An introduction to family therapy
In this wide-ranging and scholarly teaching text on family and systemic therapy, authors Rudi Dallos and Ros Draper bring us up-to-date on developments in the field. They divide theory and practice into three phases: the directive first order approaches; the later second order approaches that bring in the therapist-observer; and finally, the social constructionist approaches that include the influence of culture and politics.

An outstanding feature of this book is its inclusion of experiential formats for teaching systemic therapy concepts. Another is its inclusion of topic bibliographies. As a final gift, the authors address a renewed interest in attachment theory in Britain and bring in the caregiver-infant relationship as a central context for therapy of any kind.

In this sense, the book acknowledges the divide between systemic and psychodynamic approaches and offers a way to bridge them. For all these reasons, this is the single most useful book on systemic therapies to appear to date.

Lynn Hoffman, chronicler of the field and author of

*Foundations of Family Therapy and Exchanging Voices*
An introduction to family therapy

Systemic theory and practice

Rudi Dallos and Ros Draper

Open University Press
Buckingham · Philadelphia
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Notes on the authors

**Rudi Dallos** is a psychologist who has been involved in systemic family therapy for over 20 years. He was previously with the Open University where he had written various texts on family life and relationships. He is currently a consultant clinical psychologist specializing in therapeutic work with eating disorders, adolescents with self-harming behaviour, and working with young offenders. He teaches on several quality family therapy training courses and is extensively involved in research and supervision. He has written several previous books utilizing both his research and clinical experiences, including: *Family Belief Systems, Couples, Sex and Power* and *Interacting Stories*.

**Ros Draper** is a senior therapist and teacher who has made major contributions to the development of family therapy and systemic practice in Britain over the last 25 years. As Senior Clinical Lecturer at the Tavistock Clinic, London, and the Institute of Family Therapy, London, she has worked in both adult and child psychiatric settings. In 1988 Ros co-founded the influential Systemic Thinking and Practice Book Series and her title *Teaching Family Therapy* (1993) remains a key text in the field. More recently Ros has developed ways of using family therapy and systemic practice in primary care and educational settings and, in addition to her private practice, is a member of the teaching and therapy team at the renowned Family Institute, Cardiff and at the Juniper Centre, an eating disorders service in Southampton.
As a beginning, we want to share with you some of the threads in our own thinking and practice that led to the creation of this book. Both of us are British systemic and family therapists and trainers and wanted to create a resource book for ourselves, our colleagues, experienced and new practitioners in this field.

There is already a rich oral and literary tradition in systemic and family therapy so this book is part story, part chronicle: part story, because we describe a series of events and intend to interest and even amuse the reader with our personal descriptions of the complex field of systemic and family therapy, a fascinating variety of ideas and practice which has emerged in the last 50 years. To the extent that these pages reflect our perspectives we can defer to modernist, postmodernist and constructionist views, and with tongue in cheek, say this book is fictitious. Equally we claim this book is our attempt to chronicle and record the people, ideas, practices and sociopolitical cultural contexts that have contributed to the field in the last five decades. As we approach the end of the second millennium, it seems appropriate to create a record of the field from a British perspective. We want this book to celebrate 50 years of development in the field and provide a useful guide for readers on all five continents that is both coherent and resourceful. Our wish is that this book, above all, be a user-friendly account that preserves important knowledge and memories of events and facts in a fascinating and developing field of enquiry and practice and is a reference book for readers.

The organization of the book reflects our attempt to offer readers a story, a chronicle and a reference book. We have divided the 50 plus years of history into a first phase, second phase and third phase and can thus locate and track people, ideas and practices as they evolve out of modernism, through postmodernism and constructivism to constructionism. We also wanted to acknowledge the overlap of people
and ideas and the way in which contributions to the field from certain individuals vary in all three phases.

The first phase covers the 1950s to the mid-1970s with some references to the intellectual climate of the 1940s which permitted the pioneering work of the following two decades to develop. This phase of systemic and family therapy is comfortably modernist.

The second phase covers the mid-1970s to the mid-1980s. The early part of the phase is characterized by the development of many different models, some of which we describe, and as postmodernism begins to influence the field we describe the emergence of second-order cybernetics and the links in systemic and family therapy theory and practice with constructivism.

The third phase covers the mid-1980s until the turn of the century and looks at the shift from constructivism to social constructionism as the main theoretical framework for the field.

We offer this schema because we are sympathetic to the amount of painkillers trainees need to take in order to assuage the migraines they develop as they attempt to follow overviews of family therapy schools – structural, strategic, solution-focused, Milan, post-Milan, narrative, postmodern, feminist, postfeminist and so on. We hope to show there are important practical, ethical, moral and political issues attached to the differences emerging in what we call the first, second and third phases of development in the field. Once we recognize these more clearly we can also start to integrate them. As Bateson (1972) suggested, recognition of difference is the key to understanding. Likewise, we agree with George Kelly (1955) that awareness of difference places ideas at contrasting ends of a continuum – this he called a construct. This does not necessarily imply rejecting either position, rather that an idea only makes sense in contrast to another idea. In our proposed three phases we suggest that there are core themes or constructs along which the approaches lie. For example the approaches differ in terms of whether difficulties are seen to result predominantly from family dynamics as opposed to societal factors, whether there is an assumption of ‘normality’ as opposed to an emphasis on diversity or whether family members are seen as self-determined as opposed to constrained by their experiences.

As trainers we know the richness of the field can often be perplexing to novices, experienced practitioners and teachers alike, so we have included with each of the three phases a series of skill guides congruent with the application of ideas and practices we describe in each phase of development in the field. We have also attempted to contextualize each developmental phase by our descriptions of the cultural landscape out of which ideas grew. Finally, in an attempt to distinguish the chronology from the lenses we, as authors use, we have a section in each of the first three chapters called Commentary, where we offer the reader our more personal reflections.
With each phase there is a story to tell so we have attempted a more factual summary early in Chapters 1, 2 and 3. To help make sense of each highly productive phase in the development of systemic and family therapy, we have also included a useful list at the end of these chapters chronicling key people and texts of each phase. Recognizing our bias in the choice of texts, we want to repeat that this book can only be our view of the landscape that is systemic and family therapy, but we have tried to offset the effects of our prejudices by pointing the reader to many recognized seminal texts and reference books with which we cannot compete.

Wishing to write a text from the British perspective, we became clearer about the particular contribution of British therapists to this field over the last 50 years. While few distinct ‘models’ of family therapy have emerged from Britain, a veritable host of creative applications and adaptations of the core systemic ideas and practices have influenced health and welfare services in Britain as well as abroad. We believe it is the capacity to creatively adapt ideas to various contexts that is most characteristic of British family therapists’ contributions to the field and, to reflect these, we have included an appendix of key British texts. As we begin a new millennium, we can honestly say, systemic therapy and practice is alive and well throughout the helping professions in Britain.

We offer this book much in the way that as therapists we offer our clients ideas, trusting some will fit and be useful or if not, will at least serve to clarify the questions you have to ask about this field. If you find this book to be like a guidebook we will be well pleased. Clearly, in many ways, the whole book consists of the authors’ reflections; while we do not dispute this, we also hope that this book offers a useful and usable description of the landscape and territory known as systemic and family therapy, that will give readers confidence as they pursue their own enquiries in this field. We are convinced that key players and contributors to the field of systemic and family therapy also contribute in a major way to the understanding of, and wider debates about, psychotherapy. Just as human beings we cannot communicate, so as systemic practitioners we cannot not pay attention to the various levels of context included in the drama of the psychotherapeutic encounter between clients and therapists. We are therefore uniquely placed in the community of psychotherapists to contribute to discussion about both the micro and macro aspects of therapeutic processes.
An Introduction to Family Therapy is a book that has been waiting to be written for some years. I congratulate the authors. It is no mean feat to write an introductory text that is thoughtful, far reaching, informative and accurate for newcomers to a field that is rich and diverse, fast changing and sometimes riven by partisan dispute.

It has been my pleasure to know both Rudi Dallos and Ros Draper for a number of years. They have both made significant and enduring contributions to the development of theory, practice and training in family therapy and systemic practice. It is no surprise then that they have written this text from a pluralist and inclusive position, which succeeds at so many levels:

- it is written for trainees in family therapy, their trainers and systemic practitioners;
- in an even-handed and non-partisan way, the text chronicles the history of the field, describing and appraising ideas and practices;
- the authors connect and link ideas through time, not seeking to ditch the past, but rather identifying what is useful and enduring in thinking and practice;
- the authors reflect the maturity of the field in their attempt to integrate theory from other social science disciplines and the arts;
- the authors offer an appraisal of the research basis for family therapy as one of the planks on which we hold ourselves accountable for our practice;
- the authors write with enthusiasm and commitment and introduce newcomers to the field to the impact of critical theory and social constructionist ideas on family therapy and systemic practice in a user-friendly way; and
- they write the text as a textbook, helping the reader to find their way around potentially complex ideas and techniques with a number of practical guides and tips.
In the UK during the 1990s we saw family therapy established as a profession, with the employment of family therapists in the public sector, and the development of family therapy training courses to practitioner doctorate level. Within the newly founded UK Academy of the Social Sciences, family therapy is recognized as an applied social science discipline. So although a relatively young discipline, it contains a richness and diversity of ideas and approaches combined with an emerging gravitas. The authors have done well to capture the main themes in the development of the field and elaborate them, without losing the overall flavour and excitement of the whole, and without falling prey to any polarizing tendencies. They have written this text for those of us teaching, learning and practising within a European context.

The authors offer the reader an orientation to the field that combines a strong respect for its history and development with an appraisal of the continuing usefulness of many of these ideas and practices. This will form the platform on which many students will launch themselves into further study and exploration within a qualifying level family therapy training. And for those who wish to complement their existing professional practice with a systemic framework in the context of systemic practice, this book offers more than an introduction: it creates the context for further enquiry and encourages a critical approach to practice.

I applaud the inclusion of separate sections on research and theories of emotion. It seems to be a reflection of the maturity of a field when integrative practice is promoted and links are sought with theories developed in other disciplines. The authors recognize that systemic theories and techniques are not always sufficient for explaining and helping family members with their dilemmas and problems. They present a clearly written integrative overview of some ideas drawn from British Object Relations theorists, from the cognitive revolution within psychology, and from Kelly's Personal Construct Theory and of how they can be linked in a complementary way with systemic ideas. They have done this in a way that will satisfy and stimulate the reader rather than overwhelm, showing how attempting to understand and explain change in complex group interactions remains a very real challenge to methodology and ethical practice.

The section on research is very welcome. As a therapist researcher myself, I value the empirical research base which promotes our practice, facilitates our creative development (including creative leaps) and enables the elaboration of our belief systems (after Kelly 1955). The authors’ approach in this section invites curiosity about the research contribution made to thinking and practice by the clinicians and academics amongst us, for the reader at the start of family therapy training, and on which a qualifying level training will build.
There is a clear and strong recognition throughout this book that learning to interview a group of people with a history of intimate emotional relationships is demanding. However, rather than daunting those eager to learn, the authors offer encouragement, wisdom and an abundance of practical advice throughout the text. Especially welcome are the skills guides, the key techniques, the topic reading lists and the formats for exploration and other appendices. This format helps the reader find their way around the text with ease.

This is an intelligently written book, located firmly within the European traditions of thinking, practice, service delivery and service development. Although written primarily for students and trainers, there is much of value here for practitioners. I expect to see this book well received within Europe. I hope to see it in translation!

_Arlene Vetere_

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I would like to thank Jacinta Evans at Open University Press for her initial enthusiasm and eventual patience about this project. I want to thank Harry Procter for his inspiration which initially led me into this field, for his wisdom and sense of fun, and for his continued validation and enthusiasm about this, and my other projects. My sincere thanks also to Arlene Vetere who has been a continual source of inspiration and enthusiasm about my work and ideas.

Of course I also want to thank Ros Draper for her perceptiveness, energy and enthusiasm throughout this project.

Thanks to my sons and my old pal Professor Graham Davey for the jokes about the progress of this book which helped to keep a smile on my face about the progress, and lack of it at times.

Finally, thanks to all the families that have provided much of the material for the book and who let me enter into their hopes, dreams and fears.

Rudi Dallos
Dedication and acknowledgements

This book is dedicated to my daughter, Sarah, whose love, generosity, aliveness and forgiveness have taught me so much about family relationships.

I will not try to acknowledge and thank everyone who deserves a mention here, rather those who come to mind as I write, trusting that anyone who feels ignored or overlooked will be forgiving.

My gratitude goes to my teachers including Margaret Robinson, John Byng Hall and Lynn Hoffman who have each in their way profoundly influenced my thinking and practice, and shared generously of their wisdom; and also to David Campbell and colleagues at The Family Institute, Cardiff with whom ideas have been developed and honed over the years.

To the families, individuals and couples who have shared their struggles and stories with me I owe an enormous debt, and to the students who have asked me questions and challenged my answers, I am most grateful for the many opportunities you provided for thinking out loud and developing ideas in simple words that make sense to you.

I do not deserve the loyalty and help I get from my secretary and friend, Sue Palfrey, and Louise Hurcombe and Cath Gray and other Family Institute staff, but I hope they know their patience and efficiency is appreciated: without it the manuscript would never have made it to the publishers.

