over. She came. His wife loved it, but after her mother left, told him that he did it to embarrass her. He felt resentful. He likened it to a family that he was seeing. He could understand that this man might not be a homosexual, but that he might feel neglected and seek consolation outside the family. I stayed quiet. This guy was thinking. I didn't want to impose my thoughts on someone who was thinking. I would like him to continue. He has a question. What is this thing we do here? He has a psychoanalyst. He takes his personal problems there. I am supposed to be teaching him. What am I doing? I hear this as an equalizing statement. He no longer looks up to me. He is ready to deal with me. Now I can confront him. "What do you want?" I asked. "Spell it out." He is on the spot. By now he likes it, but he also is seeing that it exacts an emotional price from him. Tough. I should charge him.

There is no question but that supervision and teaching of the family are a very difficult job. Too many take it as something interesting or entertaining. The basic notions of triangles, fusion, distance, etc., are so different from ordinary dynamic psychology. The best and perhaps only way to really understand these ideas is to try them out in one's own family. The trainee can be encouraged to do this by having him view it as an innocent experiment. If one can predict to him what will happen when he tries it, then he is impressed and fascinated. This may disturb him if he is used to taking emotional problems to his analyst. This also sets up another potential triangle between the supervisor, the supervisee, and the analyst. It offers a concrete example of what a triangle is. It offers an opportunity to see self as part of a continuum which spreads through the

family, the analysis, and the teaching. In this sense, there is no difference between treatment, teaching, and living in one's own family, or one's professional life. Any supervision that limits itself to the trainee and the family he is seeing is practically worthless. It becomes but an intellectual exercise. Supervision should cease as such. The whole family of the supervisee should be involved just as in "treatment" or having a family picnic. This would eliminate much of the artificial flavor. A professional who comes to me with a family problem invariably learns more about family therapy than any pure supervision experience can produce by itself.

> George brings a family in for me to interview. He is obviously impressed by the interview. He discusses the family and what he sees me doing. Then he compares me to another family therapist and says that I am really not so different. Toward the end of the hour, he raises an issue. Something about his family is bugging him. He has been getting letters from his mother which indicate that things are not going well in the extended family. One of the reasons he moved to New York was to get away from them. He had thought that the problem was solved. Now he is concerned and wondering if this is so. He can feel the emotional pull from the extended family. Mother tells him that he doesn't care.

The particular details of George's difficulty with his extended family do not particularly matter. What is clear is that he does have to work on his parents. Growing up, he was triangled into his parents. He was overly close to his mother and distant from his father. The third leg of the triangle was the distance between father and mother. When George married, he moved away from mother and created a pull in that overly close leg of the triangle. Now he was hearing rumblings and repercussions from the extended family. This was a golden opportunity for him to do something. It would have to be something different since you would not want to duplicate the previous dysfunctional triangle. He wrote them a letter. As usual, it was addressed to both. Despite this, the content of the letter was directed to his mother. She answered the letter. When he replied, he opened by directing the content to his father. He asked specific questions about his father's business as father alone could answer. Toward the end of the letter, he dropped a "reverse fusion" on his mother, who told him that he didn't care. She had fused with him. She had acted as though she could read his mind and his motivations. She had acted as if she was inside his head. She had acted like a psychiatrist. The reversal is just like the old statue-of-liberty play in football. He wrote that he had been getting the impression lately that she was cool to him and that she really was ignoring and not caring about him. George had much difficulty understanding precisely why he even wrote this letter.

> George came to the next visit fairly glum. Nothing was going right. His wife read the letter before he sent it. She felt that he was being unnecessarily cruel to his mother, just as he was to her at times. Father had written a long reply which didn't seem to amount to much, except that he hadn't replied before. Father included a message which said that his mother wanted George to call her. George was discouraged. Fortunately he had a session with his analyst that afternoon and would be able to cathect his discomfort.

George was beginning to learn. Now he could appreciate that there is such a thing as an emotional system. As soon as he changed, everybody in the system told them to get back in his place. His father tried to move away into his distant position and get his mother to deal with George again. Mother got hurt and pulled into herself. Even his wife fused into telling him his motivation was cruelty. George was also beginning to learn that change is difficult, more

difficult than sitting in a chair reciting problems to harmless others. It meant action, movement. It often meant doing things which would create discomfort in others and doubt, confusion, and unrest in self. It meant that writing a letter to father could change the position of mother and wife. He could now begin to see the interconnection between members of the family system. He said: "My God, I married someone just like my mother."

> George and I finished out the rest of the year, fritzing around between the families he was seeing and his own family. It never really became work on his family because he never even seriously thought of bringing his wife in. He fritzed around at the periphery. Yet he did learn something. One year later, I ran into George again. He hadn't seen a family in that whole year. He was still interested in systems and somehow thought that he could eventually use this in his work in public health.

The following paper was written in the early 1980's by one of Guerin's most productive and best known protégés, then known as Judith Gilbert. She was a coauthor of The Evaluation and Treatment of Marital Conflict *(Basic Books, 1987) and of* Working with Relationship Triangles *(Guilford, 1996). In her professional career she had considerable experience with alcoholic patients, and her paper illustrates the sort of insights that can illuminate substance abuse by viewing it through the lens of family systems thinking.*

Family Process in the Alcohol System

Judith G. Kautto, C.S.W., A.C.S.W.

Before joining the faculty and staff at CFL I worked for eight years with a chronic alcoholic population in a VA hospital. During that time it became apparent to me that there was a significant degree of complicity within the treatment system in maintaining the under-responsible position of the patient by labeling him a passive dependent personality. In an effort to develop a method of combating this, I began to work in the halfway house on the grounds of the hospital, organizing a group of men to move back into the community. From this experience I moved on to the task of setting up a community-based halfway house program, founded on the premise that there had to be a way for the symptomatic person to take responsibility for his own life.

At about the same time, family systems theory began to link up for me the ideas of over-functioner, under-functioner, the resulting reciprocity, and how it works around the symptom of alcohol abuse. Since that time, I have been attempting in my clinical work to apply family systems theory to the alcoholic family system. In doing this I ascribe to a treatment modality which includes the use of AA, Al-Anon, and detoxification – along with a family systems approach.

Added to my inpatient work in the last two years, I have worked with over 30 outpatient families in which a member presented with an alcohol problem. The work with these families has piqued my interest in the phenomena of the wet and dry states as defined by Berenson. From observation it appears that they exist in juxtaposition to one another over time in the same nuclear unit, and alternate over the generations with one another in the extended family. The dry state refers to cessation of the drinking and a condition in which "the individual or family has only a partial repertory of behavior and feelings." Characteristic behavior of the dry state can be described as distant, non-experiencing, boring, and unassertive. The wet state refers to the condition of alcohol abuse and the resultant "drunken" comportment of the individual and the family. The behaviors may be described as exciting, over-experiencing, impulsive, and angry. The concepts of the wet and dry states represent spots on the continuum of behavior in the alcoholic family and as such provide a useful context in which to observe some of the process in these families.

As I worked with these 30 families, I observed that even if the alcohol abuser came in for treatment, and asked for help with his or her drinking, went to AA and generally followed the program – and the nondrinking spouse went to Al-Anon – it became clear over time that it was not only difficult to see and move the dysfunctional process in the wet stage, but even more difficult to make changes once the family slips into the dry stage. One of the factors in this is an enormous (and understandable) fear in the family, especially in the nondrinking spouse, that the drinking will return.

What are the factors that make substantial modifications of the family process difficult? First of all the alcoholic system has a high chronic level of anxiety. The alcoholic system can rival the psychotic family system in its high level of anxiety and the extent of its blocked communication. Some indicators of the closed nature of a family system can be gauged by examining the degree of openness of communication around toxic issues in the family and how this affects the relationship process. The presence or absence of emotional cutoffs among family members is another major indicator of the functional openness in a family. In taking the genogram information from the family during evaluation, I often hear about an aunt Susie or a grandma who had a breakdown. The family has not had contact with her in years. Those family members who do maintain contact often do so in a ritualized manner.

In working with families with alcohol abuse, the therapist's expectation for rapid change must be kept realistically low, or treatment is doomed before it starts. From my work, it has become evident to me that what had been described as the "wet stage" or active stage, and the "dry stage" or inactive stage is in reality all part of the active stage. Even if drinking stops and the system reaches control and moves into the dry state, the process behind the alcohol abuse continues. It is in fact an ongoing trans-generational process. Even though there seems to be no logical reason behind the shift in movement from wet to dry, there do appear to be some identifiable characteristics that play a part in the movement.

Time and Family Rhythm

A quiet, slow-moving family will stay drier longer and will make the shift to wet in a much more gradual way than a family whose rhythm is quick. A family with a quick rhythm could have four or five moves between the wet and the dry stage, and back again, before a family with a slower rhythm begins its first swing through the cycle. George and Sally are a quiet, refined couple who

are cautious and conservative with one another as well as with the rest of the world. They spend a good deal of time planning and weighing pros and cons before making a decision. When George began to drink again he did so very slowly, over a period of many weeks – first one beer then a few days later another. Sally gradually became aware of George's drinking. Ultimately he began to drink uncontrollably. This entire process took over a month. On the other hand Harry and Andrea have a cycle that is weekly. Andrea is a young impulsive woman who speaks in a hurried manner. She has held three different jobs in the last year. Harry is the kind of man who enjoys hopping into a car and taking off for parts unknown. Harry is dry for four days – time enough for him to recover from his hangover and make up with his wife, and then he begins to drink again, usually starting off with an all-nighter. George and his wife have only traveled through the cycle once during the time Harry and Andrea have been around the merry-go-round four times.

Intensity and Emotionality

The intensity and emotionality of the family also contribute to the fuel that drives the pendulum between wet and dry behavior. Often that emotionality springs from one family member pumping up the anxiety level until the process slips into the wet state. That person is often the non-drinker. He or she is *not the cause* for the swing to wet but is the emotional vocalizer in the opera. Vinny and Ellen came for therapy because he was involved in an affair. Ellen was also disturbed because her husband drank heavily and when drunk was violent. Ellen's mother was an alcoholic. The typical scenario was the following: After a pleasant family weekend, Vinny would work late several nights in a row. Ellen became increasingly upset, pursuing Vinny with questions as to where he had been and why he had to work late. Vinny's response to Ellen's increasing nagging was to watch TV. When he no longer could stand her coming after him with her tears and questions, he would leave the house. Ellen would then go upstairs to her sister-in-law's where she would continue her complaints. When she would hear Vinny come in she would return to their apartment and find a drunken husband. The argument would continue until he would hit her, or leave and go to his girlfriend's home where he would spend the night. Ellen would cry herself to sleep.

Longing for Intimacy and Emotional Space

Least observable in the alcoholic family system, but of great importance, is the desire for intimacy and also the desire for emotional space that all human beings have. Both are particularly elusive in the alcoholic family system. The word "denial" is often associated with the alcoholic and his family. To be sure, the defense mechanism of denial is operating at many levels within the alcoholic family system. However, to say that the alcoholic and others in the family use denial is simplistic. I believe that there is a reactive emotional process which operates on an underground level within the individual and the alcoholic family system which is observable in the wet stage and only barely visible in the dry stage. This process appears to be related to the shift between wet and dry behavior.

The desire for intimacy is not explicit when the family is immobilized and compartmentalized, but can be seen as the family comes together around the alcohol crisis. To that degree, the crisis may serve a functional purpose. The pseudo-closeness and intimacy that comes around the crisis may overheat the family's thermostat and can swing toward violence, sexual abuse, or self-destructive behavior. It follows, therefore, that there is often a sense of relief in the family after

such a crisis ends, and people return to their more distant positions. It seems as if there is a non-permeable membrane between the emotional compartment and the behavior manifestations present in all members of the alcoholic family system, and that only an alcohol crisis can reestablish a flow. There is an artificial cutoff between the internal feeling system and the external behavior system. In addition there is a direct relationship between this cut off in the individual's internal feeling dimension and a relationship cut off from their extended family system. I suspect that this cut off in the extended family is equal in intensity to the cut off in the individual's internal emotional system. To the degree the alcoholic is isolated from his inner and outer systems, he is puzzled and confused about his move towards alcohol. This confusion leads to an inability to track his movement becoming wet. Clinically, you hear "I found myself at the bar and didn't know how I got there;" or "I realized as I was drying out that I had been depressed all summer." It is almost as though the move to the alcohol simultaneously connects the drinker with his or her insides and mobilizes the family from the frigid zones of their compartmentalized dry stage.

A similar process appears to be going on in the non-drinking spouse. A young woman reported that the only time she felt alive inside and able to make a move was when her alcoholic husband got drunk. They would end up in a physical fight which culminated in her pursuing him sexually. At other times, when he was not drinking, she was passive and shy. Both of these individuals are cut off from their extended families.

Clinical Observations

The following example illustrates my point. Frank had been an alcoholic for 20 years, active in AA for the past 10. His parents were elderly and had moved to Florida five years ago. His father had recently undergone cancer surgery. Frank's younger sister had died two years ago from a long illness. Frank had not seen much of her since she married. He described their relationship as distant. The last time he had seen his parents was at his sister's funeral. Frank, in the past, had some contact with his father but felt dad was critical and hard to talk to. He avoided talking to his mother.