Thank you to Rudi Dallos, my co-author, for patience and the opportunity to collaborate.

Finally, my thanks are due to Open University Press editorial, production and marketing departments for their professionalism, support and hard work in bringing the book into being. Thank you all.

Ros Draper
Family life in the West on the one hand has typically been seen as private, as a haven – yet at the same time there have been repeated attempts to explore, intervene in, direct, discipline and educate families. There have been attempts to correct the morals of the so-called ‘feckless’ or ‘irresponsible’ families, to see single-parent families as ‘welfare scroungers’ and so on. Aside from such overt attempts at shaping family life and conduct there is a proliferation of more covert and insidious influences, such as images in magazines, television and films about what is desirable and acceptable – from interior decor to children’s education and sexual practices.

These images and stereotypes have spread further to embrace not just families but also the activities of professionals in the business of bringing about change in families. Systemic and family therapy, like other therapies, has changed and developed to acknowledge that a consideration of people’s understandings and how these are related to the culture in which they live is vital. There is a growing overlap between the various models developed since the 1950s, the psychological frameworks that professionals employ, and ‘ordinary’ people’s knowledge. Most people these days have powerful ideas and expectations about what therapy will be like as well as their own explanations about what is wrong and what should change.

In this introductory chapter we will consider some voices from people who have experienced systemic and family therapy and from the therapists who have worked with them. How do people experience this process called systemic and family therapy? Is it really experienced as helpful? Do they feel that something has been done to them? How does it change their relationships with each other? Is there some kind of magical experience that means severe problems can change and disappear?
Experiences of systemic and family therapy

A family's view

What follows is an interview with the Taylor family at the end of the last of five one-hour family therapy sessions which suggests some answers to the questions above. Present were Mr and Mrs Taylor and their daughter Barbara (aged 17). The parents had separated prior to Barbara developing a severe eating disorder (anorexia). She had been an in-patient in an eating disorder unit and had taken part in family therapy towards the end of her stay in the unit.

*Interviewer:* What were your expectations of what this [family therapy] would be like?

*Mrs Taylor:* We thought it would be pretty stilted for a start and wooden and difficult to talk, and horrible long silences while everyone was staring at their feet and hoping that someone would say something and a wish not to expose the personal things, sort of . . .

*Mr Taylor:* Being analysed I think . . .

*Mrs Taylor:* Yes, wanting to curl up and hide everything rather than wanting to properly talk about it, that’s my view before we came.

*Mr Taylor:* Mine was we don’t need this. But we’ve got to go because we have been asked. I’ve softened about that since because we’ve got on well.

*Interviewer:* What about you Barbara?

*Barbara:* I thought it was a really bad idea. I thought it was going to be awful, I just wasn’t going to say anything at all. Being put on the spot and made to say things that you didn’t really want to . . .

*Interviewer:* How has the therapy been different to your expectations?

*Mrs Taylor:* I thought it was much easier to talk. I was much more relaxed, I was quite surprised and impressed about how easy it was to talk. We all talked, particularly Harry [Mr Taylor], he doesn’t like talking. I’ve been impressed how my family, we’ve all talked together, talked about things much easier than at home, possibly because you’re the adjudicator and perhaps triggered off questions that would have been difficult to get round to in a sensible way in a more intense claustrophobic atmosphere at home when we are getting wound up about talking about things.

*Interviewer:* Barbara?
Barbara: [laughing] I don’t know. Mum sort of said it all. Yes, it’s been a lot easier here I think.

Interviewer: [to Mr Taylor] How’s it been different to what your expectations were?

Mr Taylor: I didn’t feel that you were analysing us. It just felt like a discussion which felt like a relief I suppose . . .

The extract suggests that the Taylor family held a variety of powerful expectations regarding what the experience of family therapy was going to be like. Some of these seem to resonate with general conceptions of therapy based on the popular views of psychoanalytic therapies, for example that the experience would be emotionally painful and embarrassing.

The family goes on to discuss what they found particularly helpful and unhelpful during the course of their therapy:

Interviewer: If you were to put your finger on it what would you say would be the most useful part of what you experienced? And the other side of it, what was the least useful?

Mrs Taylor: I thought what was most useful was hearing Barbara talking about things . . . to hear what was going on in her head . . . can’t think of anything that was not useful . . .

Barbara: Yeah, getting my point of view across rather than getting into an argument.

Mrs Taylor: I thought these cameras and the two-way mirror would be a bit off-putting but in fact it hasn’t bothered me at all . . .

Interviewer: Could you focus on anything that strikes you as a turning-point or a critical moment in the sessions?

Mrs Taylor: Yeah I can, when Barbara first put her point of view . . .

Mr Taylor: She criticized us [laughter].

Mrs Taylor: Yeah and it’s the first time I got an insight into what she was thinking, and it was a big surprise because she was talking in front of you . . .

Barbara: What was I saying? I can’t remember.

Mr Taylor: You were saying that I was making you nervous, talking about you eating, not eating enough . . .

Mrs Taylor: A particular example of how . . .

Mr Taylor: That’s right I’d done something . . .

Mrs Taylor: Focusing on something we had a go at her about.

Interviewer: It was about not having milk in her cereal?

Barbara: It was because you [Mr Taylor] had only full-fat milk and I watered it down and you said something like . . .
An introduction to family therapy

Mr Taylor: A sarcastic comment . . .
Barbara: Yeah . . .
Mrs Taylor: And I’d given you an evil look . . .
Interviewer: Do you have a main memory [of the sessions] Barbara?
Barbara: I suppose it was that as well because I was thinking about that a lot and I wasn’t going to say anything but perhaps it made me angry in some ways . . . it felt good, I said what I meant . . .
Mrs Taylor: We had to listen to you and take you seriously.
Barbara: Yeah I thought you would say I was being stupid or something . . .
Mr Taylor: It’s pretty rare that you criticize us.
Mrs Taylor: No it’s not, you do me . . .
Barbara: Yeah, I do it quite a lot.
Mrs Taylor: More and more . . . [laughter]

For the Taylor family the initial prospect of family therapy was clearly quite threatening and anxiety provoking.

Two therapists’ views

For therapists too the experience of working with a family embraces a variety of expectations and feelings ranging from apprehension to excitement, competence and impotence at the prospect of being able to assist with what at times appears to be insurmountable mountains of distress. The following is one therapist’s description of his experience of family therapy:

The first meeting with a family is often tinged with a sense of apprehension similar in some ways to other important personal meetings. In some ways it reminds me of the dual feelings of anticipation and apprehension of going to a party or meeting a new group of students, where I will meet strangers who I may in time become close to, or even good friends with. Your thoughts turn over questions, will we get on? will we be able to connect? will I be competent? My feelings also tend to alternate between a pressure that I should be an ‘expert’ and need to take charge, to make things happen and alternatively an attempt to reassure myself that it is not my role to do that, things don’t work that way.

I still feel an enduring enthusiasm and excitement about meeting families and a sense of privilege of being allowed into their personal world. Even after 16 years of working with families I find myself being surprised at the diversity, complexity and uniqueness of the ways they live their lives. I think of families
through a metaphor of a snowflake – every snowflake has some structures and elements in common in terms of its physical properties but each also has a unique structure. Working with families I am looking for the patterns that they share but also for the creativity and uniqueness.

Perhaps one of the overriding impressions I have about family therapy is that I anticipate that early on I may feel engulfed, confused, overwhelmed and sometimes even despairing that I can help to ease the anger, frustration, pain and suffering they are typically in. However, I now have an expectation that eventually a sense of connection and empathy emerges when I start to gain an insight into how family members see things: their beliefs, understandings, hopes and dreams. From this I then start to be able to understand why they are acting as they are – how these beliefs shape their dynamics and patterns. I can then start to see their actions in a more positive and sympathetic light.

I think families start to pick this up and together, between us, a sense of optimism starts to take over. Usually this also includes an ability to be able to start to joke and tease each other, to be able to play with different ways of looking at things. I think it’s rare that from this point of connection that things don’t usually develop positively. When this starts to happen for me it’s one of the most positive and worthwhile experiences I can have.

Another therapist’s view of her experience of family therapy goes like this:

These days the anticipation and apprehension of a first meeting with a family includes curiosity about how the impressions I have formed from the referral process will fit or not with the experience of meeting family members in the flesh. It never ceases to amaze me how different people can be from my imaginings. There is a tension in first meetings which for me is focused on whether or not we can find a way to talk that seems useful to the family. Can I interest them in the way I am talking and thinking about what they are so generously willing to share with a stranger? Conveying respect and appreciation of the courage it takes to come and talk with a stranger about troubling personal issues is important.

For a therapeutic relationship to develop there has, in my view, to be some shared meanings and beliefs about the distresses leading people to seek therapy, and creating these shared ideas is the risky and exciting part of therapy. Can I offer ideas to family members in a way that makes sense or creates a space in which family members can risk exploring new ideas and thinking out loud with one another? I see my job as finding ways that work for family members to speak what may have become unspeakable and to
somehow convey that it is safe enough to go together into uncharted and unsafe territory. The territory is uncharted for all of us and does produce butterflies in the stomach. The satisfaction and excitement of working with families comes from the moments when family members realize it is possible for things to change and convey feelings more empowered and less daunted by the work this will take. I hear this less often in words and more often in changes in body language and the emotional atmosphere becoming lighter with less seriousness. In trying to sum up what I believe I hope for as the essence of a therapeutic encounter, I would see it as a meeting from which new connections and meanings emerge for both therapist and family members so that all are left at the end with a sense of ‘something potentially good having happened’.

In these accounts from families and therapists we can hear both their internal voices – their personal beliefs and views of themselves and the world – and also the common or shared voices of the culture in which they live. We might even argue that it is impossible to separate these; that the personal and the public are invariably intertwined. To be a person, a part of a relationship, a member of a family, involves being bound by a wide variety of meanings shared by our cultures. In particular we all have some ideas about what it is to be emotionally ‘healthy’, what it is to have ‘good’ relationships, what is a ‘functional’ as opposed to a ‘dysfunctional’ family. These values tend to be represented in a variety of images in advertising, books, films and in our everyday conversations. Even though we may not agree with some of the common values, or even hold that these are relative and pernicious, we will still be influenced by them in setting out the territory of our thinking – our contrasts or points of opposition for which these common values provide an anchor.

What is the ‘family’?

As this book is about families and relationships, it is necessary to offer an overview or map of what the term ‘family’ may be seen to include. There have been great upheavals and changes in what is meant by the family and family life. In many western countries, for example in the UK, over 40 per cent of new marriages end in divorce. Many people choose not to marry and there are increasing variations, such as single-parent families and homosexual families. Also, there is greater diversity in people’s expectations such that men no longer are expected to be the sole or main breadwinners and there are expectations about greater sharing of domestic roles, such as childcare. Arguably some of
these changes are less extensive than might be assumed, for example women, even if they work outside of the home still tend to take on the bulk of domestic duties as well (Muncie et al. 1997). It is easy to assume that in some ways the family is in ‘crisis’, which is also seen as a fundamental threat to the stability of society. However, it is important to note, for example, that due predominantly to death at childbirth, stepfamilies were as common historically as might be indicated in the many negative images of ‘wicked stepparents’ in folklore. So though there have been changes, the voices of concern can be seen not just as responding to these changes, but also as attempting to institute or encourage a particular form of family life and values (Robinson 1991). Arguably some of these traditional values, stressing domestic duties, passivity and duties to be responsible for providing care of children and ageing relatives have not been in the best interests of women (Perelberg and Miller 1990; Muncie et al. 1997).

What we take to be ‘the family’ and ‘family life’ is influenced by the ideologies and discourses inherent in the society in which we live at a particular historical point. An analysis at the level of society and culture suggests that ‘family life’ is shaped by dominant ideologies or discourses about what family life should be like. We can see families as reproducing themselves, both literally and ideologically. For example, though the roles of men and women in families and other living arrangements has changed significantly in the last 30 years, by and large women still take most of the responsibility for childcare, men are expected to be the main breadwinners and most of us (in western cultures) live for the majority of our lives in an arrangement not too dissimilar from a nuclear family. Above all, for many of us the image of the nuclear family still governs our behaviours, expectations and feelings. We may be ‘for’ or ‘against’ the nuclear family, but either way it has, until recently at least, set the agenda of our thinking, feeling and choices.

Yet, within western (and other) societies there is clearly a diversity of ways that people choose to live together. Some of these choices are variations on the nuclear family model, others are deliberate and explicit attempts to reject it, such as communal and some single-parent relationships. If we accept that many people make such choices the question remains of how people go about constructing their own varieties of ‘family life’. How do they decide how ‘normal’, as opposed to how ‘deviant’ they will be? To take a conventional example, a heterosexual couple need to decide when or whether to marry, whether to have children and if so how many, how to divide up the family tasks such as childcare, when a child should leave home, whether the couple should divorce, whether they should marry again, how they should relate to any stepchildren they might have and so on.

Above all, these decisions suggest the possibility that families do not simply absorb ideologies and discourses but translate them within
their own ‘family culture’ and the traditions and current dynamics in their own families. Between society and the individual is a set of shared premises, explanations and expectations – in short, a family’s own belief system. Metaphorically this can be represented as a deck of cards offering a range of options from which particular choices can be made. These options are derived mainly from personal experiences, family traditions and societal discourses. Continuing the metaphor, each family has its own unique set of ‘cards’ which serves to constrain their perceived options and consequently the choices they make: family members make choices, but not simply in circumstances of their own choosing.

Our ‘windows’ or accounts from families and therapists can be seen to capture two aspects of family life which at first sight might appear contradictory: on the one hand people do appear to make autonomous decisions about their lives; on the other hand family life can be seen to be characterized by repetitive, predictable patterns of actions. Families are inevitably faced with various tasks – difficulties and problems which they have to find ways of managing. These tasks alter as they proceed through their developmental cycle.

**The family life cycle**

To capture this notion of a changing, evolving process, the concept of the family life cycle (Haley 1973; Duvall 1977; Carter and McGoldrick 1980) was developed in order to chart some of the major changes or transitions that family life presents, such as the birth of children, children leaving home and bereavements. (The family life cycle will be described further in Chapters 1 and 2.) It is argued that families need to continually adapt and adjust to deal with these tasks, but particularly at these critical transitional points. Each family is seen as developing ways of dealing with the tasks facing them – attempted solutions. In turn the choices they make, their attempted solutions, are shaped by the beliefs they hold as individuals, as a family and those they hold in common with wider society. The recursive combination of tasks, attempted solutions, outcomes and beliefs constitutes the family system.

It is possible to see a family evolving and changing as it proceeds through the life cycle as needing to develop and negotiate its way through three distinct but interconnected areas:

1. *the social, cultural and spiritual* – what is perceived as acceptable and desirable in any given society, including traditions, local customs, rituals, mores, legal framework, organization of work and the economy of a group;
Introduction

2 the familial – how people in families jointly negotiate decisions; this is based partly on the internalizations of the cultural discourses and partly on their joint evolution of a set of shared beliefs;

3 the personal – each family member has a more or less unique set of personal beliefs. For the parents this may emanate from accumulated experiences prior to forming a family; for all members the personal beliefs also develop as a result of contacts outside the family.

Each family or grouping can be seen as creating, usually from an initial coupling of two people who may become parents of children and later grandparents, a unique interpersonal system. This becomes a family – a system of meanings and actions, encapsulating a version of family life which develops from the amalgamation of its members’ negotiations and choices based upon their personal and shared beliefs and histories. Though this process is creative, involves a variety of complex issues and is widely thought of as unique, there are some fundamental themes common to any social grouping: external and internal relationships.

In the main external relationships are the connections to the ‘outside’ world. A key aspect of this is the development of a family identity. Members develop a set of perspectives, beliefs about themselves as a ‘family’ and what kind of a family they are: close/distant, argumentative/harmonious, formal/informal, traditional/modern and so on. Families also need to establish ways of interacting with a variety of other systems, such as schools, workplaces, local community, neighbours, friends, in-laws and extended family. Families vary in the beliefs they have about boundaries: some believe that a rigid separation is required, stressing family privacy and self-determination; others believe in a looser, more permeable boundary, with easy access, an ‘open house’.

Family identities are not simply constructed by families but in some cases rigid definitions may be imposed, as in ethnic minority families or those containing members who have a ‘disability’, such as mental health problems or learning disabilities.

As well as functioning in relation to the external or outside world, a family defines itself by various internal relationships:

1 power, intimacy and boundaries – while family life is complex and varied, these three key issues continuously surface and require families to develop a set of beliefs enabling rules and procedures to be formed (Minuchin 1974; Haley 1976a; Dallos and Procter 1984). The issue of power requires the development of beliefs about responsibilities, decision making, duties, obligations and commitments. The issue of boundaries includes beliefs about personal space and privacy – the boundaries of the self vs shared activity in the family. The issue of intimacy embraces a complex array of psychological
emotional tasks and needs that have to be met, such as affection, sympathy, support, sexual intimacy and so on;

2 rules and tasks – in order to function, a family or any other social grouping has to establish some ground rules and to develop some organization so that the basic physical and material necessities are met;

3 gender – cutting across these dimensions of family life there is the central issue of gender roles and expectations. The development of gender-specific roles, division of labour, identity, patterning of activity and so on, will be affected by how the issue of gender is negotiated.

These areas of family life – the internal private world and the interface with the wider community – will in turn be influenced by dominant ideologies and discourses. For example, the division of responsibilities within a family is guided by prevailing discourses about appropriate gender roles so that, until recently at least, boys grew up believing that their role in families would be as providers and major decision makers; and girls that they would be mothers and run the domestic arrangements.

More broadly, families are also expected to undertake certain duties, such as the ‘appropriate’ socialization of children. Similarly, the recurring public panics about the family being in crisis and moral decline, falling apart, not shouldering its responsibilities and so on, are likely to be absorbed by family members and further regulate a family’s internal activities and external relations. Each family develops a set of beliefs governing the boundary between its private, internal world and that of a public, external one. Some families, for example, appear to hold the beliefs that whatever happens under their roof is essentially private and should be free from outside interference, while others expect, and even invite, outsiders to help manage their affairs or are keen to interact with other families and the local community.

Allowing the family a voice

The beginnings of family therapy, like many histories, took place not in a linear way but in spirals. As an example, we have started this chapter with the voices of some families and therapists, their experiences of family therapy. In one sense this helps to capture the moment in hopefully offering a sense of where systemic and family therapy is now and where it may be heading. Families, however we attempt to define them, are made up of people intimately involved with each other. Each member of a family has their own personal story of their joint journey together and the web of stories, their intersection and weaving together constitute family life.
Many therapists currently emphasize that it is essential that we respect and allow families to voice their stories. To offer analyses, generalizations and statistical descriptions without offering the family a voice simply imposes our beliefs as therapists in a disrespectful way. We will have much more to say about all this throughout the book.

It is salutary to note, however, that despite many critiques of early family therapy approaches early writings were widely illustrated by rich transcripts of conversations with families. Minuchin, the founder of the structural school of family therapy, for example starts his seminal book with this conversation:

Minuchin: What is the problem? So who wants to start?
Mr Smith: I think it’s my problem. I’m the one that has the problem . . .
Minuchin: Don’t be so sure. Never be so sure.
Mr Smith: Well . . . I’m the one that was in hospital and every-
thing.
Minuchin: Yeah, that doesn’t, still, tell me it is your problem. Okay, go ahead. What is your problem?
Mr Smith: Just nervous, upset all the time . . . seem to be never relaxed . . . I get uptight, and I asked them to put me in the hospital . . .

(1974: 1)

You may have various thoughts about this short extract; perhaps Minuchin seems somewhat patronizing? Maybe he seems to be too challenging to the family’s preferred story? Is he being too charismatic and leaping in before even having collected the barest clinical history? Whatever we may think, however, his work here is open to scrutiny. It offers us a chance to make up our own minds about what is going on, what meanings are being explored, what Minuchin is up to.

Many years ago when we first encountered systemic and family therapy, this visibility and presentation of verbatim material was a breath of fresh air compared to stuffy statistically driven papers, or, slightly better, dead case study accounts from the therapists of their version of what had occurred in therapy. So even the early writings can still feel refreshing and vibrant.

There has also been much change afoot in family therapy. Families’ voices have moved centre stage such that some therapists regard therapy as essentially the process of conversing, of engaging in storytelling and making. Minuchin would not have described his approach as mainly this. We do not want to fudge changes and evolutionary steps in family therapy’s history but neither do we want to miss the opportunity to point out that some of the exciting new territories that have been discovered, and are now on the edge of the map, also resemble some of the impressive earlier ones.
We propose the use of a three-phase framework which can help to clarify both the differences and also the connections between various models and perspectives. Specifically, we suggest that the distinction drawn between first- and second-order cybernetics can be misleading, particularly in that it fails to draw attention to the important and radically different propositions contained within social constructionism and constructivism. Social constructionist ideas emphasize processes whereby choice in families is constructed and constrained by inequalities of power and culturally shared discourses. This contrasts sharply with constructivist views that emphasize individual uniqueness, freedom and autonomy. We suggest that recognition and articulation of these differences can be a step towards developing ways of integrating perspectives as opposed to unnecessary abandonment of useful ideas from the three phases of systemic thinking.

Our organizing framework of first, second and third phases provides a structure that offers the reader both advantages and disadvantages. On the positive side it helps in organizing and simplifying complex subjects and issues, making them more manageable and comprehensible. Thinking is very much concerned with organizing our experiences into conceptualizations and narratives of various sorts. On the negative side the organization may distract us from and make invisible the complexities and potential contradictions in our knowledge and experience. It is useful to consider Korzybski’s (1942) famous phrase, ‘the map is not the territory’. Our organization is more or less helpful, but it is not reality itself. Arguably we may never be able to objectively establish that there is a ‘real’ reality out there.

Early family therapy approaches (first phase in this book, mid-1950s to mid-1970s) are located in what has been called ‘modernity’ – the dominant twentieth-century view that the processes of science would enable us to form accurate theoretical, predictive models of the world. Included in this was the view that psychology could and should be science based, on the collection of objective evidence through rigorous observation and experimentation. In effect this represented the methods applied in the natural sciences, and which had appeared so successful in delivering a variety of technological benefits. In family therapy examples of this perspective were early attempts to systematically explore and classify families according to a number of variables and types in order, for example, to establish what characteristic dynamics caused schizophrenia, anorexia or depression in one or more family members (Wynne et al. 1958; Kantor and Lehr 1975; Doane 1978; Wynne 1988).

Similarly attempts were made to establish what kinds of treatments were most suited to dealing with different types of disorders (Gurman
and Kniskern 1978). Though research outcome and evaluation has not been a strong feature of the development of family therapy many of the assumptions of a scientific–modernist approach were evident in the early studies of the family. For example, that organizational features of a family, such as an ineffective parental executive subsystem (inability of the parents to work together to control the children) could be objectively identified and steps taken to remedy this.

As research and therapy progressed, however, it became increasingly evident that such objective descriptions of families were problematic, not least because different observers tended to perceive a family in different ways. It also became apparent that contrasting ways of working with families could produce equally impressive positive changes. Eventually this led to a shift in family therapy and more broadly in psychology and the social sciences to a postmodern (Papp 1980; Keeney 1983; Hoffman 1993) or constructivist view of the world (second phase in this book). Briefly this questions the possibility of an objective view of the world and suggests instead that our perceptions of reality are invariably diverse and contested. We can argue that there is a ‘real’ reality out there but we can only know it through our personal lenses.

Consequently this has led to a distinction being made in systemic and family therapy between approaches based on first-order cybernetics and those based on second-order cybernetics, which mirrors the shifts in beliefs from a modern to a postmodern epistemology.

Specifically this represents the move from initially applying an objective, positivist framework to families which believed that through observation and analysis we could come to accurately and reliably map their dynamics. It became increasingly evident that when different therapists and researchers viewed a family their perceptions were frequently quite different. Furthermore, often their interpretations contrasted starkly with the families’ own perceptions. This led to what has come to be called second-order cybernetics, namely the view that reality invariably involves a construction, occurs in relationships and is based on feedback. There is not one accurate view of reality but invariably differing perceptions and constructions. These might be called different hypotheses about reality.

The strong version of this view is embodied in Maturana’s (1978) concept of structural determinism, which states that the organization of our brain largely determines what we are capable of seeing. We do not simply perceive reality out there but actively construct it. Tom Andersen (1990: 39) offers an elegant metaphor:

The brain is constantly in action and influences from the sense organs only modify an already ongoing process in the brain. It has been compared with a room crowded with talking people. If a person from outside opens the door and speaks, the speaking is analogous to the influence of the sense organs. The ongoing activity
in the room is changed only to a small extent by the talking from the door.

It is our contention that it is helpful to identify a third phase of development in systemic and family therapy. This emerges from social constructionist theory which suggests that language is a critical ingredient in family life and dynamics. The constructions of reality that family members form can be seen as both unique and diverse in detail but are also constructed from the material, the building blocks that are shared in any given culture or society. Language can be seen to contain these materials, a shared currency of meanings. To take a simple example, until recently gendered language, for example chairman, housewife, the use of Mrs or Miss to denote marital status, was largely accepted without question as a convention. Racial examples can be seen in the unquestioned use of terms like ‘primitive societies’ in contrast to western ‘civilized’ societies. In clinical areas there was the unquestioned use of terms like neurotic, hysterical, mad or even the apparently benign term ‘mental health’, which contain assumptions about the nature of distressing experiences, such as these being like an illness, due to personal weakness and lack of will. A social constructionist analysis, however, reveals these terms to be powerful constructions that become established as natural, self-evident truths and which unquestioningly come to shape our thinking, expectations, gender roles – in short help to construct family life. Most importantly it is suggested that such concepts help to maintain a variety of inequalities of power, such as women’s subjugation by men, oppression of ethnic minorities and of those experiencing forms of mental distress.