Frank's wife, Sonja, an active member of Al-Anon, was concerned about the degree of dependency she felt toward Frank. Although he considered himself sober at the time, Sonja felt anxiety and fear that he might suddenly go back to drinking, as he had at different times in the past. She was also experiencing a good deal of stress, most recently over her father who was in his 80s and whose health was deteriorating. He was in and out of the hospital often. Sonja began to feel that he was becoming senile. When her mother died several years ago, Sonja took care of her father out of duty. She knew that was what her mother would've wanted. Sonja was beginning to feel trapped, having no one to share this burden. She was an only child. She tearfully confided that she felt nothing for her dad except annoyance, and at times anger. He was a selfish and nasty old man. Sonja tended to walk on eggs both in her relationship with Frank and with her father.

Initially, I was impressed by the number of emotional cutoffs in Frank's extended family. There was no one with whom he had contact. This was not true for Sonja. She saw various cousins and aunts from both sides of her extended family from time to time. However, these contacts were mainly ritualistic in nature. Sonja turned to her two oldest daughters when she needed to talk to someone; there was no one else to she could go. She did discuss certain things with Frank, but

was careful not to bring up issues that would upset him. Frank, on the other hand, discussed nothing with anyone. His philosophy was to work it out by himself.

Sitting with this couple, I often felt at a loss since little of their internal difficulties surfaced. It became evident that Frank and Sonja not only edited things they said and felt with one another, but they were living in emotional isolation from themselves. Sonja would cry and not know why. Frank would be full of advice and suggestions when someone was upset. This was especially true when the upset involved Sonja's father. Frank urged her, for her own good, to stop seeing him. Sonja tried, but remembered her mother's unspoken request to look after her dad.

Frank labeled himself as an angry man but did not know at what. He had spent years going from job to job, back and forth between drinking and getting himself out of debt. When not drinking he felt he was a good father and husband. Sonja agreed; she loved him.

In deciding where to begin with this family, I knew the following: Frank was totally cut off from his extended family, and Sonja was partially cut off, left only with the negative and trapped feeling inside. Both reported emotional numbness in their relationship. Both were fearful of the future. This family was in the dry stage, stuck and unable to move. I began by trying to unstick that process. First, I pulled Frank back from monitoring Sonja's relationship with her father. I sent him to connect with *his* father. I did this in the context of his father's cancer and probable time limitation since his cancer was terminal. Although Frank did not see the relevance of doing this for himself, he agreed when he began to see that he might be in his father's position with his own children one day. He flew to Florida where he spent two days with his father and mother. He felt nothing special as he made the trip, but Sonja observed that he was unusually tense and distant before he left. When he was with his father, Frank felt sad and cried. He had not felt so emotional in many years. The temptation to drink was strong but he was able to resist. Upon his return he quickly went back to advising Sonja more strongly than ever about her relationship with her father. Sonja was struggling to deal with her dad and began feeling anger and hurt. All the years he had not been there for her! She also began to object to Frank's intrusiveness.

As therapy progressed and Sonja began to deal with her father in a different and less reactive way, she began to feel lonely and to wonder how she would survive after her kids were grown and she would be alone. It was at this point that Frank began to drink again. He eventually left home for several weeks. While he was gone Sonja continued to work on spending time with her father, feeling hopeless that neither he nor Frank would ever change. Then Frank contacted her and returned home. He realized when he was away and drinking that he felt upset inside. He felt scared and lonely. He thought about suicide but decided that he would come back and try to sort out his life.

The couple are still in treatment, slowly learning to know what they feel and trying to connect that to behavior. The place where that has been of the most value for them has been their work in their extended families. The difficulties in allowing themselves to feel and then to translate these feelings into functional moves in their extended families have at times been almost insurmountable.

Frank and Sonja's system is fairly closed. There are many emotional cutoffs and a number of toxic issues; death, alcohol, and parenting, to name a few. The rhythm of this family is now slow and plodding; the movement is at times imperceptible. Emotionality is underground. The process

must be looked at over many months to be seen. The compartmentalization of the internal feeling system is difficult to break through. Working back and forth, connecting what is going on inside of Sonja and Frank with their families of origin is an extremely slow process. Expectations on the part of the therapist, as well as Frank and Sonja, must be kept to a minimum. When there is stress in the family there is often the tendency to return to a former disconnected state. It is possible, and perhaps predictable, that Frank will drink again. However, Frank and Sonja both agree that they have begun to alter the pattern in their nuclear family and are more aware of how they operate.

Conclusion

In summary, those families that organize their anxiety around the issue of alcohol and present with a dysfunctional family member abusing alcohol, demonstrate a process that may be categorized into stages labeled *wet* and *dry*. The problem clinically is that during the wet phase, when the dysfunctional process is easily visible and explicit, the family is understandably concerned with eliminating the symptoms of the alcohol abuse. When the drinking has stopped and moves to the dry stage, the process goes underground and the distance becomes reset, making it difficult therapeutically to get at and move the process in a more functional direction. The clinical artistry comes into play when the therapist is able to guide the process from wet to dry in a way that the family gains more than symptom relief. In doing this the stage is set for further exploration and the climate of safety exists, allowing family members to take risks toward change even in the dry stage.

The factors that appear to determine the prognosis of the alcoholic family in treatment are (1) the duration of the symptoms; (2) the ability of the more functional non-drinking family members to see the process behind the alcohol abuse; (3) the ease with which emotional cutoffs between nuclear and extended family can be reconnected thereby offering more relationship options to the nuclear family members, and (4) the ability of the individuals in the family, especially the alcohol abuser and his or her spouse, to connect with their own feeling system.

PART IV: THEORY AND APPLICATIONS

Among many other things, Guerin is a movie-lover. He saw very early the potential in some movies for functioning as "displacement material:" that is, artifacts where therapists and patients could see in the film family process, its consequences, and, perhaps, more functional ways to act. I Never Sang For My Father*, a 1970 film starring Melvyn Douglas and Gene Hackman and written by Robert Anderson, was one of his very favorites.*

The Use of the Arts in Family Therapy: I Never Sang for my Father

Philip J. Guerin, Jr., M.D.

> *Death ends a life, but it does not end a relationship, which struggles on in the survivor's mind toward some resolution which it never finds. . . . Alice said I would not accept the sadness of this world. What did it matter if I never loved him, or he never loved me? . . . Perhaps she was right. But still when I hear the word "Father" ... it matters.*
>
> Robert Anderson, *I Never Sang for My Father*

The use of the arts in family therapy is a natural spinoff from the use of displacement material in other areas. Therapists, educators, theologians, and parents have used displacement materials for generations to help people focus on problems that they are too involved in emotionally to see clearly. Long before the arrival of family therapists, people sat in open fields and in darkened theaters and watched skilled performers acting out situations that were a part of their own everyday existence. The externalization of the process of day-to-day family life seems to facilitate a more objective view of how it works. Children's literature, for instance, is often concerned with stories that teach lessons about how to handle most of the problems of childhood, including stories about imaginary creatures, fashioned out of their own fear and uncertainty, and assorted ways to outwit parents and siblings. Child psychiatrists frequently use displacement techniques in play therapy with an individual child. The story about a baby bird who falls from the nest while his mother is out searching for food can serve to open up to verbalization and examination the child's own anxiety about being separated from his mother.

One of the reasons frequently given to explain the effectiveness of multiple family therapy is that it enables families to gain a new perspective on their own emotional process by listening to other families describe the problems that they are experiencing. In the early 1960s, Bowen began using the technique of telling families in treatment about other anonymous families that he was working with in order to prod them into new ways of thinking about their own problems. I became intrigued with this technique, which I called the use of displacement stories, and expanded it to include the use of movies, plays, and other displacement forms. I will illustrate the technique here using the film *I Never Sang For My Father* as an example —first from a historical perspective, and then from a more operational, practical perspective.

In 1970, Columbia Pictures released the film of Robert Anderson's play *I Never Sang For My Father.* It is a story about the Garrisons, an upper- middle class WASP family. Its major thematic thread is the relationship between father and son over two generations.

The father, Tom, and mother, Margaret, are in their eighties. They live in Westchester County in a house that has been theirs since their children were small. The father is a successful businessman, who was also a former mayor of the town. He has been retired for fifteen years.

The mother is in poor health with a deteriorating cardiac condition. Anderson tells us nothing of the mother's extended family, and she is clearly idealized by the author; however, there is a pattern of almost continual criticism from her aimed at her husband.

The father's extended family is presented through the father's eyes. He was the oldest of three children, and his mother died when he was ten years old. She had been deserted by her husband who was an alcoholic. Tom clearly bastardized his father and idealized his mother. The process of idealization began while she was alive, and became further intensified following her premature death. Tom Garrison is portrayed as a self-made man, pompous and opinionated, invulnerable to feeling, who sees himself as devoted to his wife Margaret whom he also idealizes.

The marriage of Tom and Margaret Garrison has produced two children. The older, a daughter Alice, is married and living with her husband and children in Chicago. She has been cut off from her parents and her brother after having been "banished" by father for marrying a Jew. Gene, the younger, is an author who lives in New York City, but who travels on tours to other parts of the country. His wife has been dead for approximately a year. She died of cancer, and the couple had no children. On a recent tour to California, Gene has met and fallen in love with a woman doctor who has been married before and has children. The fate of her first marriage is not made known.

The film opens with Gene picking up his parents on their return to New York from Florida. They drive from the airport to their home. During the ride home, certain parts of the family process become clear. The brusque pompousness of the father is contrasted with the soft over-tolerant mother, whose faint twist of bitterness lies somewhere just beneath the surface. The distance between the parents becomes evident. This and later developments in the film define the father as an emotional distancer, one who moves toward objects, productivity, and material markers of accomplishment. He is somewhat addicted to ritual, and his prevalent mood varies from negative to hyped-up enthusiastic.

Mother on the other hand is a normalizer, more of an optimist, emotionally more tuned in and more relationship-oriented than her husband. She has obviously handled her husband's distance by emotionally overinvesting in her children. She has accepted his distance, and resigned herself to his negativism. The father has been relieved of the job of dealing with his wife's intensity by her overdose relationship with her children, especially with her son. Only at times has the father allowed himself to feel that he is on the outside looking in.

My wife and I saw the film a few short months after the death of my father-in-law, and it set off a lot of emotional triggers in me. After seeing the movie, I spent a lot of time thinking about how quickly time and life pass by, and how very important fathers are to the quality of one's own life. I had a lot of thoughts about my wife's relationship with her father, and also about my own relationship with him, which led me to think about my relationship with my own father and his relationship with his father and so on through the generations. I also thought a lot about my kids, and how I might make myself more knowable to them as their father without occupying too much of their life space. Although the movie was thus a very moving experience for me personally, as a family theoretician and clinician I also could not help thinking what a beautiful piece of teaching material the movie would make for family therapists and families in therapy. A few weeks later I discussed this aspect of the film with a colleague; it turned out that through a combination of circumstances and people, she was able to get the rights to use the film for study, teaching, and noncommercial showing.

The full-length film was first used for family therapy training at the 1970 Fordham-Einstein Family Symposium. The audience was made up of about 300 mental health professionals from throughout the country, and their responses were mixed. Some walked out about half way through, while others left in the middle of the confrontation scene. Some people cried, while their neighbors appeared bored and indifferent. In the discussion that followed, it was evident that the audience for the most part quickly personalized the story, especially in terms of the difficulties entailed in trying to attain a person-to-person adult relationship with one's parents. Some were angered at the father, and saw him as an impossible bastard; others were angry with the son for not confronting his father sooner. The movie clearly triggered intense affect, but the question was how to channel this affect so that it became more than just another emotional experience. How could we use this film so that its effect could be carried over into a new way of thinking about a different relationship with one's own family?

Over the past five years I have used the film with large groups, such as the Fordham-Einstein Symposium; with Therapists-Own-Family seminars and Community Education Programs with families; and also at specific points in therapy with an individual family. In this last context, it is usually used when a family is having particular difficulty seeing the importance and relevance of their extended family to both their present and future emotional functioning. What has been developed is a teaching structure, the major components of which are the genogram, capsulized theoretical concepts, and a series of questions that can be proposed to the audience prior to showing the film or segments of the film. A genogram is a structural representation of the family relationship system which allows facts about the family to be organized in such a way that the process in the important relationships is easily demonstrated. The pertinent information available in the film is then pulled out and placed into the structure of the genogram.

A brief attempt is then made to teach a few basic concepts about viewing the family as a system, and the meaning of an emotional relationship system as it pertains to the family. The basic concept that no family member exists in isolation, and that each member occupies a place in the family emotional field, is discussed. Each family member is seen as constantly receiving inputs from the field, and depositing his own outputs. What affects any one family member in some way has an effect on every other family member. After these basic assumptions are established, a scenario is proposed that takes the Garrison family as it appears in the film and uses the genogram that has just been drawn.

The audience is asked for example, to suppose that they are entering a time tunnel which will take them back thirty-five years to a time when the Garrison children were still young. We know from the genogram that father has an intense sensitivity to alcoholism and drunken behavior as a result of his experiences with his father. Suppose that on his way home from work, while stopped at a traffic light, the father sees a disheveled, obviously intoxicated man staggering down the street. He feels a tightness in his stomach, and begins to replay in his head a lot of painful stuff from the past. He forcibly blots it out of his consciousness, but on arrival home the toxic parts of his own behavior become prevalent. He is edgy, critical, and wants somebody to listen to a hero story about his latest business accomplishment.