This book, like any other textbook, is a punctuation in time and therefore at this point in what we are calling the third phase (mid-1980s to the turn of the millennium) there are more questions emerging about the relationship between systemic and family therapy and other psychotherapies, and specifically whether the differences between the intrapsychic and interpersonal need to be so rigidly held. Perhaps as we come to the end of the second millennium it is an appropriate moment to talk both about similarities and differences in a field of psychotherapy that is undoubtedly different and distinctive due to the skills and conceptual framework required to usefully converse with more than one person at a time.

At the end of Chapters 1, 2 and 3, we have included a selection of skill guides. The selection reflects our views of what we find useful in our current practice as systemic and family therapists and teachers, as well as skills that seem to us to be enduringly relevant in the field. We hope the skill guides will provide a starting point for new practitioners in the field and do not believe the lists are in any way exhaustive. The skills we have included however are representative of the field and will be taught in most systemic and family therapy training courses.
For the sake of coherence we introduce each skill guide by describing the background to the skill, offer some ideas about relevance and usefulness and then describe an exercise that will help the practitioner become familiar with and integrate the skill into their repertoire. In order to be able to develop skills for systemic practice, all skills need, in our view, to be experienced by practitioners being, for example, the subject of their own personal genogram or family sculpt or of an enquiry about their family relationship based on circular questioning. Therefore the skill guides we list are for use both in training therapists and therapy with clients. Trainees and therapists alike will be able to make relevant adaptations so that each skill most appropriately fits the context in which it is being used. We do not, in this book, describe many possible adaptations but offer references for further reading as required.

Chapter 4 centres on the emotional aspects of family and though central to family therapy, this has produced less in the way of specific techniques. We offer a skill guide based around the use of a family genogram to facilitate a mapping of emotions and traditions of attachments which we have found a helpful approach. In Chapter 5 there are no specific skill guides but instead this consists of a series of descriptions of important and hopefully stimulating examples of different research paradigms that have been employed.

Rather than Chapter 6 being an endpoint, we see it as yet another punctuation and, in it, offer some of our thoughts about where the field is now and where it could go. We take license to do some crystal-ball gazing.

There are three final sections which we hope will help readers recognize the usefulness and diversity of the field of systemic and family therapy and provide further resource for teachers and trainees alike. There are topic-specific reading lists (that are included thanks to The Family Institute, Cardiff, Wales, where they were created), guides to such things as first and last sessions in therapy, which we have called Formats for Explorations, as they are our adaptation of core systemic ideas to our practice and therapy not specific skills associated with a particular model and concept. The third and final section is a glossary of terms used throughout the book.
An introduction to family therapy


The first phase – 1950s to mid-1970s

Cultural landscape

Appropriately for a psychotherapy based on ideas that the whole is greater than the sum of its parts, there were a range of developments in psychology, communications, psychotherapy and elsewhere which prompted the development of systemic theory and therapy and no one person or event can be credited as its author. Some of these developments were:

• dissatisfactions with the effectiveness of psychoanalytic and other individual therapies, especially in relation to severe clinical problems such as schizophrenia;
• the emergence of general systems theory as a model and its application to research on human interaction;
• research into the role of communication in the development and maintenance of severe intractable clinical problems such as schizophrenia;
• the evolving practice of child and marital guidance which brought parts of families together and started to shift the exclusive emphasis from individual treatments;
• the development of group psychotherapies which revealed the powerful therapeutic impact of bringing people together to communicate about their difficulties;
• indications that psychoanalytic approaches could even lead to an escalation of the problems. Jackson (1957) for example, described how working in a psychoanalytic way with a woman on her own, resulted in the deterioration and eventual suicide of her husband, leaving the woman in a considerably more distressed state than at the start of therapy;
Influential people and ideas

Seeds of systemic and family therapy

Early systemic ideas appeared to have developed and evolved along two pathways. The start of systems theory and cybernetics – a term coined by Norbert Weiner (1961) from the Greek word for steersman – dates back to the Macy conferences in New York in the 1940s, which were attended by scientists, engineers, mathematicians and social scientists with a strong interest in communication and control. The interests were partly driven by military applications in the Second World War and centred on the development of guidance systems for targeting missiles and rockets. A key notion was the principle of feedback – how information could loop back into a system in order to enable control in the form of adjustments to be made. A system was seen as able to maintain its stability through a process of self-regulation by using information about past performance, and specifically how this deviated from the desired or optimal setting to make corrections. This not only offered some important practical applications but was also an important philosophical leap in explanations of causation. Rather than seeing events in linear sequences, cybernetics proposed that causation was a continuous circular process taking place over time. This offered a dynamic rather than static model of the world.

These early ideas appeared to develop along two related but different pathways. The first path was a mechanistic one in which cybernetic ideas were employed to design various forms of mechanical control systems. A simple example is a central heating system, a
Early family theorists, researchers and therapists focused in the 1950s on the study of schizophrenia in the context of family relationships. The intellectual soil out of which this work grew can be traced to the Josiah Macy Foundation Conferences in the 1940s, at which leading scientists, engineers, mathematicians and social scientists of the time explored issues of communication and control.

Ludwig von Bertalanffy, a biologist, proposed a general systems theory as an attempt to develop a coherent theoretical model which would have relevance to all living systems. He believed that the whole is greater than the sum of its parts and in order to understand how an organism works we must study the transactional processes occurring between the components of the system and notice emerging patterns and the organized relationships between the parts.

Norbert Weiner, a mathematician, coined the term cybernetics and was especially interested in information processing and the part feedback mechanisms play in controlling and regulating both simple and complex systems. For Wiener, cybernetics represented the science of communication and control in humans as well as in machines.

William Buckley, a social scientist, proposed that human relationships could be seen as analogous to a ‘system’ in that groups of families could be viewed as a set of a network of components (people) which were inter-related over time in a more or less stable way.

Another influential author was Korzybski, who in 1942 published Science and Sanity: An Introduction to Non-Aristotelian Systems and General Semantics. His now famous phrase, ‘the map is not the territory’ was used by Gregory Bateson as he developed ideas of the importance of both content and process in human communication.

Gregory Bateson, an English-born anthropologist and ethnologist, recognized the application of these mathematical, engineering and biological concepts to the social and behavioural sciences and introduced the notion that a family could be viewed as a cybernetic system, particularly since by assuming social systems, like physical and mechanical systems, were rule governed, both the uniformity and variability of human behaviour could be accounted for. Although the family was only one of many different types of natural system that interested Bateson, he is credited as providing the intellectual foundation for the field because of his ideas and studies of patterns and communication.

In 1952 Jay Haley and John Weakland joined Gregory Bateson to study (with a Rockefeller Foundation Grant) patterns and paradoxes in human and animal communication.
In 1954 Don Jackson joined their research team and (with a Macy Foundation Grant) they studied schizophrenic communication patterns and in 1956 published the seminal text ‘Towards a theory of schizophrenia’ (Bateson et al. 1956). He was also the first to formally and elegantly articulate the model of families as operating in an analogous way to homeostatic biological systems in his paper ‘The question of family homeostasis’ (Jackson 1957).

In the late 1950s other now well known family therapy pioneers were studying schizophrenia: Carl Whitaker in Tennessee was developing with colleagues a psychotherapy of chronic schizophrenic patients. Lyman Wynne and colleagues were developing ideas about pseudo-mutuality in the family relationships of schizophrenics. Murray Bowen in Washington proposed an approach to schizophrenic families based on an idea of emotional divorce between members. Theodore Lidz in Baltimore was looking at ‘marital schism’ and schizophrenia. Ronald Laing in England was proposing schizophrenic family members were the most sane members of a family system. Ivan Boszomenyi-Nagy in Philadelphia (newly emigrated from Hungary) was also researching into schizophrenia.

In Massachusetts, New York and London respectively, John Bell, Nathan Ackerman and John Bowlby were working with families who had problems other than a schizophrenic family member.

The end of the decade saw Don Jackson found the Mental Research Institute (MRI) in Palo Alto (1959). Nathan Ackerman created the Family Institute in New York in 1960 (renamed the Ackerman Institute after his death in 1970).

By the end of the 1960s Virginia Satir at MRI was recognized as a pioneer in the field with her ‘unshakable conviction about people’s potential for growth and the respectful role helpers needed to assume in the process of change’ (Simon 1992).

Salvador Minuchin et al. had published Families of the Slums (1967) and Minuchin become director of the Philadelphia Child Guidance Clinic. Jay Haley worked there with him from 1967. The Brief Therapy Project was begun in 1967 at MRI, and Don Jackson died suddenly in 1968.

In Europe, Robin Skynner was creating the Institute of Family Therapy in London and a systems group was developed in the Department of Children and Parents at the Tavistock Clinic, London. In 1969 Sue Walrond Skinner founded the Family Institute in Cardiff, Wales. Mara Selvini Palazzoli had begun with colleagues in Italy to look beyond psychoanalysis for a model to work with anorexic and schizophrenic patients and their families. Helm Stierlin in Germany was looking at ‘the family as the patient’.

This phase saw in the early 1970s, distinct schools of family therapy emerge: structural (Minuchin); strategic (Haley and Madanes); communication and validation (Satir); existential (Whitaker); family of origin (Framo and Bowen) and more – all of which supported the interventionist role of the therapist.
The first phase – 1950s to mid-1970s

more complex one a rocket guidance system. In its emphasis on the interpersonal nature of problems, first-order cybernetics presented a profound and significant challenge to the existing psychiatric orthodoxy. This challenge held sympathies with the emerging anti-psychiatry movement in the 1960s which voiced extensive critiques of the oppressive nature of the practices of confinement, medication and isolation of those suffering mental distress. In sympathy with anti-psychiatry, it was argued that organic illness models of problems were essentially misguided. A view of problems as interpersonal suggests, for example, that medication should at most be a temporary measure. The systemic view of problems was liberating not only for members of families who were displaying the problems but also for the therapist, as the practice of family therapy promised to offer support and relief for other members. However, this revolution was not without its critics, and there was considerable reluctance to abandon some practices, especially the use of medication for ‘serious mental health’ problems.

The second path or strand of development was in the application of systems theory concepts to biological systems. Walter Cannon (1932) had earlier suggested the concept of dynamic equilibrium to explain how the body is capable of maintaining steady states despite external changes. For example, despite large changes in external temperature we are capable of maintaining body temperature very close to 98.6°F (37°C). Similarly the body is able to maintain an optimal level of blood sugar, light into the eyes, arousal of the central nervous system, balance of various hormones and so on. However, though biological systems can be described in similar ways to mechanical systems it is important to note some differences and confusions about these that have plagued early systems theory thinking in family therapy. In fact it is possible that the elegantly simple mechanical metaphor used in early discussion, such as a central heating system, subsequently caused an oversimplistic view of families:

1 biological systems, unlike mechanical ones, are not artificial but are designed through processes of natural selection. Hence they have evolved within and in response to the demands of the external environment in which they are located;
2 biological systems are fantastically complex and basically we have at best an approximate idea of how they work. It is only possible to develop approximate explanations which have the status of inferences, not absolute knowledge;
3 biological systems have the capacity to evolve and change. This can be in the short term in that systems can make adaptations, for example we can acclimatize to colder or warmer climates. In the long term through natural selection more fundamental adaptations may be made;
4 biological systems have a developmental process and history and the environment impacts on the basic design or phenotype to influence the development of the system;

5 in mechanical systems the patterns displayed are determined by the designer; in biological systems we do not determine the patterns but merely observe them. This observation in itself is an active process and different observers may see different patterns, for example at different levels of the biological system – its behaviour, overall macroscopic structure, microscopic structure, chemical and electrical activity and so on.

It is possible to list further differences but these point to some important issues, perhaps one of the most fundamental being that mechanical systems are fully determined and predictable, whereas with biological systems we can only develop hypotheses or inferences. Put simply, human and biological systems are infinitely complex.

The seeds for the evolution of systemic and family therapy probably germinated simultaneously but at first relatively independently in a number of different settings. Significantly though, the emergence of family therapy, its guiding theories and practice, was rooted in research. The failure of psychoanalytic and other psychological treatments for serious conditions, such as schizophrenia, led to funding for research into its causation. In turn this research suggested that communication played a strong role in its aetiology and this led to explorations in therapy with families to provide further research data (Lidz et al. 1957; Wynne et al. 1958; Haley 1962; Bateson 1972). Initially the process of family therapy was in itself seen as a form of research and as providing a rich vein of new and significantly different type of interactional evidence.

There is a story that the development of the first attempts at family therapy resulted from a misunderstanding. John Bell, one of the unsung pioneers of family therapy, is said to have overheard a casual remark while visiting the Tavistock Clinic in London in 1951 that John Bowlby (1969), a prominent psychoanalyst and researcher into childhood emotional attachment, was experimenting with group therapy with entire families. Bell assumed from this that Bowlby was undertaking therapy with families regularly and when he returned to the USA this idea inspired him to develop methods for working therapeutically on a regular basis with entire families. In fact Bowlby only occasionally held a family conference as an adjunct to individual therapy with the ‘problem child’.