This type of behavior will predictably trigger an emotional reaction in mother. On the one hand, she feels criticized and undervalued, on the other somewhat guilty and responsible for her husband's unhappiness. There is also a trace of anger in her at his self-preoccupation and his not coming home ready to move in and take over with the kids. This reaction on mother's part gets

converted into behavior. She moves toward a more intense involvement with fixing dinner and helping the children with their homework. Father senses the move away. To some degree he's bugged, and the thought runs through his head that no one cares about him here anyway; all he is is the money-making machine. On the other hand he's relieved to be able to go up to his study, be alone with his miseries, and take refuge in the leftover work from the office. A short time later at dinner, daughter becomes whiney and demanding; father quiets her with a more than adequate dose of "for your own good" criticism. Mother is quiet, somewhat sulky, and subdued. Son tries to cheer everybody up, especially father, by telling his own hero story about winning the prize essay contest at school. Father responds by telling son how nice that is, but that he'd better put more effort into becoming proficient in math, because that's what will serve him well in the real world. Father then proceeds to tell another hero story of his accomplishments in business. As he proceeds, mother, daughter, and son, at varying rates, slowly sink into their mashed potatoes. At the end of his story father senses this reaction, and, becoming somewhat embarrassed, excuses himself and returns to his room to take refuge again in his work. Mother excuses daughter to do her homework. She and son clean up after dinner, and then he plays his latest piano piece for her in the living room.

What are the problems in that family? Is the father's isolation his problem? Is the daughter's whiney behavior and unhappiness her problem? Is mother's distance from her husband and overinvolvement with her son her problem? Are son's anxious attempts to please his problem? Or are they all a symptomatic representation of what isn't working well in that family? Everyone will answer on cue. This leads to a brief consideration of the concept of triangulation, which also serves to reinforce the idea of the family as a system. At this point, I usually defer to those people in the audience who have had ten years of psychoanalysis by mentioning that this way of conceptualizing the process in a family is only one of many ways of doing it, since any theory is an abstraction of a natural process, and as such is merely one explanation. The suggestion is made that any theory should be tested by its usefulness as a guide to producing change, which usually detoxifies any ideological warfare that may be brewing and simplifies and enriches the experience for most of the participants.

In introducing the concept of the triangle, it is often useful to explain briefly what it means and then return to the previous scenario for a short elaboration. The concept of triangulation is based on the premise that in a dyadic relationship the process between the two people involved is an unstable one. Think of your best functioning personal relationship. Now imagine isolating that relationship in time and space. Having done that, imagine attempting to confine all communication to personal thoughts and feelings about your own self and the other. It won't be long before you are talking about the Mets, Aunt Suzie, or somebody or something else. The process in the relationship has moved to stabilize itself by triangulating in a third person and/or object.

In order to understand how this process operates in a system, suppose that the Garrison son develops a symptom of fear of darkness to the degree that he can't sleep, and neither can the rest of the family. To make it even more incredible, let's suppose his parents bring him to a family systems therapist. The therapist listens to the family, asks some questions, and decides on a plan for engaging the family and responding to the symptom. The central triangle as viewed by the therapist is one in which the distant conflictual relationship between the parents has been covered over. The mother ends up in an overclose relationship with the son; the son and father have an overly distant relationship. In his initial intervention, the therapist has the father take over

responsibility for dealing with the son's fear of darkness; he also assigns the father the task of taking his son to work with him for two days in one week, and the following week take his son to the city to see a play. The result is magical. Son's symptom disappears, father and son become closer. Hey, but what about mother? How is she taking all of this? It is impossible to tamper with the father/son relationship without disturbing the mother/son relationship. Mother is now on the outside looking in. She becomes depressed. The triangle has shifted, and so has the symptomatic focus in the family. The problem is no longer a son problem, but has now redefined itself as a family system problem.

After this discussion, a brief description of how family scripts tend to pass from generation to generation is elaborated. This can be done by using the script of distant fathers, and its reoccurrence over the generations in spite of pledges to the contrary. An interesting point can be used here— namely, that the generational repeat of distant fathers involves people carrying a last name from the paternal side of the family, while emotionally being a part of the mother's side of the family. Raising this point is often an effective way to get distant daddies to see the relevance of extended family to their present relationships with their kids.

The stage is now set for offering a set of questions to the audience to serve as a structure for viewing the emotional process in the film. The questions most commonly used are:

1. What are the conflictual issues in the family?
2. What are the central triangles, and how do they appear to operate?
3. What is your idea of a personal relationship? Is it possible to have a personal relationship with the father in this film?
4. What are the nodal point or points around which, if one member of the family changed his/her predictable, behavioral pattern, a whole new series of options might have opened up for the family?

If the entire film is being shown, you are now, as they say, ready to roll. When restrictions of time make the use of ninety minutes of film, plus teaching time, impossible, however, selected segments of the film may be used. Ideally, it is best to have a group view the film in its entirety, and then rerun segments for review and study; but the use of segments, plus teaching and discussion, generally is more practical. The choice of segments from this film will vary according to purpose. Segments dealing with the process of aging and death may be chosen, but for general family process teaching, I usually use two segments. One I call the "garage scene"— it begins in the parents' garage and ends as the son pulls out of his parents' driveway to return to his own apartment. The second segment is the last thirteen minutes of the film, which I call the "confrontation scene."

In watching the garage scene segment, the audience is asked to keep in mind the first two of the four key questions.

1. What are the conflictual issues in the family?
2. What are the central triangles, and how do they appear to operate?

In order for the therapist who is presenting this film to clarify the process he should review the script of the play before the showing and keep these key questions in mind. Here is the garage scene, with a running commentary about the main points in the family process.

(GENE *can hear* FATHER *trying to start the car in the garage. He starts out the kitchen door toward his* FATHER, *and gets there as his* FATHER *starts the old Buick. Tom shows immense satisfaction that the old car starts. He guns it a few times and then shuts it off)*

Tom: Where did you say your mother was?
Gene: In her garden.
Tom: You know, Gene, the strain has been awful.
Gene: Well, she looks well.
Tom: I know. But you can never tell when she might get another of those damned seizures.
(He looks at the ground and shakes his head at the problem of it all)
Gene: It's rough, I know.
(puts his arm around his FATHER'S *shoulder)*
Tom: Well, we'll manage. She's a good soldier. But she eats too fast. The doctor said she must slow down ... Oh, well. . . .
(GENE *moves toward the door of the garage.)*
Tom: Gene ... We got your letters from California.
(fishes in his inside coat pocket) I've got them here someplace. Well, we do look forward to your letters, old man…. there isn't much else for us these days. . . . But this girl, this woman you mentioned several times….
Gene: I'll tell you all about California at dinnertime.
(he starts to move.)

[The development of the central triangle in this family evolves from the beginning of this scene.]

Father talks to son about mother, transmitting his anxiety about mother's health and his inability to deal with her in Gene's absence. Gene's letter about a possible move to California has triggered his father's anxiety, and he moves to reinforce son's position as his mother's emotional lifeline and anxiety sponge.

Tom: You seemed to see a lot of her.
Gene: I did.
Tom: Carol's been dead, let's see now, what is it?
Gene: Over a year.
Tom: And there's no reason why you shouldn't go out with another woman.
Gene: No.
(GENE *just waits, puzzled.)*
Tom: I was in California once many years ago. Beautiful country. I can understand your enthusiasm for it.
Gene: I like it a lot.
Tom: But, Gene .. .
(He bites his upper lip and his voice is heavy with emotion)
If you were to go out there, I mean to live, it would kill your mother.
(He looks at his son with piercing eyes, his tears starting. This has been in the nature of a plea and an order. GENE *says nothing. He is outraged that his father would say such a thing.)*
God, you know you're her whole life.

(GENE *is further troubled by his father's expressing what he knows to be the truth.)*

Gene: Dad ….

Tom: Yes, you are! ... Oh, she's fond of your sister, but you . . . are her . . . life! Don't you suppose I've known that all these years?

[Father pulls out all the stops, and continues the triangulation. He makes no statement about what effect the son's leaving for California would have on him. Father reinforces son as Mother's emotional lifeline.]

Gene: Dad, I realize we've always been very close, but ...

(MOTHER *appears in the near distance. They both notice her.)*

Tom: Just remember what I've said. Well, now let's look after the luggage.

[After getting settled in the house, Gene takes his parents out to dinner. During this restaurant scene, the distance between Tom and Margaret is demonstrated. This is an important part of the process that ties Gene to Margaret in an overly intense way. The scene also introduces Father's oft-repeated diatribe on the horrors of his boyhood. The central parts of this are the bastardization of his father, and the idealization of his mother.]

Tom: Have I ever shown you this ring?

Margaret: You've shown it to him a hundred times.

[Mother's reactive intolerance to Father's ritualized story telling.]

Tom: (ignoring her remark) I never thought I'd wear a diamond ring, but when T. J. Parks died, I wanted something of his. Last time I had it appraised, they told me it was worth four thousand. Of course, when I go to see a doctor, I turn it around. *(a sly smile as he turns it around)* Don't want them to think I'm rolling in money.

[Father, undaunted continues.]

Margaret: It's his favorite occupation, getting that ring appraised . . . that and telling everyone the gruesome details of his life.

[Mother escalates her complaints.]

Tom: Now wait a minute!

[Father tries to draw the line.]

Margaret: I can't have anyone in. Your father won't play bridge or do anything. He just wants to watch Westerns on TV or tell the story of his life.

Tom: People seem to be interested.

Margaret: What?

Tom: I said, people seem to be interested.

Margaret: He keeps going over and over the old times. Other people have miserable childhoods, but they don't keep going over and over them. That story of your mother's funeral.

[Mother continues complaining to son, describing her social isolation, father's distance from her, and his involvement with objects (TV), along with his ritual story telling. Almost by the character of her complaint she paradoxically encourages father to add yet another of his ritualized tales.]

Gene: I don't remember that one.

[Gene, sensing his father's hurt, moves to placate him. The stage is set, and in two more steps the father will fall into his predictable pattern.]

Margaret: Oh, don't get him started. He keeps telling everyone how he wouldn't allow his father to come to his mother's funeral.

Tom: Are you suggesting I should have let him?

Margaret: I'm not saying—

Tom: —He'd run out on us when we were kids—

Margaret: Can you imagine going around telling everyone how he shoved his father off the funeral coach.

Tom: And I'd do it again. I was only ten and we hadn't seen him in over a year —living, the four of us, in a miserable two-room tenement, and suddenly he shows up at the funeral, weeping, and begging and drunk as usual. And I shoved him off. I never saw him again till some years later, when he was dying in Bellevue . . . of drink.

[Father's tale spells out clearly his intensely negative relationship with his own father. His intense idealization of mother is left until after Margaret's death, when in the casket room of the funeral parlor Tom weeps over a casket that reminds him of his mother's. His idealized version of his mother flows spontaneously. At this point in the play, the repetitive intergenerational triangles and the family scripts are obvious.]

(His hatred and anger are barely held in. GENE *is fascinated by the intensity and hatred after all these years.)*

Margaret: (has been looking at menu) What looks good to you?

Tom: I have not finished yet. . . . I went down to see him, to ask if he wanted anything. He said he wanted an orange. I sent him in half a dozen oranges. I would have sent more, except I knew he was dying, and there was no point in just giving oranges to the nurses. . . . The next morning he died.

(There is silence for a moment, while GENE *and* MARGARET *look at the menu, and* TOM *grips and ungrips his hand in memory of the hatred of his father.)*

Margaret: (gently) Look at your menu now, Father. What are you going to eat?

Tom: I don't feel like anything. I have no appetite. *(He lights a cigarette)*

Margaret: This is the way it's been.

INT: MOTHER'S ROOM IN THE HOUSE—NIGHT

(This is a nice room with family photographs, a comfortable old chaise longue, which is mother's "place," sewing table nearby—comfortable old pieces of furniture. As GENE *enters the room from the upstairs hall, we can hear the blare of the television downstairs, a Western with plenty of gunfire.* MARGARET *is looking through Gene's new book of short stories.)*

Margaret: This is lovely, dear.

Gene: Thank you.

Margaret: I don't know how he can stand listening to those Westerns hour after hour.

[As the process continues in the parents' home, we see a further elaboration of the central triangle.]

Gene: I think he always wanted to be a cowboy.

Margaret: He won't listen to the things I want to hear. Down in Florida there's only one TV in the lounge, and he rode herd on it. And then he'd go to sleep in two minutes. . . . Still, he's a remarkable man.

[Mother catches herself, and shifts to excusing father's idiosyncrasies. She seems to want Gene to know that his parents' relationship wasn't always so distant and empty.]

Gene: Good old Mom.

Margaret: Well, he is. Not many boys have fathers they can be as proud of.

Gene: I know that. I'm very proud of him.

Margaret: (she catches his tone) Everything he's done, he's done for his family.

(GENE *just looks at her smiling)* So he didn't dance with me at parties. *(She smiles at* GENE) You took care of that.