Bell started his ‘family therapy’ in the early 1950s but possibly due to being relatively non-ambitious and modest did not publish a description of his work until 10 years later (Bell 1961). This story also indicates the central position that an exploration of communication came to occupy in family therapy. It also suggests, though this has been less emphasized, that even misunderstandings can have creative effects.
Systemic thinking – from intrapsychic to interpersonal

One of the most enduring contributions of systemic thinking has been to offer a view of problems and ‘pathology’ as fundamentally interpersonal as opposed to individual. Systems theory offered both a compassionate view of individual experience but also a reductionist and possibly mechanistic one. Regarding symptoms as interpersonal helped to liberate individuals from the oppressive and pathologizing frameworks that had predominated. Particularly for children and other disempowered family members, it offered a lifeline from the double abuse of being oppressed by the family dynamics and simultaneously being stigmatized for the consequences experienced.

More broadly the view of individual experience shared with other theories, such as symbolic interactionism, emphasized the centrality of relationships, communication and interaction for the development of identity and experience. Furthermore, it suggested that identity, personality, the self is malleable; individual experience was continually being shaped. People are not prisoners of their pasts, as psychodynamic and to some extent behavioural theories had implied. Systemic thinking suggests that as family dynamics change, so individual identity and experience can change alongside it.

Certainly early theorists were not blind to the importance of individual experiences of family members, but nevertheless such individual experience took a back seat in theory and clinical formulations. Each family member’s identity and experience appeared to be determined by their part in the pattern and as a consequence this led to some confusion around the question of individual autonomy and responsibility.

The spotlight of problem explanation moved from the narrow beam that had focused on the individual, to a broader one which illuminated the rest of the cast. Eventually it became clear that this spotlight needed to be extended further to consider who was holding the spotlight and where and why the play was being staged. This shift was a profound one and shook the psychiatric establishment to its roots, as well as much of psychology and other person-centred sciences. Problems and ‘pathology’ which had hitherto been regarded as individual phenomena came to be viewed as resulting from interpersonal processes.

Early formulations promoted the idea of functionalism, which had also gained ground in behavioural theories of pathology. This rested on the idea that problems could only arise and survive if they offered some forms of gain for members of the family. Work with children provided some of the clearest illustrations and applications of a systemic model. It was suggested, for example, that a child’s problems might have developed from her response to her parents’ escalating quarrels, for example by her becoming upset or ill. Eventually these actions would function to distract the parents from their own conflicts to show
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concern over the child. If this process continued for some time the family might come to, in a sense, ‘need’ the child to be ill or deviant in order to continue to distract or detour the conflicts between the parents (see conflict detouring page 28). Such an analysis came to play a central part in early systemic and family therapy and became increasingly more sophisticated as it was realized that the analysis needed to include all of the family members, so for example, a functional analysis might also suggest that the child’s symptoms would eventually confer some power and privileges on the child.

Systems theory – biological analogy

Using a biological analogy, systems theory proposes that various activities of the body are composed of interconnected but distinct systems of components that operate together in an integrated and coordinated way to maintain stability (von Bertalanfly 1968; Bateson 1972). This coordination is achieved through communication between the components or parts of the system. To take a simple example, the regulation of body temperature involves an interaction between the sweat glands and perspiration, physical activity, breathing rate and control mechanisms in the brain. These components act together (much like a thermostat) to maintain the temperature of the body within tolerable and ‘safe’ limits.

Very simply, a system is any unit structured on feedback (Bateson 1972). More fully, a system is seen as existing when we can identify an entity made up of a set of interacting parts which mutually communicate with and influence each other. The parts are connected so that each part influences and is influenced by each other part. In turn these continually interacting parts are connected together such that they display identifiable coherent patterns. These overall patterns are not simply reducible to the sum of the actions of the individual’s parts – a system is more than simply the sum of its composite parts. It is the observed pattern that connects the parts in a coherent and meaningful way.

Aspects of mechanical models were also applied to families, with Jackson (1965a) suggesting that a family was similar to a central heating system in that it operated on the basis of a set of rules, with deviations from these rules being resisted. For example, there might be a pattern of interaction which featured an escalating conflict between mother and daughter during which the father would withdraw in exasperation. Eventually the mother would turn to him in anger, accusing him of not helping or caring. Following some hostile exchanges between them, the mother would turn to accuse her daughter of upsetting the whole family.

The family members would not be aware of this pattern of behaviours acting as a rule, but in effect their repetitive and predictable pattern
of interaction would suggest that some such rules were in place. This led to the idea that such groupings of components constituted a system.

**Emergent properties of a system**

Central to systemic theory was the idea that a system has characteristics that are *emergent*. When two or more people interact they are involved in a creative process – a joint construction of actions and meanings. It is not possible therefore to fully predict how two or more people will interact, how they will get on, what sort of relationship will emerge. The nature of the relationship and how it develops is seen as emergent and evolving rather than as determined by the individual characteristics of the people involved. Each and every interaction is therefore seen as, to some extent, unique even though it may superficially appear to share similarities with other relationships.

**Circularities**

Systems theory stresses the interdependence of action in families and other relationships. Each person is seen as influencing the other/s and their responses in turn influence them, which influences the first person’s responses and so on. Any action is therefore seen as also a response and a response as also an action. Paul Watzlawick and his colleagues (1967, 1974) coined the term *circularities* to capture these essentially repetitive patterns of interaction. This represented a fundamental shift from how relationship difficulties had previously been explained. In effect the question of looking for a starting point – who started it – is seen as unproductive. Even if we can identify who appeared to start a particular family sequence (such as an argument), this may in turn have been a response to a previous episode. Related to this is the common pattern found in families and other relationships, when, as a result of an escalating conflict between two members, a third person is drawn in. This may occur at a largely unconscious level so that all of them may be unaware that the third person is repeatedly involved in this way. These repetitive patterns, these circularities, stress a continual, mutually determined pattern of action over time. The following exchange is a common circularity identifiable in many families:

*Sandra:* Can I stir that, Mummy?
*Diane [mother]:* Not just now, be careful, you’ll burn yourself.
*Sandra:* [climbing on to a chair near the cooker] What’s that? Can I put some sugar in?
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Mother attempting housework, cooking etc.

Child gets cross (Father not playing ‘properly’)

Father plays half-heartedly

Child attempts to get attention

Mother lingers (anticipates ‘trouble’)

Mother tries to work

Father joins in reluctantly (anticipates mother will interfere)

Girl demands attention

Mother attempts to placate her

Mother becomes distraught

Mother asks father to help

Figure 1.1 Circularity encapsulating a ‘peripheral’ father role

*Diane:* You can cut up some pastry, don’t drop it . . . all right, don’t worry, don’t wipe it, we’ll use some more . . . [exasperated] John, do you think you could do something with Sandra?

*John [father]:* Doesn’t she want to help you?

*Diane:* Look, she is going to burn herself . . . I’ve asked you before.

*John:* Come here, Sandra, get down . . . let’s go out to the workshop, we can do some hammering. [Ten minutes later, Diane thinks she has heard Sandra cry and comes to the workshop.]

*Diane:* Oh god, John, she’s cut her finger, can’t you see? I thought you’d watch her.

*John:* It’s just a scratch. She’s OK . . . I couldn’t get this screw out.

*Diane:* It’s all right sweetie. Come on, I’ve made some more pastry.

The behaviour of this family can be seen to be repetitive and we can predict how they might interact in a variety of different situations,
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**Linear causality**
John, due to his childhood experience of rejection has a fear of expressing his feelings, which makes Mary feel rejected and hurt.

**Circular causality**

```
   avoids expressing feelings
   John         Mary
   asks for show of feelings
```

*Figure 1.2* Linear vs circular causality

such as bedtime, bathing, going to the park and so on. The presence of these regularities in behaviour makes it look, to an outsider, as if the family is following a set of rules which seem to be necessary to maintain some form of equilibrium (Jackson 1957).

As observers, we can see regularities in the actions of members of a family and we can go on to infer a set of rules that might give rise to such regularities. These are, however, only inferences in the minds of us as observers. The examples in Figure 1.1 illustrate the different ideas of causation inherent in systemic thinking.

Participants in the relationship may explain their own and each other’s actions in linear terms, as in Figure 1.2.

Within a circular explanation each partner’s behaviour in the examples in Figures 1.2 and 1.3 are maintained by the actions of the other. So John’s inability to express his feelings may serve to fuel Mary’s demands for show of feelings and affectionate behaviour which in turn leads to more of the same from John. Likewise, Mary’s dependent actions and demands may serve to fuel attempts by John to withdraw and become detached.

Linear explanations are often couched in terms of invariant personality traits, such as John’s avoidant or introverted personality, or Mary’s dependency. Whether Mary is more or less insecure than other people is less relevant than the fact that her level of insecurity may be maintained by the interaction between herself and John. Likewise, John’s level of detachment is maintained by Mary’s seemingly demanding behaviour. Although the gender positions reflected in these examples may be reversed in some couples, these are common gender patterns. This suggests that, though interpersonally maintained, such cycles are also shaped by dominant cultural gender roles.
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Linear causality
Mary might say that the way John withdraws makes her feel vulnerable and that is why she acts in a dependent way.

John might say that Mary is so dependent and demanding that it makes him feel suffocated so he has to withdraw.

Circular causality

Figure 1.3 Linear vs circular causality II

Bateson (1972) employed evolutionary metaphors to argue that biological and human systems developed on basic stochastic or ‘trial and error’ processes. Thus a family system is seen as continually adapting to its ecological context. That is, a family is situated within its extended family network, the local community and culture which place various and shifting demands upon it. A variety of actions or responses may be emitted as a response but only some fit the demands and are allowed to endure. A typical example is of a young couple with a new baby experiencing various pressures and conflicts where a variety of actions may emerge, such as the couple avoiding each other, arguing, talking to others, the baby becoming distressed, crying, sick, not sleeping. Distress in the baby may have the effect of temporarily distracting the couple from their conflict but may evolve over time into a pattern whereby the distress in the baby functions to stabilize the family system. Arguably systems theory is essentially a theory of stability rather than change and development. The models describe how patterns can be maintained and suggest that once patterns are established homeostatic tendencies compel a system to remain the same.

Triads, triangulation and conflict detouring
A key step in the development of systems theory was to move from a study of individuals and pairs to an exploration of triads (three-person interactions). An analysis of the dynamics of triads helped to illustrate how the twin concepts of closed and open systems could operate side by side in such a way that overall a stability or homeostasis
could be preserved. For example, escalating conflict (open system) in a pair might be offset by the involvement of a third person. Such a repetitive dynamic could thereby preserve stability (closed system). In effect such a system displays a rule along the lines of ‘if the conflict between two persons escalates beyond a critical point then involve the third person to restore stability’.

Importantly it was suggested that if the involvement of the third person was through a symptom then the system overall was functioning so that this symptom helped to maintain the balance or homeostasis of the triad:

When therapists observed that what one spouse did provoked the other, who provoked the first in turn, they began to see that a dyad was unstable and it required a third person to prevent a ‘runaway’. For example, if two spouses competed over who was most ill, total collapse could only be prevented by pulling in a third party. Rivalrous quarrels that amplified in intensity required someone outside the dyad to intervene and stabilize it. If a third person is regularly activated to stabilize a dyad, the unit is in fact not a dyad but is at least a triad. With this view, the unit becomes a unit of three people. Similarly if a husband and wife regularly communicate to each other through a third person, the unit is three people instead of a married ‘couple’.

(Haley 1976a: 153)

Similar triadic patterns can occur in other, various relationships, for example between colleagues or friends, as shown in Figure 1.4. Mary, a young assistant, may respond to the conflicts between her superiors Bill and Ted by making some minor errors and becoming emotional herself. Her ‘symptoms’ may temporarily distract the men from their conflicts. The focus may then move to Mary and ‘her problems’ leading the men perhaps initially to try to protect her and possibly accuse each other of upsetting her. However, if they are stressed, overtired and irritable they may find it hard eventually to avoid blaming her for being ‘overemotional’ or ‘weak’. Mary’s distress consequently may escalate to the point where she develops a ‘problem’, perhaps taking time off work and so on. The focus of the difficulties may now move firmly to Mary’s problems, perhaps even more generally about the
‘difficulties of working with women’, ‘women’s high level of emotionality’ and so on, and the conflict between Bill and Ted becomes submerged, except perhaps over disagreements about how to deal with the situation, whether Mary should be replaced and so on.

A person in a conflict detouring position becomes drawn into the relationship between another two people but then their involvement can also serve to prevent resolution of their underlying problems and conflicts. Related to the emotional processes are likely to be changes in perceptions, for example Bill and Ted above come to see themselves as similar, that is, as male, less emotional and more free of problems than Mary.

In social interaction the functioning of groups of people made up a pattern, a meaningful whole which was greater than the sum of its individual parts. By analogy, family dynamics are like a piece of music or a melody which we hear as a combination of notes but each individual note gains its meaning in the context of the others – the total gestalt or whole. The concept of homeostasis was employed to describe the tendencies of systems to preserve a balance or stability in its functioning in the face of changing circumstances and demands. A system was seen to display homeostasis when it appeared to be organized in a rule-bound, predictable and apparently stable manner. As an example Hoffman (1976: 503–4) cites a triadic family process:

The triangle consists of an ineffectively domineering father, a mildly rebellious son and a mother, who sides with the son. Father keeps getting into an argument with son over smoking, which both mother and father say they disapprove of. However, mother will break into these escalating arguments to agree with son, after which father will back down. Eventually father does not even wait for her to come in; he backs down anyway.