Gene: You were just a great dancer, Mother.

Margaret: What a shame that children can't see their parents when they're young and courting, and in love.

Tom (O.S.): Gene . . . Gene . . . Come and watch this one. This is a real shoot-'em-up.

Gene: I'll be down in a minute, Dad. *(closes door)*

Margaret: (as she moves toward her chaise longue) Now ... tell me about California.

Gene: (uneasy . . . but he has decided to tell her) Well, I like it a lot.

Margaret: It was good for you to get away for a while from the apartment and memories of Carol.

Gene: (wonders for a moment if he'll pick up that "for a while" . . . then:) Yes.

Margaret: I didn't want to suggest it earlier, but I think you should consider moving out of that apartment. It's so bound up with Carol.

Gene: (after a moment) Mother .. .*(There is a long pause. . . .* MOTHER *has some sense and fear of what is coming.)* I wrote you about the woman I met out there, Peggy.

Margaret: The doctor with the children.

(There is a long look between them. She now knows . . . but waits. He goes on very gently.)

[On Mother's prodding, Gene proceeds to tell her about California, his new woman, and his plan to move out there and marry her. Up to this point the configuration in the central triangle has put

mother and son as overclose and father in the outside, distant position. As she senses Gene's leaving for California his mother pulls somewhat back from him and toward father, almost as if she were trying to loosen the bond between them to shield herself and allow him to go. True to form, she says little about her own reactions to Gene's leaving, denies it will kill her, and instead translates that to father. We thus have each parent talking about the other's response, and not his or her own.]

Gene: I'm thinking of marrying her.

Margaret: She sounds like a lovely person. And people would expect a man of your age to marry again.

(She apparently hasn't gotten the whole point.)

Gene: She has a practice out there, and her children have their friends and school. . . .

Margaret: (tears come to her eyes . . . she nods) Well . . . there are still trains and planes. And Alice comes from Chicago once or twice a year with the children.

(GENE *smiles gently, understanding her pain. He takes her hand.)*

Margaret: Your father and I can take care of each other. He makes the beds, which is the only housework I'm not allowed to do, and I'll remember where he put his checkbook.

Gene: I'm sorry it's worked out this way.

Margaret: (holding herself in control with difficulty) We've been fortunate to have you so near us for so long. . . . Have you told your Father?

Gene: No. But he guessed something from my letters, and told me if I went out there to live it would kill you.

Margaret: Why can't he say it would kill him? He doesn't think it would hold you or mean anything to you. *(She shakes her head.* GENE *doesn't want to go into that, and just looks down at their hands.)* I'll talk to him. He'll make a dreadful scene, but—

(MARGARET *looks down at their clasped hands. At last her emotion is beyond control, and she cries.* GENE *understands that this was inevitable . . . but his* MOTHER *does not mean it to deter him. She just can't help it. He touches her face gently.)*

Gene: —No. You always have done that for Alice and me. I'll do it.

[The triangle operates in such a way as to prevent a mutual personal communication in any twosome. Mother talks to Gene about father, father talks to Gene about mother, he talks to each of them about the other, and on it goes. Momentarily we have seen the triangle shift so that Gene is on the outside; however, mother's anxiety about father's reaction to Gene's news pulls her back into offering to be his spokesman. Gene, hoping to be grown up, refuses her offer. He goes downstairs and finds his father has moved from one object of his distance, the TV, to another, sleep.]

INT: NIGHT

(As GENE *enters the room where his* FATHER *is watching TV, he pauses. He is saddened by the picture of the old man asleep in front of a babbling TV screen. ... He wonders too, if he should talk to his father tonight. He turns down the volume knob on the TV.)*

Tom: (waking up at the silence) What? What? *(sees* GENE *crouching near him)* Where's your mother?

Gene: She's all right. She's upstairs, going to bed.

Tom: (sits back) Oh . . . *(blinks his eyes to wake up)*

Gene: (hesitantly) Dad . . .

Tom: (looking at TV) Oh, this is a good one. This fella can really handle the guns. *(He reaches past* GENE *to turn up the volume)*

Gene: Dad . . . I want to talk to you.

Tom: Just a minute. *(He adjusts the picture, and leans forward to watch)*

Gene: (gives up, after watching FATHER *a few moments)* Well, I've got to go now.

[Gene makes a valiant effort to connect with his father. He stands in front of the TV, and wakens him. Father physically moves Gene out of the way, re-establishing the link between himself and the TV, with Gene on the outside. Gene's reactive triggers are fired, and all hope of connecting fades.]

Tom: Oh, so soon? We see so little of you.

Gene: I'm up at least once a week, Dad.

Tom: Oh, I'm not complaining. *(but he is)* There just doesn't seem to be any time. And when you are here, your mother's doing all the talking. Well . . . "All's lost, all's spent, when we our desires get without content. 'Tis better to be that which we destroy, than by destruction dwell with doubtful joy."

(GENE *is always puzzled by his father's frequent use of this quotation. It never is immediately appropriate, but it indicates such unhappiness that it is sad and touching to him.)*

Gene: We'll get a chance to talk, Dad. Maybe you could have lunch with me in town in a couple of days. I'd like to talk to you.

Tom: That's a wonderful idea. You set the date.

Gene: I'll call.

(They move to the porch.)

EXT: PORCH—NIGHT

(Single light in roof of porch) ….

[Father puts the finishing touch on by adding a ritualized quote, and by instructing his son on how to pull out of the driveway and what directions to take on his way home.]

Tom: I can't tell you what a comfort it is knowing you are just down in the city. Don't know what we'd do without you. No hat or coat?

Gene: No.

Tom: It's still chilly. You should be careful. (GENE *kisses* FATHER *on cheek.)* . . . You're coming up for your Mother's birthday, aren't you?

Gene: Yes.

Tom: It'll be my party. . . . And, Gene . . . remember what I said about California.

Gene: (pauses on the step for a moment, then turns to go) Good night, Dad.

Tom: (calling) Drive carefully. I noticed you were inclined to push it up there a little. (GENE *moves on.)* Make a full stop going out of the driveway, then turn, right . . . traffic is terrible out there now . . . take your first left and second right. It's a little tricky down there.

[This segment defines the conflictual issues as the father's death, alcohol, emotional distance and closeness, physical distance, emotional cutoffs, bitterness, and business accomplishment versus artistic accomplishment. Each of these issues can be tracked through the relationships over the generations.]

EXT: DRIVEWAY—NIGHT

(GENE *has opened the car door and sat down. He now slams the door unnecessarily hard, and starts the car with a vengeance. He turns the car in the drive and leaves.* TOM *is left alone on the porch, under the one light, waving vaguely after the car.)*

This segment clearly illustrates the fact that one of the methods most commonly used by parents to keep from getting into painful issues with their adult children is to treat them exactly as they did when they were very young. Gene plays right into this by allowing it to happen; he eases his own conscience about not discussing his California trip by making an appointment to discuss it with his father at a later date. After this segment, Gene's mother has a heart attack, and is placed in an intensive care unit. Gene and his father retreat when she falls asleep, and go out for the evening to a Rotary Club meeting. During the night Margaret dies. The daughter, Alice, comes for the funeral, and she and Gene discuss what is to be done with Tom. Alice advises Gene to get out of town, remarry, and leave him to live alone with a paid housekeeper. They also talk about how sorry they are for not having found more time to spend with their mother, and Gene mentions that he became his mother's life because his father had "quit on her."

After the funeral Alice reiterates her position on what should be done with their father, and says that having him live with her and her family would be impossible. She volunteers to approach Tom on the subject of hiring a housekeeper, and tells Gene to back her up when the father turns to him. Tom predictably dismisses her from any obligations, but hastens to add, "Gene will keep an eye on me." It is Alice who finally reopens the topic of Gene's remarriage and move to California, and Gene who just as predictably backs down and tries to get Alice to drop the subject. The scene ends with Tom telling Alice that everyone has gotten along just fine without her.

Gene's next step, after Alice leaves, is to visit nursing homes; he becomes thoroughly depressed. Peggy comes from California for a meeting; she comes to see Tom, who does his best to pretend that he does not know who she is. Their meeting leads inevitably to the final confrontation scene, which follows. Before screening it, the audience is asked:

(1) What is your idea of a personal relationship?
(2) Is a personal relationship possible with this father?
(3) What are the nodal points where the son could have turned the process around?

(TOM *is in his pajamas and bathrobe kneeling by his bed, saying his prayers. Again, a touching sight.* GENE *enters when* TOM *starts to rise.)*

Gene: Ready to be tucked in?

[This scene begins with an enactment of a pseudo-buddy-buddy ritual between Gene and his father. In spite of this ritual, the mutual longing for closeness comes through. Again they try. Earlier, while talking with Alice about the days following their mother's death, Gene complained that he wanted to talk with his father about his dead mother, but that his father wouldn't allow it. He is about to get his chance.]

Tom: (smiling at the phrase) Yes . . . look at the weight I've lost.

Gene: Well, you had quite a little pot there, Dad.

Tom: But look, all through here. Through my chest.

Gene: Well, we'll put some back on.

Tom: (looking at his own chest) You know, I never had hair on my chest. I don't understand it. You have hair on your chest. I just didn't have any. . . . Well, I'm confident if I could get some exercise. . . . Do you remember when I used to get you up in the morning, and we'd go down and do calisthenics to the radio?

Gene: (smiling) Yes.

Tom: (stands very straight and swings his arms) One, two, three, four. One, two, three, four …. *(he totters a bit)*

Gene: Hey, take it easy. . . . Why don't you wait till morning for that?

Tom: And we used to put on the gloves and spar down on the side porch? The manly art of self-defense. *(He crouches in boxing position)* Gentleman Jim Corbett .. . *(he spars a moment with Gene . . .)* Oh, well . . . I intend to get over to the club and play some golf, sit around and swap stories with the boys. Too bad you never took up golf. *(He fishes in his top bureau drawer, which he has brought to his bed)* I was looking through my bureau drawer . . . I don't know, just going over things .. . *(takes out a packet of photographs wrapped in tissue paper)* Pictures . . . I think you've seen most of them . . . the family.

Gene: (very tentatively) You know, Dad, I've never seen a picture of your father. (Tom *looks at him a long time. Then finally, with his hatred showing in his face, he unwraps another tissue, and hands over a small picture.)*

Gene: (surprised) He's just a boy.

Tom: That was taken about the time he was married. . . . Oh, he was a fine-looking man before he started to drink. Big, square, high color. But he became my mortal enemy. . . . Did I ever show you that? *(Takes out a small piece of paper, hands it to* GENE) Careful . . . When I set up a home for my brother and sister, one day we were all out, and he came around and ripped up all my sister's clothes and shoes. Drunk, of course. A few days later, he came around to apologize *and* ask for some money, and I threw him out. . . . The next day he left that note. . . .

[Tom again builds a case for bastardizing his father, and openly proclaims him as his mortal enemy. In response, Gene searches for something positive that might mitigate Tom's intensely negative stance.]

(Rumpled piece of paper . . . scrawled on it: "You are welcome to your burden.")

Tom (V.O.): You are welcome to your burden.

Gene: And you kept it?

Tom: Yes, I never saw him again until many years later he was dying, in Bellevue, and someone got word to me and I went down, and asked him if he wanted anything. He said he'd like some fruit. So I sent him in a few oranges. He died the next day.

Gene: There must have been something there to love, to understand.

[Tom blocks Gene's attempt, and shifts to the positive things about his relationship with Gene. It is as if each of them has made a pledge not to let their relationship with one another be a repeat of the previous generation.]

Tom: In my father? *(He shakes his head no . . . then he shows* GENE *another card)* Do you remember this? "To the best dad in the world on Father's Day." *(turns it over and reads the notation)* 1946…. Yes. *(emotional)* I appreciate that, Gene. That's a lovely tribute. I think I have all your Father's Day cards here. . . . You know, I didn't want children, coming from the background I did . . . and we didn't have Alice for a long time. But your mother finally persuaded me. She said they would be a comfort in our old age. And you are, Gene.

Gene: (touched, but embarrassed and uncomfortable) Well ….

Tom: (fishes in the drawer and brings out a program)
A program of yours from college . . . some glee club concert . . . I've got everything but the kitchen stove in here. . . . Do you still sing?

Gene: (smiling) Not in years.

Tom: That's too bad. You had a good voice. But we can't do everything. ... I remember your mother would sit at the piano, hour after hour, and I'd be up here at my desk, and I'd hear you singing.\

[The theme of singing for father is clearest here. We see the process in the central triangle: Tom, alone in his room upstairs working, Gene downstairs singing to the accompaniment of his mother. Here father and son almost touch in a real way, when the process of how it really was surfaces, and father is again thrown back into the past.]

Gene: You always asked me to sing "When I Grow Too Old To Dream."

Tom: Did I?.... I don't remember your ever singing that…. You always seemed to be just finishing when I came into the room. *(looks at* GENE) Did you used to sing that for me?

Gene: (not a joke any more) No.... But you always asked me to sing it for you.

Tom: Oh. *(puts program away)* Well, I enjoyed sitting up here and listening. *(He pokes around in the drawer, and takes something out . . . in tissue paper. He unwraps a picture carefully)* And that's my mother.

Gene: (gently) Yes, I've seen that, Dad. It's lovely.

Tom: She was twenty-five when that was taken. She died the next year …. I carried it in my wallet for years …. And then I felt it was wearing it out. So I put it away.... Just a little bit of a thing .. .

[As Tom again begins his idealized version of his mother, his vulnerability surfaces for the first time. It is hard to tell whether he is mourning his wife or his mother, or a combination of the two. The stage is set—two men, father and son, both longing for a mutual closeness. Both have experienced the loss of their mothers and their wives.]

(He starts to cry, and the deep, deep sobs finally come and his emaciated body is wracked by them. It is a terrible, almost soundless sobbing. GENE *comes to his* FATHER *and puts his arms around him and holds him. Then, after some moments . . .)*

Tom: I didn't think it would be this way . . . I always thought I'd go first. *(He sobs again, gasping for air.* GENE *continues to hold him, inevitably moved and touched by this genuine suffering. Finally,* TOM *gets a stern grip on himself)* I'm sorry .. . *(tries to shake it off)* It just comes over me. It'll pass ... I'll get a hold of myself.

Gene: Don't try, Dad. . . . Believe me, it's best.

Tom: (angry with himself) No . . . It's just that . . . I'll be all right. *(He turns and blows his nose)*

Gene: It's rough, Dad. . . . It's bound to be rough.

Tom: (shakes his head to snap out of it) It'll pass. . . . It'll pass. *(He starts to wrap up the picture of his mother)*

Gene: Can I help you put these things away, Dad?

[Gene faces his wished-for opening. His father is vulnerable, bleeding openly. How does he respond? Does he talk about his own emotional reaction to the death of his wife or his mother? No. Instead he responds on an object level, offering to help father put his things away. All is still not lost. His over competent father allows him to do it, and the opening still exists. Gene, with magnificent timing, opens the issue of moving to California and marrying Peggy. The opening is slammed shut. The automatic reactive pattern reestablishes itself. Gene and his Father now proceed, against both of their wishes, to repeat a piece of painful process from the generation before.]

Tom: No …. no …. I can …. *(he seems to be looking for something he can't find)* Well, if you would. (GENE *starts to help.)* I don't know what we'd do without you, Gene. *(And together they put the things back in the box. . . . As they do so,* GENE *is deeply moved with feelings of tenderness for his father. After a few moments, he starts, with great consideration.)*

Gene: Dad?

Tom: Yes?

Gene: (putting it carefully and slowly) How did you like Peggy?

Tom: Who? …. Oh . . . Oh, yes. Very nice. Very attractive.

Gene: I'm thinking very seriously, Dad …. of marrying Peggy .... and going out to California .... to live. (Tom *straightens a little.)* Now, I know this is your home, where you're used to . . . but I'd like you to come out there with me, Dad. It's lovely out there, and we could find an apartment for you near us. *(This is the most loving gesture* GENE *has made to his father in his life)*

Tom: (thinks for a moment, then looks at GENE *with a smile)* You know, I'd like to make a suggestion. . . . Why don't you all come live here?

Gene: (explaining calmly) Peggy has a practice out there.

Tom: A what?

Gene: She's a doctor. I told you. And children with schools and friends.

Tom: We have a big house here. You always liked this house. It's wonderful for children. You used to play baseball out back, and there's that basketball thing.

Gene: Dad, I'd like to get away from this part of the country for a while. It's been rough here, ever since Carol died. It would be good for you too, getting away.

Tom: Your mother would be very happy to have the house full of children again. I won't be around long, and then it will be all yours.

Gene: That's very kind of you, Dad. But I don't think it would work. Besides her work and the children, all Peggy's family is out there.

Tom: Your family is here.

Gene: Yes, I know.

Tom: You know, Gene, I'm only saying this for your own good, but you went out there very soon after Carol's death, and you were exhausted from her long illness, and well, naturally, very susceptible. …. I'm wondering if you've really waited long enough to know your own mind.

[As this insidious process surfaces, Tom tries to coax Gene into compliance. Gene holds onto his California anchor in desperation. Father pulls out the stops and pushes all the guilt buttons.]

Gene: I know my own mind.

Tom: I mean, taking on another man's children. *(looks at* GENE *a long moment, sees it's hopeless)* Did you mention this business of California to your mother?

Gene: (gets the accusation, but keeps calm) Yes. She told me to go ahead, with her blessings.

[Mother's ghost appears, and the central triangle is again spelled out.]

Tom: She would say that, of course. But I warned you.

Gene: (turns away) For God's sake.

Tom: (gives up, angry) All right, go ahead. I can manage. *(sarcastic)* Send me a Christmas card . . . if you remember.

Gene: (enraged) Dad!

Tom: And I've told you I'm not going

Gene: I understand that, but not this "Send me a Christmas card, if you remember."

Tom I'm very sorry if I've offended you. Your mother always said I mustn't raise my voice to you. *(suddenly hard and vicious)* Did you want me to make it easy for you the way your mother did? Well I won't. If you want to go, go!

[Mother's ghost, plus her position in between them.]

Gene: God damn it. I've always known it would come to this when your mother was gone. I was tolerated around this house because I paid the bills and –

Gene: Shut up!

[The dam bursts.]

Tom: (coming at him) Don't you –

Gene: (shouting) Shut up! I asked you to come with me. What do you want? What the hell do you want? If I lived here the rest of my life it wouldn't be enough for you. I've tried on every conceivable occasion, Easter, Christmas, birthdays, Thanksgiving.... Even that Thanksgiving when Carol was dying and I was staying with her at the hospital. "We miss you so. Our day is

nothing without you. Couldn't you come up for an hour or two after you leave Carol?" You had no regard for what was really going on. My wife was dying!
Tom: Is it so terrible to want to see your own son?
Gene: It is terrible to want to possess him… Entirely and completely!
Tom: (after a moment… coldly) There will be some papers to sign, for your mother's estate. Be sure you leave an address with my lawyer.

[Tom attempts to dismiss his son, and bring the discussion back to object level.]

Gene: (cutting in) Dad!
Tom: (cutting, with no self-pity) From tonight on, you can consider me dead. (*turns on him in a rage of resentment)* I gave you everything. Since I was a snot-nosed kid, I've worked my fingers to the bone. You had everything and I had nothing. I put a roof over your head, close on your back –

[Tom's answer is the same as with his own father and his daughter Alice: a complete emotional cut off.]

Gene: – Food on the table.
Tom: – Things I never had
Gene: I know.
Tom: You ungrateful bastard.
Gene: (as though he would hit him) What do you want for gratitude? Nothing, nothing would be enough. You have resented everything you ever gave me. The orphan boy in you has resented everything.… I'm sorry as hell about your miserable childhood. When I was a kid, and you told me those stories, I used to go up to my room at night and cry. But there is nothing I can do about it… And it does not excuse everything… I *am* grateful to you. I also admire and respect you, and stand in awe of what you have done with your life. I will never be able to touch it. (TOM *looks at him with contempt.)* B ut it does not make me love you, and I wanted to love you.… You hated your father. I saw what it did to you. I did not want to hate you.
Tom: I don't care what you feel about me.
Gene: I do!

Conclusion

Enlightened by the successful use of *I Never Saying for My Father*, I have looked for other films which might be equally useful. *Double Solitaire,* another of Robert Anderson's works, deals with the marriage that is 25 years old, and is about to rupture. This marriage is seen against the backdrop of the marriage of the husband's parents, who are celebrating their 50th wedding anniversary. The similarities between the two marriages are very clear. The 50-year-old relationship survives by closing things over, pretending everything is all right, and living at a fixed distance, a distance filled with games of solitaire. The younger marriage is a series of repeating patterns in the marital fusion. This is elucidated very clearly in the sequence in which the husband and wife spend the weekend together in a remote beach house, and the husband tries vainly to reach his wife and change her mind about leaving him.

Another film that is an excellent study of marital fusion, especially reciprocity, is Ingmar Bergman's *Scenes from a Marriage.* This film shows how the relationship between Mariana and Johanne shifts over the course of his affair, this separation, and the subsequent process of their divorce and reconnecting after they have both married other people.

John Cassavetes' film *Woman Under the Influence* lends itself very nicely to a study of the invalidation process in families as it ties into acute psychotic reactions.

The study of human relationships and the way they determine how much of the potential of any individual is realized never ceases to fascinate. It has been estimated that most people use something like one-fifth of their actual abilities in a lifetime. How much more of their inherent talents and intelligence might people use if they were masters of their own relationship space. It has always been easier to see what's going wrong with the family across the street, or how other wives and husbands might improve their lot. And life would be easier if your spouse would change, so that you wouldn't have to. Displacement material offers the student of humanity an exercise in planning how to change others while offering a chance to learn enough also to change himself.

 The author gratefully acknowledges the assistance of Richard and Eloise Julius, Leslie and Elizabeth Ogden, and Seymour and Muriel Epstein, whose benevolence and network connections were responsible by my being able to acquire a copy of the film for my research and teaching.

The following is chapter 13, the conclusion, of Working with Relationship Triangles: The One, Two, Three of Psychotherapy, *by Guerin, Fogarty, Fay, and Kautto (1996, Guilford). The book is a proposal that triangles by considered to be present in almost* all *emotional dysfunction, whether individual, couple, or child problems, no matter the treatment modality being used (i.e., analysis, behavioral therapy, cognitive therapy, or family therapy. In the final chapter, written largely by Guerin, he presents a protocol for how a therapist can do that.*

Becoming a Triangle Doctor

By Philip J. Guerin, M.D.

THE PERVASIVENESS OF TRIANGLES IN RELATIONSHIPS AND IN THERAPY

Normal people and mental health professionals automatically think about ones and twos. When things go badly in our lives or in therapy, each of us quickly moves to questions like, "What did I do wrong?" or "Who did me in?" Our purpose in this book has been to facilitate our readers' ability to think about threes and to recognize triangles when they do occur.

One way of looking at life is to see it as a never-ending series of relationship triangles to be recognized and resolved. From conception on, we are part of our primary parental triangle. As we negotiate childhood, triangles with our siblings, grandparents, aunts, uncles, and cousins dot the relationship landscape. Adolescence, with its famous emotional storms, makes triangles inside and outside the family explicit and easy to see. As young adults move to form their own marital and nuclear family units, relationship triangles multiply in number and in interlocking complexity. If we are aware of the developmental density of triangles in our own lives and in the lives of our patients, we can more easily find, define, and neutralize the specific triangles that may be defeating us at a particular moment in time.

For purposes of efficiency and cost effectiveness, as clinicians we deal with the matter at hand—whether anxiety, depression, or relationship conflict—by freezing it in time, analyzing it, and treating it. This doesn't take away from the fact that each symptom or clinical episode, with its accompanying triangle, is just one in a connected series that has occurred over time.

Our lives and our therapeutic efforts are complicated immeasurably by the often invisible power of relationship triangles. Remember the time when you were 7 years old, on a neighborhood exploration with your best friend, and you wanted to cut across the frozen pond on the way to the candy store? Your friend said his mother wouldn't let him. Undaunted, you did it anyway, and he ran home and told your big sister. She not only came and got you, and dropped you home before you got a chance to buy your candy, but she also ratted on you to your mother. Your mother sent you to your room with the familiar threat: Wait until your father gets home. It was bad enough that your father thought your big sister was perfect and you left a lot to be desired, even though you could already dribble a basketball at age 7.

Did you ever tell your best friend your deepest, darkest secret only to arrive at school the next day and find a group of the most popular and powerful kids gathered in a corner of the schoolyard laughing together in a way that by instinct told you that your friend had told? Now, for the rest of the year, you'd be an outcast. Or in college, when you found out your friend was pursuing your sweetheart? Then you grew up, went to graduate school, found a life partner, and received an intense postgraduate course in mothers-in-law.

Triangles surrounded you when, in clinical practice, little boys who were targets of their fathers' criticism, husbands who couldn't control their libidinal compulsions, and wives driven to depression by the critical squeeze of their mothers and their husbands kept finding their way to your office. It is just this pervasiveness of triangles and of the fallout they produce that inspired us to take up the challenge of writing this book.

METHODS OF MANAGEMENT OF RELATIONSHIP TRIANGLES

Our approach to the clinical management of triangles is best summarized in the following five steps: (1) Find the triangle; (2) define the triangle's structure and the flow of movement within it; (3) reverse the flow of movement in the triangle; (4) expose the emotional process; (5) deal with the process and move toward improved functioning.

When Scott O. met Carolyn W. one summer on the beach, they were both 23. They were a year out of college, tired of the bar scene and the unending string of beer parties. Each of them had an unspoken longing to meet someone special who might turn out to be "the one." Neither of them believed that the chaotic madness of another Newport summer would provide the fulfillment of these wishes.

Now, 18 months later, Scott finds himself in a place he never dreamed he'd be: a psychiatrist's office. Scott and his family didn't really believe in psychiatry or "any of that mental health crap," but for the past 3 months Scott had been experiencing anxiety attacks at work, while driving to pick up Carolyn in the city, and even at a Giants' game with some old friends. The anxiety attacks included a pervasive sense of impending doom, with no rational stimulus, profuse sweating, heart palpitations, and nausea. All this in spite of the fact that his job was going well and his relationship with Carolyn was building in a beautiful way. In fact, in the past few months, especially around Christmas time, they had begun to talk about the possibility of becoming engaged on Carolyn's birthday in April.