A pattern of actions can be discerned here but how do we draw this as a system? One version might be to focus on the smoking as the trigger, which when it is perceived, leads to the activation of a set of beliefs and rules leading to further actions (see Figure 1.5). However, there are potentially an infinite number of other ways we could describe this system, for example focusing on father’s level of dominance, or the level of collusion between mother and son, or even on the son as a system – his nicotine intake, arousal level, level of addiction and so on. A system is not static but always in motion, ever changing. In the example above, what we are seeing, arguably, as homeostasis is patterning over time. We can even call this a narrative or story about how these people interact over a period of time. However, during this period the system will look different at any given point, that is, the son does not always have a cigarette in his hand, at times the parents are not discussing his smoking but doing something totally different and unconnected to it, going to work, making love and so on.
No behaviour, interaction, or system . . . is ever constantly the same. Families, for example, are perpetual climates of change – each individual varies his behaviour in a whirlwind of interactional permutations . . . a ‘homeostatic cycle’ is a cycle that maintains constancy of relations among interactants through fluctuations of their behaviour.

(Keeney 1987: 68, 119)

**Rules, pattern and process**

Families do of course have explicit rules, such as the children’s bedtimes, manners at the dinner table and so on, but the more interesting rules were seen to be the implicit ones that we, as therapists, could infer, for example that when mother scolds her son, the father usually pretends to go along with it but subtly takes the boy’s side. The smoking example given earlier can be seen to contain a covert rule that the mother will take the boy’s side in family arguments even over issues where she actually agrees with the father. However, we could suggest various alternative rules depending on where we choose to look, such as the fact that contact between the boy and his father is initiated through his smoking. In practice what constitutes a system is always a construction, a belief or an idea in the mind of the observer. Keeney (1987) had suggested that within a cybernetic epistemology we can depict a family in terms of as many cybernetic systems as we can formulate distinctions about the system. Which view we adopt is partly a question of choice and usefulness. However, some versions may certainly appear to make more obvious sense than others.

**Feedback**

The concept of feedback, as applied to human systems, encapsulates the idea of **reflexivity** – a system has the capacity to monitor or reflect
on its own actions. It is possible to build simple mechanical systems to demonstrate some adaptability (e.g. a central heating system) but in human relationships the notion of a system contains the idea of assessing what the needs of a particular situation or relationship are and adjusting to deviations from attaining these.

Feedback is a method of controlling a system by reinserting into it the results of its past performance. If these results are merely used as numerical data for the criticism of the system and its regulation, we have the simple feedback of the control engineers. If, however, the information which proceeds backwards from the performance is able to change the general method and pattern of performance, we have a process which may be called learning.

(Weiner 1967: 84)

An important point to note, though, is that because people in a relationship are capable of reflexivity this does not mean that the most effective, functional or ‘healthy’ course of action is always pursued. The experience of various forms of therapy reveal that insight into problems does not always guarantee the ability to change them. As we will see later, reflexivity is based upon a set of underlying premises or beliefs that we hold and these may function in a self-fulfilling way so that problems are maintained or even aggravated.

**Family coordination through communication**

Returning to a biological metaphor, systems theorists suggested that the body could be seen as a set of components which operated together in an integrated and coordinated way to maintain stability (see also homeostasis, p. 35). The coordination was seen to be achieved through communication between the components or parts of the system. Bateson (1958) was one of the first to suggest that a variety of social relationships, rituals, ceremonies and family life could be seen as patterns of interactions developed and maintained through the process of feedback. This became a key concept in family therapy, namely that some information about the effects or consequences of actions returns to alter subsequent action. Rather than focusing on how one event or action causes another, it was suggested that it is more appropriate to think of people as mutually generating jointly constructed patterns of actions based on continual processes of change.

**Double-bind concept**

The influence and importance of family communication sequences was highlighted by Bateson and his colleagues in their research on
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the causes of schizophrenia. They asked the question, ‘in what context would schizophrenic behaviour make sense?’ One of the answers they proposed was that it made sense in an interpersonal context characterized by repeated contradictory and confusing communications. In particular they employed the concept of levels of communication and ‘logical types’ to explain the nature of some characteristic forms of communication that were apparent in the families of young people with a diagnosis of schizophrenia. The following is a now-famous example cited by Bateson (1972: 216).

A young man who had fairly well recovered from his acute schizophrenic episode was visited in the hospital by his mother. He was glad to see her and impulsively put his arms around her shoulders, whereupon she stiffened. He withdrew his arm and she asked, ‘Don’t you love me any more?’ He then blushed, and she said, ‘Dear, you must not be so easily embarrassed and afraid of your feelings.’ The patient was able to stay with her only a few minutes more and following her departure he assaulted an aide and was put in the tubs.

Relationships are seen to proceed through successive attempts to make sense of what is happening. At times people communicate directly about this by phrases, such as ‘what do you mean?’, ‘you don’t seem too happy about that’ and so on. A feature of the double-bind phenomenon is that such meta-communication is not allowed, apparently due to unconscious fears of provoking anxiety. ‘According to our theory, the communication situation described is essential to the mother’s security, and by inference to the family homeostasis’ (Bateson 1972: 221).

**Meta-communication**

Communication takes place at two levels – at a surface or content level, and at a meta-communication or qualifying level. These higher-order communications or meta-communications play a significant role in managing relationships (Watzlawick _et al._ 1967, 1974). In fact this multilayered appraisal may be one of the distinguishing features of long-term relationships. The reflexivity or meta-communication in a relationship system can be seen to be at ascending levels, with each higher level defining those below.

Bateson subsequently revised the double-bind theory to suggest that the process is a reciprocal one, with the child also engaged in double-binding communication. Even less attention appears to have been paid to Weakland’s (1976: 29) suggestion that it can in fact be seen as a three-person process: The three-person situation has possibilities for a “victim” to be faced with conflicting messages in ways
that the inconsistency is most difficult to observe and comment on that are quite similar to the two-person case.’

At a verbal level parents may express unity, ‘we want you to be independent’ but may negate this by how they individually express this message to the child or how they act, that is, overt agreement and covert disagreement. For example there may be an overt message from the father that he disapproves of hostility and that everyone in the family is happy. Though appearing superficially to support this the mother frequently criticizes the father’s dislike of physical activities. Further she may offer justification for her difference to him, not in terms of her disagreement with him but in terms of a ‘benevolent’ interest in the welfare of the children – thereby laying responsibility for parental differences of opinion on them. Weakland (1976: 33) offers the following example of a family with a schizophrenic son:

The father and mother insisted for some time that they were in agreement on all matters and that everything was right in their family – except of course, the concern and worries caused by their son’s schizophrenia. At this time he was almost mute, except for mumbling ‘I dunno’ when asked questions. During several months of weekly family interviews, the therapist tried to get the parents to speak up more openly about some matters that were obviously family problems, such as the mother’s heavy drinking. Both parents denied at some length that this was any problem. At last the father revealed himself and spoke out with only partially disguised anger, accusing his wife of drinking so much every afternoon with her friends that she offered no companionship to him in the evenings. She retaliated rather harshly, accusing him of dominating and neglecting her, but in the course of this accusation she expressed some of her own feelings much more openly and also spoke out on the differences between them... In the following session the son began to talk fairly coherently and at some length about his desire to get out of hospital and get a job, and thereafter he continued to improve markedly.

Open and closed systems

An open system is one with boundaries that allow a continuous flow of information to and from the outside world, while a closed system is one with more rigid boundaries that are not easily crossed. Early theorists (Jackson 1957; Bateson 1972) suggested that relationships could be described as reflexive systems which operated on the basis of two types of feedback: open systems in which feedback serves to produce escalation (e.g. an argument between two people which runs out of control and leads to physical conflict and perhaps the termination
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of a relationship; and closed systems, which employ feedback to correct any deviations from a setting or a norm. The latter therefore tend to reinforce stability and the maintenance of existing patterns. In order for a relationship to function or be viable as a social unit, it needs to show both patterns. Functioning as an open system allows change and adaptation to alterations inside or outside the system (as long as the escalation did not proceed so far as to destroy the system). Alternatively, a system that is rigidly closed would be unable to adapt to new demands and changes in the environment.

In order for a relationship to function or be viable as a social unit, it needs to contain and be able to alternate between these two patterns. Functioning as an open system could bring about change and adaptation to alterations inside or outside the system, as long as the escalation did not proceed so far as to destroy the system. Alternatively, a system that was rigidly closed would be unable to adapt to novel demands and changes in the environment. Positive examples of mutual escalation in relationships are also possible, for example mutual joking or sexual arousal or flattery.

**Family homeostasis**

The body has an automatic tendency to maintain balance or equilibrium and this homeostatic tendency can also be seen in family systems. Jackson (1957) proposed that a symptom in one or more of the family members develops and functions as a response to the actions of the others in the family, and in some way becomes part of the patterning of the system. Attempts to change the symptom or other parts of the system were seen to encounter ‘resistance’ since the system operated as an integrated whole and strove to maintain homeostasis. By ‘resistance’ Jackson implied not a conscious but a largely unconscious pattern of emotional responses to change in one or other family member. For example, ‘a husband urged his wife into psychotherapy because of her frigidity. After several months of therapy she felt less sexually inhibited, whereupon the husband became impotent’ (Jackson 1965a: 10).

Don Jackson (1957) suggested that relationships containing ‘pathology’ could be seen to function as closed systems. These operated so that any change in the symptomatic member would be met by actions in the others which would have the sum effect of reducing, rather than encouraging, change. Despite family members expressing a desire to change, it was argued that in some sense the symptoms had been incorporated into the relationship dynamics and the habitual behaviour in relation to the symptoms served to maintain, rather than change the problems. Jackson borrowed the term homeostasis to describe this process and added the idea that relationships could be seen as if
governed by a set of largely unconscious rules, which guided people’s actions and embodied the homeostasis.

Family life cycle (FLC)

An influential model of change and development was proposed in the concept of the family life cycle (FLC). This emphasized how development and change in families followed common patterns which were shaped by the shifting patterns of internal and external demands in any given society. Families may at times be faced with massive demands for change and adaptation. This may be the result of changes in family composition – the birth of a child, a divorce or remarriage, a death – or perhaps due to changes in autonomy within the family – children becoming adolescents, a woman going back to work after childrearing, retirement. It was argued that the emergence of problems was frequently associated with these life cycle transitions and their inherent demands and stresses. However, less was said about the possible positive effect of external inputs, for example, the arrival of a child possibly uniting a couple or a bereavement drawing family members closer together. Without an analysis of the meanings such events contained for family members, accounts of change tended to be merely descriptive.

A key issue for any family was how to maintain some form of identity and structure while at the same time needing to continually evolve, adapt, change and respond to external stimuli. There may also be community demands such as local social upheavals and major cultural changes. Duvall (1977) extended the idea of the individual life cycle model to the idea of a family life cycle. The implications of this model for the practice of family therapy were first set out by Jay Haley (1973) in his book describing the therapeutic techniques of Milton Erickson (see Chapter 2).

Haley (1973) describes how Milton Erickson had noted that problems were often associated with critical periods of change and transition in families. For example, psychotic episodes in late adolescence were seen to be related to difficulties for the family over the departure of the young person about to leave and set up his or her own home. Haley described the following stages as critical, transitional stages for families (see Figure 1.6).

Milton Erickson’s (Haley 1973) concept of family development emphasized a lifelong process of socialization, adjustment and learning within families. Hence socialization did not end with childrearing but involved a reciprocal process whereby parents were also continually learning and adjusting to their children. Haley did not expand greatly on the subject, but he does make clear that the model assumes that there exists a common set of values and norms inherent to western society and to which families are expected to comply. For example, he
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(a) The external and internal demands for change are continuous but become critical at transitional points in the family’s life:

Family life cycle stages: transitions
1 Courtship; 2 Early marriage; 3 Birth of children; 4 Middle marriage; 5 Leaving home; 6 Retirement and old age.

(b) The external and internal demands for change are continuous but become critical at transitional points in the family’s life:

Family life cycle stages: transitions
1 Courtship; 2 Early marriage; 3 Birth of children; 4 Middle marriage; 5 Leaving home; 6 Retirement and old age.

External

Cultural expectations

Internal

Family organization: rules, hierarchy, intimacy, alliances

Pressures to change:
(a) Biological – growth change, development
(b) Social/psychological needs, expectations, roles, etc.

Figure 1.6 The family life cycle: External and internal demands for change
(Source: adapted from Dallos 1991)

describes how young people ‘need’ to practise courtship skills in order to successfully find a suitable mate. Disruptions with this process, for example through involvement in family conflicts, can cause problems for the young if it leads to disengagement from their peers.

Carter and McGoldrick (1980) have offered some elaborations of the FLC model by additionally noting the significance of intergenerational traditions. They propose a two-dimensional model as shown in Figure 1.7. Carter and McGoldrick (1980: 10) describe their model as follows:

The vertical flow in a system includes patterns of relating and functioning that are transmitted down the generations in a family . . . It includes all the family attitudes, taboos, expectations and loaded issues with which we grow up. One could say that these aspects of our lives are like the hand that we are dealt: they are a given. What we do with them is the issue for us.