Scott had consulted his family physician, concerned that he might have a cardiac problem. The physician had examined him and run the appropriate battery of tests, including an EKG and stress test, before telling Scott that he was physically fit and suffering from anxiety attacks. He prescribed small doses of Xanax, which gave Scott some relief. However, on a follow-up visit, Scott reported awakening at 3 A.M. each morning, in panic over the dream he was having that his mother was in a hospital with terminal cancer. In response to this information, the physician had referred Scott for a psychiatric evaluation.

The psychiatrist discontinued the Xanax and prescribed moderate doses of imipramine at bedtime. Imipramine is a tricyclic antidepressant with an excellent track record for controlling panic attacks. The psychiatrist assured Scott that his condition would respond to the medication if Scott complied with the treatment plan. He also asked some questions about Scott's life, looking for the developmental anxiety in him as well as the relationship processes that might be involved in the formation or maintenance of his symptoms.

Finding the Triangle

In Scott's case, the active triangle (Scott, his mother, and Carolyn) surrounding his anxiety symptoms was easy to see from the content of Scott's dream and the developmental timing of the symptoms (just at the time his relationship with Carolyn was moving toward engagement). However, this clear presentation isn't the usual case: Finding triangles isn't always so easy. More likely someone like Scott would present his symptoms oblivious to their connections in time and relationship space. From shame, embarrassment, or denial, he would not mention his relationship with Carolyn or his repetitive dream about his mother, not seeing them as relevant. If the clinician Scott consulted thought only about biology, the treatment would consist only of prescribing an appropriate drug.

If the clinician believed in the importance of relationship process, his or her evaluation would include a search for developmental or situational issues in Scott's life. A logical focus would

have been Scott's work and love life. Probes into either of these areas would have produced glowing reports from Scott. Only if the clinician had added a systems perspective to his knowledge of individuals and dyads would questions be directed toward potentially active relationship triangles in Scott's life.

For the fullest possible perspective on Scott, and to catch problems that might otherwise remain invisible, the clinician must be able to think about threes. Once the clinician does that it becomes simple, because the same tracks are followed to look for symptomatic triangles in any clinical case as are used to nail down individual and dyadic factors. The major tools in finding the relevant triangles are the patient's genogram and asking questions about the developmental and situational threats or challenges that are going on and about the triangles in the patient's relationship system that would most likely be activated. The genogram very quickly helps the clinician to visualize the developmental and situational challenges in the patient's life and so directs the flow of process questions. If Scott had presented clinically without making the key triangle explicit, these two sets of tools would do the trick.

But so what? In this case the imipramine would manage the symptoms well enough, and the panic attacks would go away. Scott would feel better and be none the worse off for lack of enlightenment about the cause of his anxiety. Clinically, one could defend this position, especially in light of the constraints of time and money and the demands for rapid symptom relief from our present models of care. This position can also be criticized, however. An equivalent, if a young patient presented to an internist with hypertension, would be for the internist to prescribe diuretics and other antihypertensive therapy without inquiring about family history, diet, and aerobic fitness.

In Scott's situation, even without the information about his marriage plans and dreams about his mother's death, a cursory look at the genogram would demonstrate the developmental challenges. A few well-placed process questions would uncover the active triangle. Process questions are formed more easily if you already have in your head a picture of possible triangles. With Scott, his mother, and Carolyn in mind, for example, some process questions might be: "How does your Mom like Carolyn?" "Did your mother have health problems or any separation anxiety when you or your sister left for college?" "How do you think your mother would do if you and Carolyn got married and your company transferred you to Europe?" "Does Carolyn admire the closeness you have with your mother?" "Does she worry about the impact that closeness might have on your marriage?"

Now, depending on how open Scott would have been to this type of questioning, his answers still might not yield much more information than you already had. Even as our society reels through this age of disclosure, psychiatry is being pushed by the edicts of managed care. After decades of probing to uncover internal and relationship conflicts, therapy has entered an age of containment. Even in the midst of this revolution, though, there remains a place for clinical discernment. Sound clinical judgment calls for at least a modest attempt to cut through denial rather than celebrate the superficial accounts of some patients by accepting their limited perspective and allowing it to dictate the course of treatment. It's worth the effort to take time to look for triangles.

Defining the Triangle's Structure and the Flow of Movement within It

Earlier in the book we spoke of the difference between a relationship threesome and a relationship triangle. If we track the central triangle in Scott's life (with Carolyn and his mother) from the time he met Carolyn through the triangle's activation, we'd assume that the potential for an active triangle existed from the start. As Scott's relationship with Carolyn developed over time, the direction and intensity of his movement were increasingly toward Carolyn and away from his mother. It may have been that when Mrs. O. met Carolyn, in spite of feeling positive about her and pleasure in her instinctive feeling that Carolyn was the one for Scott, she found herself involuntarily asking Scott critical questions about Carolyn and their relationship. At this point the triangle was activated. Its structure, and the flow of movement in it, were largely determined by Scott's developmental challenge to separate from his mother and form a new primary relationship. Scott and Carolyn are closer in relation to one another, and Scott's mother is on the outside of their twosome.

There are many variations on this theme that could have occurred. Mrs. O. and Carolyn might have taken to each other and spoken so glowingly about each other to Scott that he might have become uncomfortable and started to wonder if he were doing the right thing. Or, their immediate appreciation of each other might have relieved Scott, as he felt Carolyn taking on the pressure of his relationship with his mother, and vice versa. In that case he might have come to believe that he was now relieved of obligations and free to spend time with his buddies without worrying about demands or criticism from either one of them. In fact, what happened was that Mrs. O. reacted with coolness toward Carolyn and was distant and critical (very much like Maureen O'Hara's character in the movie *Only the Lonely).* Carolyn responded by insisting that Scott get his mother under control and that he defend her against his mother or even that he choose between her or his mother.

The point is that, no matter what the variation, the problem Scott presents clinically will not be resolved successfully unless it's seen in triangular, as well as biological, individual, and dyadic terms. The underlying triangular process is the same whatever form the structure and movement take. It has to do with Scott separating from his mother and forming a new primary relationship: All three twosomes are interconnected and have to be dealt with—both separately and in their interconnectedness. Every new relationship in a person's life is affected by existing relationships. If the new relationship is (or should be) a primary one, it sets up the likelihood of conflicts about the primacy of attachment and the hierarchy of influence between the new relationship and the old ones.

Reversing the Flow of Movement

Once the therapist has a clear idea of the structure and the way the movement flows back and forth within the triangle, the first task is to create an experiment that reverses the direction of the relationship movement. Essentially, such experiments attempt to engage one or more members of the system to stop moving in the direction called for by affect and reactivity and to begin moving in a planned, experimental direction that usually is the opposite of what's been going on.

There are several reasons for doing this. First, the intervention increases self-focus, as people become aware of how difficult it is to do an apparently simple experiment in relationship movement. They begin to see themselves as caught and controlled by their emotions. Second, it gives people the sense that they have options in their behavior. There *are* ways of doing things differently from what they've been doing, which hasn't been working. Third, people's reactions to doing (or even thinking of doing) something different bring the underlying emotional process into the open.

The medication in the current case relieved Scott's panic attacks and took the edge off his inner turmoil. The psychiatrist offered him the option of accepting this as the result of treatment or of moving on to deal with the source of the anxiety that was driving his symptoms. Scott decided on the latter. Rather than deliver a lesson on triangles this early in therapy, which often creates confusion and misuse of the concept, the therapist suggested a relationship experiment. He pointed out to Scott that this was just that—an experiment, not necessarily a solution. While doing it, Scott was to monitor his own internal emotional reactions as well as the response in the relationship where the experiment is taking place.

He suggested that Scott move toward his mother (the opposite of what he had been doing). He suggested that Scott ask her what she thought about his closeness to Carolyn and the strong possibility that they might marry. Scott could open up with his mother the feelings he was having about not being so close to her anymore and talk to her about how they could stay connected in ways appropriate for a mother and her married son. Scott could also just spend some relationship time with his mother, hanging out with her and talking about old times. By this time, Carolyn had joined the therapy, and the therapist asked her, too, to perform an experiment. He predicted that she would have an emotional reaction of some kind to Scott's moves toward his mother, and he asked her to monitor it carefully. He suggested she might want to keep a journal of her reactions and bring it into the therapy. Carolyn did raise objections to Scott's spending more time with his mother, saying that Mrs. O. was against her and the marriage. The therapist pointed out that unless this triangle were resolved in some way, it would remain a permanent threat to their marriage. He said that Scott was doing the experiment for them and for the long-term health of their relationship, not for his mother.

The goal of Scott's experiment was to face his phobic avoidance of this mother, her understandable anxiety over losing her son, and the effect her anxiety had on him. The therapist offered two choices. One was for Scott to move directly toward his mother and spend some relationship time with her. Eventually he would talk to her about his anxiety, his symptoms, his plans with Carolyn, even about his and his mother's special relationship, and how they were going to deal with this difficult time in their lives.

A second option was for Scott to move toward his father and to discuss with him how to deal with his relationship problem with his mother. At first glance this option might appear to the novice triangle doctor as the activation of another triangle. But remember the distinction we made earlier between threesomes and triangles; we pointed out that behavior in an active triangle is driven by emotional reactivity. If Scott is moving toward his father to return the gift of his mother many years later, it's a developmentally appropriate, thoughtful, planned behavior. (Of

course, if Scott's movement were laden with reactive feelings of anger and resentment toward his father, it would in fact represent the reactivation of Scott's primary parental triangle.)

At this point you may be thinking, "Well, if men are from Mars and women are from Venus, the families you see must be from Pluto if you can get them to do an experiment like moving toward either of their parents." This thinking raises the issue of clinical judgment: Which families and family members are coachable, and which will require the direct intervention of getting everyone into the treatment room? In general, coaching as a technique requires highly motivated, high-functioning adults with significant relationship leverage in their families. It also requires a belief that, through the modulation of anxiety and affect, and by means of relationship experiments, people's behavior in relationships can change. In the absence of some of these characteristics, it can still be useful to attempt coaching a patient through a relationship experiment. If coaching fails, then you can resort to enlarging the membership in the sessions to deal directly with the triangle.

In the meantime, let's return to Scott and his dilemma.

Exposing the Emotional Process in the Triangle

Six weeks later, after two more therapy sessions and a cancellation, Scott had yet to move toward his mother. Discussion with Scott uncovered his apprehension and aversion toward making this move. He also revealed that, in talking about this experiment with Carolyn, she kept saying she didn't get it. She thought that grown-ups drew boundaries between themselves and their parents. This was the reason she had moved from Baltimore to Connecticut and kept her visits home to a minimum.

The therapist repeated his earlier point that Scott didn't have to engage in the experiment. He could just take his medication and forget the project with his mother. However, he also offered Scott a plan to help him make up his mind about how to proceed. He lent him a video copy of *Only the Lonely,* a John Candy film about the struggle of a single Chicago cop who lived with his mother to separate from her and marry the woman of his dreams. The therapist suggested that Scott watch the tape with Carolyn and invite her to the next therapy session.

One of the purposes of a relationship experiment is to bring underlying emotional process to the surface. Just proposing this relationship experiment had revealed the following pieces of process:

1. Scott had an intense relationship with his mother and an inability to open up for discussion between them important issues in his and his mother's life. This lack of openness had forced the anxiety about these issues underground. The anxiety then came out by triggering Scott's biological vulnerability to panic attacks.

2. From his experience over the years, Scott had grave doubts about whether his father could or would be a supportive refuge for his mother as she suffered through the separation from Scott. In addition, his relationship with his father was weak enough that Scott couldn't ask his father to provide this support.

3. In his apprehension about the experiment, Scott's anxiety had been elevated, with two important side effects. First, there had been a moderate return of his panic symptoms. Second, a therapy triangle had been activated, consisting of Scott, Carolyn, and Scott's therapist.

It became the therapist's job to establish a plan to neutralize this threefold process.

Neutralizing the Process and Detriangling

The therapist had begun Scott's treatment by managing his symptoms of anxiety and then moving on to assist him in addressing the symptomatic triangle with Carolyn and his mother. The relationship experiment, designed with this triangle in mind, did its job by opening up the process described above: Scott's anxious attachment to his mother and his inability to communicate with her about difficult issues; his insufficient attachment to his father; the formation of a therapy triangle around the experiment.

The activation of a therapy triangle almost always calls for dealing with it immediately. Scott's taking *Only the Lonely* home to watch with Carolyn was the first of a number of steps designed to involve her in the therapy. Perhaps now is a good time to raise a philosophical (and perhaps ethical) question about the methods we're describing. Someone who adheres to a minimalist approach to therapy might argue that all this playing around with Scott's triangles is producing iatrogenic problems—not to mention prolonging the therapy and increasing its cost. Such a critic might add that, if Scott's panic attacks had failed to respond to medication and cognitive techniques, or that, if after initial relief he had suffered multiple relapses, the treatment described here could be offered as an adjunct to fortify the primary intervention. However, we believe in a heavy emphasis on patient education and efforts at prevention. Primary care medicine today emphasizes the importance of changes in diet, exercise, and life style in caring for cardiac- and cancer-prone patients. In much the same way, we believe that work on relationship triangles is essential to the comprehensive care of anxiety, depression, and relationship conflict. It's important to educate patients about the choices available to them for elective procedures and to allow them to make a choice.

We return now to Scott and his fiancée. Carolyn came to the next session and, in a clear and forthright way, gave her thoughts on Scott's situation. She said that they had both enjoyed *Only the Lonely* and after watching it had a long discussion about driving to Baltimore so that Scott could meet her family. They saw this as a step on the road to getting engaged. At that point, the therapist asked Carolyn about her family and how it differed from Scott's. He also asked her directly if she thought the separation between Scott and his mother might go better by dealing openly with the issues between them rather than leaving them unspoken and having everyone anxious about them. Carolyn said that she could imagine it but had never seen it work. The therapist asked her to help him by trying to get emotionally neutral about the idea and by sitting back and evaluating the results with him. He added that, with Scott's and his parents' permission, he would videotape the sessions and allow her to study them as a part of her evaluation. If she liked the results, she might even get Scott to take the camcorder along to on the trip to Baltimore.

Carolyn expressed the thought that the therapist was even more relentless than her mother, but she agreed to the challenge. Scott agreed to speak with his parents about coming in for a series of three sessions to deal with some issues that were important to him.

All these steps were aimed at neutralizing the therapy triangle that the proposed experiment had activated. The therapist depolarized the triangle by decreasing the distance between him and Carolyn, thereby diminishing the emotional reactivity in the therapy triangle. If the therapist had tried to bring Carolyn in to lecture her on how she was blocking Scott's therapy, to convert her to the therapist's way of thinking, or to shut her out of the work Scott would do with his parents, the triangle would have gotten further polarized and reactive. Therapy might in fact be dead in the water for the foreseeable future.

The therapist hoped that, in addition to neutralizing the therapy triangle, by his engaging Carolyn actively in the process, other good things would happen. If Scott and his parents were successful, enough of a conversion would take place in Carolyn that she would support the present therapeutic efforts and that the potential for future problems (or at least the fallout from future problems) would be diminished.

With the therapy triangle under control, the work with Scott and his parents could begin. Scott's reluctance when the experiment had been suggested made it clear that coaching him was unlikely to work. Directly involving his parents in therapy seemed the most efficient way to deal with Scott's overly strong attachment to his mother and his weak attachment to his father. The feelings of loss that go along with kids growing up are as predictable as the moon and tides, but they're usually handled by angry distance or silent emotional paralysis. The first item on the agenda, therefore, was making it safe enough for Scott and his mother to talk about the emotional side of their developmental problems.

To make the therapy "safe," the therapist's questions in the first session gently and curiously addressed the family's ability to deal with the hard feelings (anger and resentment) versus the tender feelings (loss and longing). Scott and his mother did most of the talking about this in the first session, and they planned to continue doing so outside the therapy. (It might seem that encouraging all this talking and connection between Scott and his mother intensifies and prolongs the separation difficulties. Our experience and our theory predict just the opposite: it's the *failure* to communicate openly and work through these overly close connections that makes separation more of a problem.)

In the second session, the therapist directed the discussion toward the question of whether either side of the family had a tradition of the men being connected to one another in a way that was emotionally supportive. The idea was to plant a seed that might germinate and foster an improvement in the attachment between Scott and his father.

In the third session, the therapist asked Scott's father for his opinion about the first two sessions. Mr. O. said he thought they'd been worthwhile; he hoped his son thought so, too. About 15 minutes into this session, Mrs. O. somewhat hesitantly said that the first two sessions brought up for her the topic of *her own* mother-in-law. She said she hadn't wanted to talk about it then but asked her husband if he would come back to the therapist with her and without Scott

to talk about Mr. O.'s relationship with his mother and the impact that relationship had had on her. Mr. O. looked thunderstruck and said that he wasn't sure what his wife was talking about. He agreed reluctantly to a session with her, but he had great difficulty settling on an appointment time.

Carolyn came in one more time with Scott. She had watched one of the tapes of the sessions with Scott's parents and said that it looked too good to be true but that she'd be willing to keep an open mind. She kidded the therapist about bringing him along on the trip to Baltimore. No further appointments were scheduled, and the therapist told Scott to call if he wanted to do some more work or if his anxiety symptoms returned.

The follow-up of treatment proved satisfactory. With the help of the imipramine, Scott hadn't had a recurrence of panic attacks for 6 months. When the psychiatrist saw him at that time, he explained that there were two options—to taper off the medicine, or to remain on a maintenance dose for a longer time. Scott asked the psychiatrist to write down the schedule for tapering off, and made a follow-up appointment. He cancelled that appointment, and the psychiatrist didn't hear from Scott, Carolyn, or Scott's parents for 4 years. At that time, Scott called for an appointment. Just the day before, on the train going to work, he had experienced another panic attack. So, he thought he ought to check with the therapist before the situation got out of hand. When he came in, Scott reported that he and Carolyn had been married for 2 years and were very happy. He also said that things were going well with his mother—she and Carolyn had been getting along fine, and he had been careful to maintain a relationship with his mother. As the session neared its close, the therapist remained puzzled that he could find no trigger for the panic attack Scott reported. On his way out the door, after making an appointment for a few weeks later, Scott smiled and said, "By the way, Doc, we just found out 2 weeks ago that Carolyn is pregnant."

SUMMARY AND CONCLUSION

This chapter has reviewed the pervasiveness of relationship triangles in people's lives, both personal and professional. Scott's developmental struggle illustrates the part triangles play in the predictable events of all our lives.

All therapists, whatever their theoretical persuasions, have listened to Scott's story and ones like it repeatedly in their offices. In their personal lives, therapists have experienced triangles activated by the birth of a baby, the death of a parent, a child leaving home for college. Our purpose has been to make you, the reader, a "triangle doctor." This chapter, therefore, together with the rest of the book, gives you the tools to do that. We've given you a developmental history of the concept of relationship triangles. We've analyzed the idea by breaking it down into its component parts: structure, movement, process, and function. To make it easier to use triangles in clinical work, we've offered a clinical typology of the most-often-seen triangles and a clinical methodology for dealing with them. We've presented information that leads to knowledge and recognition of triangles. We've shown how triangles set up structurally, how emotional process flows through the structure, and how triangles serve functions for any relationship system.

In order to make a working knowledge of triangles more useful clinically, we proposed our five-step paradigm in this chapter. This method allows for identifying the triangles that people bring to us and the ones that we create in therapy and in our own lives, for understanding them, and for intervening with them. Now, using the genogram to grasp the context of the individual's or the dyad's symptoms, and with the topology of triangles in your head, you *can find* the triangle or triangles that you need to work on. Having done that, you can now *define the structure* of the triangle and *see the flow of movement* in it. Once you're clear about structure and movement, you can then begin to intervene by *reversing the flow of movement* experimentally. If people follow your suggestion and do the experiment, inevitably that will *expose the emotional process* that has been hiding underneath the symptoms. The experiment will expose the emotional process to you and to the individual, couple, or family, and now you can *deal with it* directly and move people toward improved functioning.

It is our firm belief, based on years of experience, that developing a radar for spotting triangles gives therapists a wider perspective on possible interventions for every case they see. This can't help but positively affect clinical outcomes.

In closing, we'd like to reemphasize a point essential to good clinical practice. To work skillfully in triangles, a therapist must also be skilled at working with individuals and dyads. As the practice of psychotherapy evolves over time and cost-effectiveness becomes more of a factor in therapy, it's important to develop the ability to integrate the following three factors: (1) the biological and psychological processes internal to the individual, (2) the emotional processes in relationship dyads that gives those individuals the important connections in their lives, and (3) the inevitable reactive emotional triangles that are an integral part of relationships and form the essential building blocks of any relationship system. Effective psychotherapy relieves symptoms, opens the door to and facilitates the process of psychological change for individuals, and improves the nature of the connections with one another. The fabric of this therapy is woven out of an integration of individual, dyadic, and triangular factors. In fact, you could say that this is the one-two-three of psychotherapy.

Guerin was, of course, a student of Bowen. The concept of "differentiation" is basic to Bowen's theory. But Guerin believed that Bowen never explicitly resolved an apparent contradiction: on one hand, Bowen believed that the goal of psychotherapy is to increase a patient's level of differentiation, and on the other he thought that a person's level of differentiation is a biological given, innate, and extremely difficult to increase even a little. Guerin notes that people can, with conscious effort and in some circumstances, act in a more "differentiated" way than their innate level of differentiation would appear to suggest. He proposes a distinction between differentiation and "adaptive level of functioning." The latter is the degree of apparent differentiation in behavior that an individual can achieve in specific circumstances with deliberate, conscious effort.

Differentiation and the Adaptive Level of Functioning Markers in Therapy and Life

Philip J. Guerin, Jr., M.D.

According to Bowen, "the level of differentiation is the degree to which one self fuses or merges into another self in a close emotional relationship." Bowen has taken his concept of differentiation and attempted to objectify it by placing it on a scale from 0-100, zero marking the lowest levels of emotional functioning as represented by schizophrenia, and 100 the highest level of functioning as represented by some biological and psychological being yet to be discovered. Bowen developed the concept while doing research on schizophrenia, and then attempted to refine it working with people from the opposite end of the scale: "the high functioners."

0-25 is described as a level in which individuals are in a state of emotional paralysis or numbness. They are going through the motions in their functioning, disconnected from their feelings, and are unable to think out clearly their relationship options. In other words, they are just floating through life on a sea of emotions. This description represents Bowen's ideas of the lowest levels of differentiation. Such people are particularly refractory to any form of psychotherapy.

The next level on the scale of differentiation includes those people falling on the scale between 25-50. These people are described as being unable to distinguish feelings from fact. The majority of their emotional investment is in being loved and approved of by others or, in alternating fashion, attacking important others for not providing that love and approval. Little energy is invested in goal-directed behavior; life decisions are made on what feels right rather than based on principle.

At 50 on the differentiation scale the first evidence of a well-developed intellectual system that is capable of overriding the emotional system appears.

Those people who fall in the category above 60 on the scale are seen as people who are impervious to influences and are wedded to their principles. They make their life decisions based on these principles. They are described by Dr. Bowen as people who are "operationally clear about the differences between feelings and intellect." They are free to state their beliefs calmly with little regard or upset if others do not accept them and their beliefs. On the other hand, they do not attack the beliefs of others; they are people who are capable of making a choice between intimate emotional closeness and goal-directed activity.

Bowen summarizes the usefulness of his scale in the following way:

> "The differentiation of self scale is important as a theoretical concept for viewing the total human phenomenon in perspective. It is valuable in estimating the overall potential of people and in making predictions about the general pattern of their lives. But it is not useful in making month-to-month or even year-to-year evaluations of scale levels. There is so much trading and borrowing and negotiating for pseudo-self in the relationship system, especially in the lower half of the scale, and such wide functional shifts in the level of self, that it is difficult to estimate scale levels on short-term information.

> "Most people spend their lives at the same basic level they had when they left their parental families. They consolidate this level in the marriage, after which there are few life experiences that change this basic level. Many life experiences automatically raise or lower the functioning levels of self, but this shift can be as easily lost as gained. There are calculated ways to raise the basic level of self, but doing so is a monumental life task, and it is easy for one to say that the possible gain is not worth the effort."

In the Bowen schema it would appear that the scale serves at least two functions. When family members are located on the scale, it can be used to predict the chances for change after clinical intervention. Second, tracking the ascent of family members on the scale over a period of time can serve as a baseline for measuring change over long periods of time. This scale is his least clearly developed, as well as his least understood, concept. At its worst it may be used as a judgmental tool about certain types of behavior. Its focus on individual family members clearly defines the Bowen principal that change in one member of the family system will eventually result in a change in the entire system.

Another perspective views differentiation as the process whereby people partially free themselves from the emotional entrapment of their families. It is "being caught" in the family emotional process that makes human robots out of most of us, and "being freed" from it, even to a small degree, represents an increase in differentiation.

What does it mean to be caught? Let's first take an example from a therapist's own family excursion. He is on his way home to visit his parents in New Jersey. Since he is an accomplished student of family systems, those mistakes commonly made by neophytes to this process are not for him. He knows that to bring his spouse and kids with them contaminates the operational field. He knows that married people bring their spouses along in visiting their parents only for refuge and protection, and bring their children as currency to be offered to their parents in place of themselves.

It's Friday night and as he drives along, he realizes it has been a reasonably good week. His records are up to date. He has just settled a long-term conflict with a coworker. He has even been reasonably calm and emotionally available to his wife in face of her worry about the news that her sister was to have a breast biopsy on Monday. As he drives by the sign marking his hometown, he notices an indefinable uneasiness in his insides, but it gradually subsides.

When he enters his parents' home he finds them sitting in the dark, in silence. Certain that at the least his brother has been run over by a truck, he asks "What's wrong?" In cadence they reply, "Nothing."

After 5 min. his mother says, "I thought you said you'd be here by six. It's 7:45."

"I told you between six and eight," he replies with just a hint of defensiveness in his tone.