The horizontal flow includes . . . both the predictable developmental stresses, and those unpredictable events, ‘the slings and arrows of outrageous fortune’ that may disrupt the life cycle process.
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**Vertical stressors**
Family patterns, myths, issues, etc.

**System levels**
- Social system
- Extended family
- Nuclear family

**Horizontal stressors**
- Developmental (life cycle transitions)
- External (war, untimely death, chronic illness, etc.)

**Figure 1.7** Developmental influences on the family

Feminist therapists argued that in fact such patterns represented wider cultural factors, such as expectations about gender roles and opportunities for work outside the family. Attempts to simply fix such patterns in families without due recognition of the cultural factors was seen as potentially oppressive and as implicitly endorsing such inequalities. Most importantly it was argued that first-order cybernetics often contained, in a concealed form, a range of normative assumptions about healthy family functioning. Structural models most clearly contained assumptions about appropriate organizations, parental control, appropriate closeness and so on. Objective, systemic neutrality, it was argued, was not possible and disguised a range of patriarchal, middle-class, white assumptions (McKinnon and Miller 1987).

**Practice**

**Structural family therapy**

At this point, theoretical assumptions were: families are regarded as evolving and capable of change but at any given time a set of rules can be discerned that govern the nature of the family organization. Central aspects of the family organization are seen to be the hierarchical structure – who is in charge, how decisions are made regarding
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various issues and difficulties which inevitably arise. Particularly sig-
nificant to this was Minuchin’s (1974) view that clarity regarding
decision making was vital: ‘Salvador Minuchin and his colleagues in
the 1960s and 70s made a simple and enduring point about families:
that children thrive when parents, or other caregivers, can collaborate
in looking after them’ (Kraemer 1997: 47).

This fundamental observation has many related strands. For ex-
ample, it is intimately related to the concept of triangulation, whereby
a child may be drawn in, or invited into the conflicts or distress
between parents. Part of the resulting difficulty may be that the child
may be enticed to take sides, for example by taking their mother’s
side against the father they may be drawn into an adult role and
appear to gain power. As a result the power balance may become
skewed, for example with the father opting out or becoming per-
ipheral, and the child increasingly being asked to adopt an inappropriate
adult role as opposed to receiving the guidance and support that they
may need from their parents.

Related structural concepts included the idea of clear boundaries
between family members and between subsystems. Most families
contain various subsystems, such as the parental/couple subsystem,
the sibling subsystem, the grandparent subsystem, adult/children sub-
system and other extended family members. Clarity between these
different subsystems is regarded as important and a particular problem
was seen in cross-generational problems or coalitions, for example where
the grandparents exercise inappropriate power over their grandchildren,
for example by undermining the parents’ authority and wishes.

This theme of clarity about decision making was also evident in the
notion of boundaries. Minuchin (1974) suggested that family members
could range from being too close (overinvolved or enmeshed) to too
distant with each other (disengaged, detached and overrigid). Enmesh-
ment could be seen in interactions and ways of relating where, for
example a parent continually spoke on the child’s behalf or acted as if
they knew more about what a child was ‘really feeling or thinking’
than the child did. At the opposite end, family members could be too
aloof and cold towards each so that they had little idea or apparent
interest in each other’s feelings and thoughts. This could lead to a
sense of isolation and inability to work together on decisions cooperat-
ively. Either pattern could be seen to incapacitate the family’s ability
to work together, to effectively deal with problems in a consistent and
constructive manner.

Beliefs and structures

Though structural approaches are seen to be focused on the organiza-
tional patterns in a family, these go hand in hand with alterations
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in the family’s belief systems. In fact, as we saw earlier on page 11, Minuchin gives an example of the start of a family therapy session where he begins by posing a challenge to the father’s (and the family’s) dominant construction of the difficulties as residing in him. When Mr Smith states that, ‘I think it’s my problem’, Minuchin immediately contests this saying, ‘Don’t be sure. Never be so sure’.

Minuchin goes on to explain that his statement, ‘Don’t be so sure’, challenges from the outset of the therapeutic encounter the dominant view of the problem as residing in Mr Smith. In fact in defining his theory of change Minuchin (1974: 119) makes it clear that alteration in a family’s beliefs is regarded as fundamental to change:

Patients move for three reasons. First, they are challenged in their perception of reality. Second, they are given alternative possibilities that make sense to them, and third, once they have tried out the alternative transactional patterns, new relationships appear that are self-reinforcing.

The ways of challenging beliefs, however, may take various forms depending on the apparent ability or otherwise of the family to be able to incorporate advice and insights. In some cases it is presumed that beliefs will only change as an accompaniment to changes in behaviours – seeing is believing.

Therapeutic orientations

The fundamental view is that alterations made to the organizational structure of a family will change the symptomatic behaviours. Once the rules of the family system alter, so too will the behaviours, for example, if instead of enlisting a child into coalitions against each other the parents start to work together, then the child will no longer display various symptoms. The implications are that as the structure of the family changes, each and every member of the family also changes in terms of their roles, experiences and identities.

Underlying the therapeutic orientation are a set of assumptions about ‘healthy’ family functioning. It is proposed that certain forms of family organizations are dysfunctional and inevitably lead to problems. At times this may be latent, for example a family may manage reasonably well despite a child being drawn into the parental conflicts, but the inherent instability of the system may become exposed when the child reaches the age at which he or she is expected to leave home and disengage from the family to find an occupation and a mate. The combination of cultural requirements and biological changes require that the family develops ways of accommodating these demands for change. Since the changes will involve all the members of a family,
there is a requirement for joint and consensual decision making which may not be possible if the family is organized triangularly. Arguably such a structural view is not simply normative and moralistic but acknowledges the cultural realities in which families operate. It has been argued that the approach stigmatizes non-standard family forms, such as single-parent families. However, it is possible to see that, for example, a clear adult decision making subsystem might equally consist of a mother and a close friend or her parents. The important point is that the child experiences support, a sense of cooperation and clarity from the adults placed in charge of her or him.

**Directive stance**

Since the fundamental assumption of a structural approach is that families have an objective structure, it follows that therapy involves a process of assessment and mapping of this structure, followed by clear attempts to alter it where necessary. The therapist therefore adopts a sympathetic but nevertheless expert role in which he or she takes on the responsibility of initiating changes. These may be interventions or manipulations that are essentially outside of the family’s awareness. We can examine three techniques briefly.

*Escalating stress and creating a crisis*

Minuchin (1974) used this technique in an experiment designed to offer a demonstration of the interconnection of actions and feelings in a family where both the daughters suffered from diabetes. The intention was to explore how changes in the relationships in a family are experienced at a physiological level and how these changes are stabilized by the patterns of family dynamics.

In order to demonstrate this, Minuchin employed a physiological measure of emotional arousal, the free fatty acid (FFA) level in the bloodstream, as changes in FFA levels have been found to relate closely to other measures of emotional arousal, such as self-reports and behavioural evidence.

Both of the children in the family were diabetic; Dede (17 years old) had had diabetes for three years, her sister Violet (aged 12) had been diabetic since infancy. There was no obvious difference in the girls’ individual responsivity to stress but Dede suffered much more severely from diabetes and had been admitted to the hospital for emergency treatment 23 times. Violet had some behavioural problems that her parents complained of, but her diabetes was under good medical control.

Minuchin interviewed the parents for one hour (9–10 a.m.) while the girls watched from behind a one-way mirror. From 9.30 onwards
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he deliberately encouraged the parents to discuss an issue of conflict between them, which led to some experience of stress, in order to see how this affected the children. Although the children could not take part in the conflict situation, their FFA levels (stress levels) rose as they observed their stressed parents. At 10 o’clock the children joined their parents and it became apparent that they played different roles in the family. Dede appeared to be trapped between her parents, each parent trying to get her support, so that Dede could not respond to one parent’s demands without seeming to side with the other. Violet’s allegiance was not sought. She could therefore react to her parents’ conflict without being caught in the middle. The effects of these two roles can be seen in the FFA results (Figure 1.8). Both children showed significant increments during the interview, between 9 and 10, and even higher increments between 10 and 10.30, when they were with their parents. At the end of the interview, however, Violet’s FFA returned to baseline promptly, but it took an hour and a half for Dede’s level to return to normal. The parents’ FFA levels increased from 9.30 to 10 a.m., confirming that they were experiencing stress, but their FFA decreased after the children had come into the room. It appeared that their conflict was reduced or detoured through the children. However, the children paid a price for this, as shown by their increased FFA levels and Dede’s inability to return to baseline.

The Collins family were seen to be organized in terms of a central pattern whereby the parents would triangulate the older daughter Dede into their conflicts by changing the subject to her diabetes problem whenever they discussed any area of disagreement between

Figure 1.8 Change in free fatty acid (FFA) levels, the Collins family
(Source: Minuchin 1974)
them as a couple. Children typically become caught up in this process and can be seen to sacrifice themselves for the sake of preserving family harmony by manifesting a symptom when the conflicts start to escalate. Minuchin blocked this pattern by removing the children from the room and continually prompted the parents to discuss their areas of conflicts. He also blocked attempts to change the subject onto the children by bringing the parents back to the conflicts in order to break up the typical pattern.

An underlying assumption of structural techniques is that people are more amenable to making changes when they are emotionally engaged and expressing rather than suppressing their feelings. However, this is not to be confused with simply encouraging conflict in families. Instead, inducing some emotional upheaval is seen as preparing the ground for directing the family to develop some more authentic and productive ways of communicating and relating to each other.

**Enactment**

Rather than simply talking about or describing situations and problems that occur at home or elsewhere outside of the therapy room, a family is invited to display the patterns there and then. For example, Minuchin et al. (1978) developed the technique with families with a child displaying eating disorders, such as anorexia. The therapy sessions would be held over lunchtime and the family would be invited to have a meal together. This could vividly highlight the patterns in the family, such as the inability of the parents to agree and work together on encouraging a girl to eat, and a shifting pattern of coalitions between each parent and the girl. It could also enable a broader discussion of control and independence. For example, through the conflict that might ensue the girl might be able make clear that her not eating was partly an act of defiance and an attempt to assert some independence from being tied up in the struggles between her parents.

**Unbalancing**

This involves the therapist in using himself or herself in a deliberate way to alter the dynamics of a relationship. For example, many couples attempt to pull the therapist onto their side, to try to convince them that the other partner is insensitive, abusive, awkward, stupid, uncaring and so on. Attempts to stay neutral and to offer a reasonable, impartial point of view may be met with further attempts at enticing the therapist to take sides. The therapist may then deliberately side with one partner against the other in order to break up this repetitive cycle.

For example, a woman who had been hospitalized with depression expressed great pessimism and hopelessness at the start of a session.
The therapist however, encouraged her to voice her distress at her husband’s failure to protect her from his intrusive family who were undermining and critical of her. As she gave vent to her feelings she appeared to grow increasingly less depressed and more empowered. The therapist then started to side with her husband in sympathizing with his predicament at trying to keep everyone happy but questioned whether he would be able to construct some clear boundaries between his family of origin and his new family. It was also suggested that the couple go out together to discuss how they might be able to work out some way of solving this dilemma. The wife wanted to solve this in the session, saying she did not trust her husband to do anything about this. They left the session with the wife appearing determined rather than depressed and the husband saying that he had heard clearly what she wanted and that he felt they could come to some decision about it themselves. Subsequently her husband took matters in hand and told his family to back off and give them more space.

Unbalancing can be seen as operating over time such that the therapist can acknowledge that each person is contributing to the interactive pattern but may at one point appear to side with one family member in order to produce a change. However, it is important to be aware of the investment that members have in their relationships.

**Strategic family therapy**

One of the sources of inspiration for strategic approaches was the work of Milton Erickson who developed a rich variety of techniques, some of which have been developed as strategic techniques and others as forms of hypnotherapy (Haley 1973). Erickson frequently worked with families but also with parts of families or individuals. One of his guiding premises was that problems apparently residing in one person are frequently associated with the difficulties resulting from a family’s need to change and reorganize at key transitional stages, such as the birth of a child or when children are about to leave home. In work with young adults, for example, he described a key task as one of ‘weaning parents from their children’. In this he recognized that frequently the parents may have a hidden interest in needing a child to remain at home, for example in order to help them to avoid conflicts in their own relationship. Hence he might sometimes work individually with a young person and assist them in finding ways to become more confident and prepare to become free of their symptoms. However, he would be very aware that improvements in the youth might lead to the parents attempting to ‘sabotage’ the therapy, perhaps by withdrawing him or her from the therapy on some pretext. Consequently he would also work with the parents. For example, in one case, involving a young woman who was suffering from acute schizo-
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Phrenia, he arranged for the girl to stay in town near to him while the parents went back some distance to their home on the coast. In Erickson’s view it is important to encourage and enable the normal separation at this age to happen rather than to get all the family together to try to talk things through before a young adult moves out.