"Your father and I know Lucille's a good wife, but she just doesn't want you coming down here like this. She wants you with *her* family."

At this point a systems amateur would say, "that's a triangle, mother, and I don't participate in triangles." But he is too advanced for that. He knows his mother is uptight and that it probably has nothing directly to do with him and his wife.

"C’m on Ma, what are you really upset about?"

At this point, his father exercises a family tradition and leaves the room. His mother, glasses halfway down her nose, glares at him and says, "It's you that's got me upset and don't give me any of that family systems stuff of yours, that because your uncle Harry called today and he was drunk, is the reason I'm angry at you."

Aha! He was almost caught, but that little piece of information momentarily frees his head. He decides to ask a simple question and assume the listening position. "How is Uncle Harry?" he asks. Mother then relates an expansive scenario about Harry and his problems with his wife and her family. As she tells it, mother's anxiety rises, and he finds his insides growing uncomfortable. Almost without his knowing what is happening, a cassette slips into place in his head, and he delivers a systems lecture on the extended family. In the middle of the speech the differentiation center in his brain lights up. He backs off, changes the subject to food, and calls for father, thereby exercising another family tradition: the all-clear signal.

On his drive back home that evening he wonders why he didn't just take one more year of analysis and call it a cure. As he contemplates, a thought occurs to him. Somewhere down deep, there is an unquenchable desire for a personal relationship with his parents, even if only a small portion of one is attainable in a lifetime. As he enters his driveway he knows, intellectually anyway, that he is fulfilling a responsibility to himself and his kids. Going toward the house he glances back toward the car and catches a glimpse of his old Mets bumper sticker, "You Gotta Believe." He smiles, also noting that the kids’ bikes are left out, again. He enters the house, goes upstairs, wakes his wife, and criticizes her for not getting after the kids to put their bikes away. Being "caught" is a way of life.

We all have triggers that get us caught. We all have people we are especially vulnerable to. Ninety per cent of the time we only know we are caught by the symptoms. Generically these symptoms fall into defensive and reactive behaviors, accompanied by significant projection: The problem with my mother is my mother.

How does one get uncaught? The best way obviously is not to get caught in the first place, but to do that one would have to settle for not being born. It is important to remember that a person is dealt his family of origin, and this fact alone has a significant impact on measuring his potential level of differentiation. This reality may on the one hand produce envy towards those dealt "better" families. But on the other hand it may also serve to provide a reality base from which to pitch one's expectations. The more one knows about the premorbid state of one's family system prior to one's birth, the better understanding one will have to put into perspective the intensity of the emotional system that one is a part of.

The opposite of "being caught" is "getting free." Both are ongoing dynamic processes that flow into one another.

First of all, "getting free" calls for the development of an ability to see oneself as an active participant in one's own relationship system. A person must give up on the character analyses of the important people in his life; such pigeonholing only serves to foster and support an automatic projection process. Rather, those people must be seen as simply other members of the same system responding to the same anxiety. Getting free demands that a person get a handle on

anxiety, take responsibility for it and for the reactive feelings and behaviors that go along with it. It is necessary to stop blaming others and look to one's self.

There is a wish in most of us that things could be different with parents and adult siblings, a wish often accompanied by a hopelessness that it could ever change. The combined emotional energy from that wish and hopelessness is often displaced into the marital relationship. There it is converted into an effort at changing the spouse to fit one's perceived needs. One way, for the therapist, to lower the pressure in marital conflict is to work with an individual spouse on the displaced conflict or bitterness from his or her extended family.

In the author's model of marital therapy, this particular clinical pathway is indicated when there are direct and explicit effects on the marital relationship from the extended family (e.g., with mother-in-law conflict), that make the relevance of extended family work easier to establish. It is also indicated when the emotional pursuer is working on his or her ability to hold a "planned distance" and the therapist introduces the importance of relationship options.

The concept of differentiation, then, serves two major purposes. First, it is a good long-term measure of an individual's and the family's baseline level of functioning. Second, it provides a justification for extended family work whether that work is done to relieve pressure on the marriage or as reinforcement of a positive therapy response. However, as a marker of progress in therapy, and/or of short-term improvement in functioning, it is of limited usefulness even in its originator's terms.

Therefore, the concept of differentiation of self is best used as a long-term indicator of one's psychological functioning, as a baseline for evaluating the strengths of the individual over time, resilience in the face of significant stress, and the accessibility to therapeutic intervention.

Because of the need for time in evaluating differentiation and the difficulty in understanding and measuring it as a phenomenon, it would seem logical that there is a need for concept of self that is more easily measured in the short term and which together with the concept of differentiation can be incorporated into a method for evaluating both the short-term and long-term functioning of the individual within the context of the family. For these purposes the concept of the *adaptive level of functioning* is important. Since 1979 the author has used a Personal Well-Being Index as a measure of an individual's adaptive level of functioning. Its categories are similar to those in Axis V and include (1) productivity, (2) relationships, and (3) personal well-being.

Productivity refers to how well an individual is functioning in whatever job he or she has to do in a particular context, for example, physician, housewife, student, etc. The amount of energy available for work, the satisfaction obtained, the efficiency and creativity expressed, should all be evaluated.

Relationships refers to how functionally an individual is connected with important others and how much attention and creativity are invested in nurturing relationships. It is often useful to compare the amount of creativity and time invested in relationships with the time and creativity invested in productivity.

Personal well-being refers to the amount of attention and creativity invested in taking care of one's own physical and emotional needs.

If the clinician uses this index for any period of time, he or she will find very few people who are doing well in all three areas. It is important clinically to reinforce positively the areas of strength, and use energy from those areas of strength to improve the less functional ones. It is also helpful for people to be aware of the order in which these areas decline under stress. Generally one area will be the first to suffer as stress develops and will be the last to return as functioning improves, or vice versa. For example in one person productivity may be the last to go and the first to return during periods of increased stress, whereas another individual may stop exercising and put on weight as the initial response to an increase in stress.

Like differentiation, adaptive level of functioning can be a fuzzy concept. Bowen has used the term in his teaching, but to our knowledge has not formally defined it. The author uses the term "adaptive level of functioning" to mean the ability to maintain functioning in the areas of productivity, relationships, and physical and emotional well-being in the face of significant amounts of stress. The difference between differentiation and adaptive level of functioning is the amount of conscious effort necessary to regulate internal stress and maintain functioning. For example, in an individual faced with a given amount of stress, a high level of differentiation will be demonstrated by an experience of less internal emotional distress, and therefore correspondingly less conscious effort is needed to maintain a certain level of functioning given the same or even greater level of stress. An increase in the adaptive level of functioning would be manifested by an ability, with a significant amount of conscious effort, to maintain functioning despite considerable internal emotional distress.

An example of the difference between differentiation and adaptive level of functioning is provided by a 50-year-old male physician who first entered therapy in stage II marital conflict at the age of 36. After three or four months of couple therapy, both he and his wife were able to obtain a workable amount of self-focus and experiment with their marital struggle in more effective ways. Following this initial success, he elected to continue therapy in order to work on his relationships with his extended family. This was prompted by two things. One was his sense that the relationship with his parents was, if anything, overly close and thereby impinged on his marital relationship. Second, he had what he believed to be an inappropriate fear that one or both of his parents would die. In therapy he talked about how this fear was present from childhood and may have in some remote way been connected to the fact that both his maternal grandparents were orphans.

He also speculated that his choice of medicine as a career might have been prompted partly by his attempt to master his fear. He joked about how during medical school he had been intrigued by psychiatry but decided it did not offer enough opportunity to be a hero. The fear that his parents would die reached its peak when as an intern in a Manhattan hospital he experienced flash fantasies of being called to the emergency room to treat an acutely ill patient only to find one of his parents dead on a stretcher. Eventually, he handled those fantasies by doing his medical residency 300 miles from New York City.

When he began therapy those flash fantasies were several years behind him, but even then when he would get an unexpected call from his brother, or when one of his parents became even moderately ill, he would overreact. He would even cancel days of office hours to fly home and check the situation firsthand. In monthly sessions for two years, he and the therapist worked on his visits home, on lowering his anxiety and decreasing his sense of overresponsibility and omnipotence. He worked on opening up the issue of his grandparents’ deaths with his mother

and her siblings, and on bridging the cutoffs in mother's sibling subsystem. He also began to talk to his father about his fears about his mother and vice versa.

The outcome of this work was quite positive. He was able to visit home with much less anxiety and take the unexpected phone calls and his parents' illnesses more in stride. He consciously overrode the impulse to fly home and gave up an appropriate amount of responsibility to his quite competent brother.

Seven years after terminating therapy he called and asked for an appointment to discuss the impact on him of his father's terminal illness. He and the therapist worked off and on for 18 months as he walked with his father through the illness to his grave. Considering the cohesiveness and relatively low level of differentiation in this family, he managed himself and his relationship with his father and other extended family members in a highly functional way. His productivity slipped somewhat, but only at those times when it was appropriate for him to be away from work and more available to his father and mother.

After his father died, he took up the work of closing the hole in the system left by his father's departure by working on the emotional fallout for himself in the relationship with his mother, siblings, and children. During this time there was a reactivation of the marital conflict. This was triggered by his resentment of what he considered a lack of emotional support from his wife. They reentered couple therapy for two months, with significant improvement.

In nine years then, there had been approximately 30 months of therapy with a total of 38 visits. The question arises as to whether his response to therapy represents an increase in this physician's level of differentiation, or simply an increase in his adaptive level of functioning. Probably it represents the latter. His ability to maintain his level of functioning was not accompanied by a significant decrease in his internal emotional stress. Rather, he suffered only minor loss of functioning with skillful management of high levels of emotional distress.

Four years later he returned to therapy, this time concerned about his 15-year-old son who was mildly depressed and under functioning academically. He had been struggling with the problem for over a year without success and found himself almost as phobic about his son's well-being as he had been years earlier about his parents'. Flash fantasies of automobile accidents involving his son had replaced the old ones about his parents. This clinical phenomenon reinforced the conclusion that therapy had produced an increase in adaptive level of functioning rather than an increase in basic level of differentiation. To say this is in no way to minimize this man's accomplishments or denigrate increases in adaptive level of functioning. Rather, it is meant to keep the therapist grounded in what is possible in therapy and short-term and what is predictable over the long haul.

Dr. Murray Bowen recently did a consultation as part of the visiting professor series at CFL. He interviewed a clinic patient, a young woman whom Bowen considered to be the epitome of the potential that exists in a motivated person who is part of poorly differentiated system. Ona, a 32-year-old daughter of Holocaust survivors, was being seen at the clinic in short-term therapy for marital conflict centered around the issue of whether or not to have a baby. The fear of "genetic damage" from her parents' Holocaust experiences was strong. The level of intense "emotional oneness" in her family, and the degree to which she was caught in this emotional process were profound and would place both herself and her family in the 25 to 50 range on the scale of

differentiation. However, in daily functioning and her ability to use the therapy experience to improve that functioning, she was doing very well. A short excerpt from Bowen's consult with Ona gives a good flavor of this phenomenon.

Ona: It's just the four of us. That's the way my father said it should be – just the four of us. I see the four of us as not even the four of us, but I see us as one.

Dr. B: You do?

Ona: Yeah, at least sometimes I feel that way. You know it's like four people sharing one body. I spend more time worrying about their lives and mortality. I think I carry their tension and their pain more than they carry mine. I think that they're better able to separate them I am and I've always been the normal one in the family.

Dr. B: You know, I hear you.

Ona: You do?

Dr. B: Yes.

Ona: So what do you do about it?

Dr. B: In that respect you're exceptional more one-of-a-kind than most.

Ona: Why?

Dr. B: I don't know. How in the world do you account for this? Is it your ability? Or maybe you might call it a liability to think of others before you think of yourself.

Ona: Well, I just do.

Dr. B: Does this kind of thing happen between your husband and you?

Ona: No, it doesn't. I think that I can withdraw with him a little bit more than I can with my parents or my sister.

Dr. B: How do you figure that one?

Ona: I figure he can make it on his own better than they can.

Dr. B: You say the four of you cannot make it on your own?

Ona: I see it as if one of us doesn't make it, the other three are going to die also.

Dr. B: Beautiful.

Ona: But that's wrong. It's not real, you know.

Dr. B: It's not.

Ona No, it's not.

Dr. B: It's not real, but the feeling in it is big.

Ona: Yes, it is.

Dr. B: So you live your life as if it's so.

Ona: Right.

Dr. B: You know, a long, long time ago when I first started this family research, that's 30 years ago, I was using this simple analogy of a three-person family being like a three-legged stool. If any leg is missing it ain't no stool no more. Only you have a four-legged stool.

Ona: Right.

Dr. B You know that's where that original concept of a triangle came from 30 years ago.

The road to an increased level of differentiation for this woman and her family will require a great deal of motivation and effort on her part. The theory has it that only a small gain in differentiation is possible in her lifetime. On the other hand, an effort to increase the adaptive level of functioning can significantly improve the quality of her relationships, her individual functioning, and her life. At a minimum this should be the goal of therapy. The effort to modify the level of differentiation is a more elective and refined procedure best left to the combination of a motivated and gifted patient such as this woman, and a motivated and competent therapist.