He also encouraged the young woman to express her resentment of the ‘bad ways’ that her mother had treated her by deliberately siding with her and apparently agreeing with her complaint that her mother had treated her badly and that she should not stand for this any longer. In fact he deliberately encouraged anger but at the same time employed hypnotic techniques, such as prompting her to simultaneously notice how her arms felt on her armchair. This was part of an attempt to enable her to get in touch with her feelings, as opposed to the disconnections and denials of feelings that she was experiencing as part of her schizophrenia. At the same time he encouraged her to feel better about herself in various ways; for example, the young woman was very overweight and through direct and indirect comments he encouraged her to accept her body and her ‘inner beauty hidden by the layers of fat’.

In conjunction with this individual work he worked with the parents, encouraging them to have a temporary separation which enabled them to renegotiate their marriage without involving their daughter. His interventions were quite forceful:

I told the father to separate from his wife and live in a different place. Now and then his wife would get agreeable and he would go home and have sexual relations with her . . . The mother was an excellent golfer and a marvellous companion. I arranged that the mother call me regularly while I was treating the daughter. She used me as a sort of father figure . . . When she’d do something wrong she’d call me and tell me about it, and I would whip her over the telephone. So I kept in contact with the parents while seeing the daughter.

(Haley 1973: 271)

Erickson’s approach perhaps appears to lack some of the niceties of gender sensitivity and political correctness but at the same time can be seen to reveal a deep compassion and acceptance of human frailty. It also suggests a sense of fun as well as the application of some benevolent trickery to produce profound and rapid changes with quite severe problems.

Strategic approaches encompass a wide range of ideas and tactics. A common feature is the focus on the dynamics of family interaction. Problems are seen as embedded in repetitive interactional patterns or circularities:
Our fundamental premise is that regardless of their basic origins and etiology – if, indeed, these can ever be reliably determined – the kinds of problems people bring to psychotherapy persist only if they are maintained by ongoing current behaviour of the patients and others with whom he interacts. Correspondingly, if such problem-maintaining behaviour is appropriately changed and eliminated, the problem will be resolved or vanish, regardless of its nature, origin or duration.

(Weakland et al. 1974: 145)

This view has many overlaps with behavioural approaches, especially in the idea of symptoms as a form of behaviour maintained by the actions of others. However, the others in a family are seen as usually not aware of how their actions are serving to maintain rather than reduce the symptoms. For example, the parents in a family may complain that their daughter is withdrawn and anxious but every time she tries to haltingly express herself one or other parent tries to ‘rescue’ her by speaking for her. For her part when directly asked a question by the therapist the girl may invite her parents to intrude by shyly looking towards one or other parent before she answers or immediately seeking confirmation once she has started to speak. The parents’ actions of ‘helping her out’ can be seen as an ‘attempted solution’, an attempt to help her by clarifying what she wants to say. However, this may have quite the opposite effect. It is suggested that these attempted solutions can in fact function to aggravate rather than relieve the problems, leading to a spiral of increasing difficulty.

Less frequently stated perhaps is the central premise of strategic approaches – that people are fundamentally strategic. All of us, including family members and therapists, are involved in making predictions about how others may act, feel and think. Based upon this we make decisions, more or less consciously, about the timing and appropriateness of particular actions and their likely consequences. Haley (1987) perhaps stated this most forcefully in terms of relationships as invariably involving a form of power struggle, for example in terms of how the relationship was to be defined, who was in charge, who initiated decisions and so on. An important implication for therapy was that the therapist and family members were seen as engaged in attempts to influence each other. For example, members of a family typically try to enlist the therapist onto their side, to see things from their point of view and to be an ally to change the others. Hence therapy is inevitably strategic or tactical in that the therapist needs to be aware of these attempts at influence by family members and to act strategically to direct rather than become simply caught up in them.

This is also consistent with a humanistic and existential view that people are fundamentally autonomous, with a desire to be in charge of and make choices in their lives. Invariably this suggests that therapy
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will involve a clash of wills. Though people may come to therapy to seek help, they also seek to maintain control of their own lives. Strategic approaches recognize this fundamental dilemma and seek ways to enable the therapist to act tactically so that change can occur. Writing about the connections between western and eastern psychotherapies Alan Watts (1961: 55) suggested that connecting is the practice of ‘benevolent trickery’:

If I am to help someone else to see that a false problem is a false problem, I must pretend that I am taking his problem seriously. What I am actually taking seriously is his suffering, but he must be led to believe that it is what he considers as his problem.

Beliefs and premises

Though the emphasis is on exploring and helping to change problematic cycles of behaviours, strategic approaches also emphasize the central role of beliefs and cognitions. Problems can be seen to develop in two characteristic ways: people may come to see and treat relatively trivial or ordinary difficulties that we may all face as examples of a serious problem, alternatively they may ‘bury their heads in the sand’ and treat difficulties (sometimes quite serious ones) as no problem at all. The first of these can be seen as what Watzlawick et al. (1974) describe as the ‘utopia syndrome’ – a belief that the inevitable difficulties and stresses of life can be avoided. Alternatively, but with equally serious consequences, problems can arise from a denial of obvious difficulties. Failure to take remedial action can lead to initially relatively small difficulties escalating to a point where eventually they become so serious that the situation may come to look catastrophic and hopeless.

The premises or beliefs that family members hold shape both what is seen or not seen to be a problem. Furthermore, these beliefs also shape the ‘attempted solutions’, such as continual concern, anxiety and desperate attempts to solve matters, as opposed to denial and avoidance of facing issues. The importance of beliefs, or punctuations as described by Watzlawick et al. (1974) was therefore seen as fundamental. Interestingly there was also an early recognition of the importance of cultural and societally shared beliefs:

Over- or under-emphasis of life characteristics is not entirely a matter of personal or family characteristics; this depends also on more general cultural attitudes and conceptions. While these often may be helpful in defining and dealing with the common vicissitudes of social life, they can also be unrealistic and provoke problems. For example, except for the death of a spouse, our own
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culture characterizes most of the transitions . . . as wonderful steps forward along life’s path. Since all of these steps ordinarily involve significant and inescapable difficulties, such over-optimistic characterization increases the likelihood of problems developing – especially for people who take what they are told seriously.

(Weakland et al. 1974: 149)

Strategic approaches appear not to hold a view of the family apart from seeing it in terms of a set of local interactional dynamics between family members and between the therapist and the family. An exception is the model of the family life cycle that offers a picture of family development through a series of key transitions and how these may be related to the onset of difficulties, which then can become aggravated by pernicious interactional dynamics. In contrast, structural approaches do have a view of the family as organized in terms of a set of roles and rules that are embodied in the overall family hierarchy, subsystems and boundaries. Furthermore, assumptions are made about ‘healthy’ family structures, such as a clear parental system with parents capable of working together to make mutual decisions.

However, neither of the approaches appears to recognize for example, that the structures and dynamics are not simply created inside the family but are constrained and constructed within the constraints of gender inequalities inherent in society. To take an example, to simply encourage a couple to have an equal role in decision making about the children may fail to recognize that this is one of the few areas of validation and power that the woman possesses. Similarly, establishing a closer or ‘overinvolved’ relationship with the children may be a result of the fact that the woman has to carry more of the childcare. Also, she may feel a need to have the children on her side to gain some semblance of influence over her partner who otherwise holds the economic and physical power.

As implied by the term ‘strategic’ the orientation is one that focuses on problems and contemplations about how to solve these. The underlying theoretical orientation (similar to structural approaches) is that family life invariably presents people with various difficulties. These difficulties may be perceived in various ways and these perceptions guide what steps, ‘solutions’ are attempted to solve the difficulties:

One of our main stated aims is to change overt behaviour – to get people to stop doing things that maintain the problem and do other things that will lead toward the goal of treatment . . . it is often just that behaviour that seems most logical to people that is perpetuating their problems. They then need special help to do what will seem illogical and mistaken.

(Weakland et al. 1974: 157)
Strategic approaches are best known for offering a relatively brief approach which focuses on the core problems and attempts to break up the pattern of maintaining behaviours and failed solutions. This is usually attempted without the family being fully aware of what the therapist is up to. In effect this represents an ‘expert’ position with the therapist and the team in charge of effecting changes.

Strategic approaches involve the following key stages:

1. detailed exploration and definition of the difficulties to be resolved;
2. a formulation of a strategic plan of action by the therapist designed to break up the sequences of interactions within which the problem is embedded and maintained;
3. the delivery of strategic interventions – these frequently involve a ‘task’ or ‘homework’ that a family is requested to carry out between sessions. These tasks are designed specifically to disrupt the problematic sequences;
4. assessment in terms of feedback regarding the outcome of the interventions;
5. reappraisal of the therapeutic orientation or plan, including continuation or revision of tasks and other interventions employed.

To illustrate strategic approaches we can look at three ‘techniques’; strategic, directive and paradoxical tasks (details are provided in the topic reading lists at the end of this book).

**Strategic tasks**

Strategic tasks can be seen to fall broadly into two categories depending on whether family members are likely to carry out instructions offered or will fail or refuse to do so: *directive* tasks – asking families to do something that the therapist hopes will alter problematic sequences of interactions – and *paradoxical* tasks where they are asked to do the opposite of what the therapist intends to happen.

**Directive tasks**

These usually consist of pieces of homework that family members are asked to carry out. Wherever possible it is seen as most effective to involve all of the members of a family in such tasks. Two examples from Haley’s work are illustrative:

In an actual case in which the grandmother is siding with her ten-year-old granddaughter against the mother, the therapist sees mother and child together. The girl is instructed to do something of a minor nature that would irritate grandmother, and the mother
is asked to defend her daughter against the grandmother. This task forces a collaboration between mother and daughter and helps detach grandchild from grandmother . . .

When a husband and wife, or parent and grandparent, are at an impasse over who is correct in the way the child should be dealt with, a therapist can provide a behaviour modification programme. One person may be excluded by this arrangement, or they may be brought together. For example, the parent can say to the grandparent that this is a new procedure being learned at the clinic and from now on parent and not grandparent is to be the authority on what to do with the child with this new procedure. Or parents who have fought over different ways of dealing with the child can reach agreement on this new way and so resolve a parental conflict that has been maintaining a child problem.

(Haley 1987: 70)

Frequently directive tasks can appear quite obvious and common sense but nevertheless the intention behind the task will be focused on disrupting pernicious patterns. Many parents, for example spend little time together as a couple and have become fixed in their views of each other. A task can be to request that they purchase each other some small gift that the other would not expect. In order to do this they must both think about each other carefully. Sometimes tasks can be employed in a metaphorical way, for example a couple who are experiencing sexual difficulties may be asked to discuss and plan a meal together. They may talk about going out for a meal and what they would have and also discuss where and what they used to eat when they were in the early courtship period of their relationship. The discussion may range over the setting, candles and romantic settings, preparation, choice of wines, length of the first course, who finishes the main meal first and so on. Following a discussion about their preferences they may be asked to arrange such a mutually satisfying meal together.

Paradoxical tasks

These are employed when families find it difficult to comply with directives offered by the therapist. Early systemic therapists referred to families frequently being ‘resistant’ to change. The concept of resistance has been extensively criticized (Dell 1982) as overtly implying a positivist and mechanistic view of families. Instead inability to comply with directives can be seen in terms of the family’s exasperation and sense of failure which makes it hard for them to trust straightforward directives. Weakland et al. (1974: 159) described the rationale for paradoxical tasks as follows:
[a paradoxical task] is used most frequently in the form of case specific ‘symptom prescription’, the apparent encouragement of symptomatic or other undesirable behaviour in order to lessen such behaviour or bring it under control. For example, a patient who complains of a circumscribed, physical symptom – headache, insomnia, nervous mannerism, or whatever – may be told that during the coming week, usually for specified periods, he should make every effort to increase the symptom. A motivating explanation usually is given, e.g., that if he can succeed in making it worse, he will at least suffer less from a feeling of helpless lack of control. Acting on such a prescription usually results in a decrease of the symptom – which is desirable. But even if the patient makes the symptom increase, this too is good. He has followed the therapist’s instruction, and the result has shown that the apparently unchangeable problem can change. Patients often present therapists with impossible-looking problems, to which every possible response seems a poor one. It is comforting, in turn, to be able to offer the patient a ‘therapeutic double-bind’ which promotes progress no matter which alternative response he makes.

Paradoxical tasks can sometimes involve an element of humour which may be helpful. de Shazer (1982) described a paradoxical intervention where a family complained that they were forever bickering and sniping at each other so that people felt upset, hurt and uncared for. In effect their family life was a form of war where no one could feel safe from unexpected attack. The suggestion was made to the family that it may be important for them to keep on acting like this but it may also be useful to explore further what it felt like when they sniped at each other and also how it was likely to lead to escalating cycles of counter-attack and retaliation. The therapist then asked the family to buy a set of water pistols and for each member to use their pistol to squirt at the member of the family who they felt was sniping at them. The family returned for the next session saying that they had done as requested but found themselves dissolving in laughter very quickly the first time. Subsequently it had helped them to see the futility of what they had been doing and were now bickering much less with each other.

Commentary

Systems theory has received considerable criticism for the implication that all problems are essentially interpersonal. In particular the stance of neutrality was severely criticized for implying that, for example
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child abuse, domestic violence and emotional abuse should be seen as interpersonal. Central to this was an unwillingness to contemplate inequalities of power within families as significant and to recognize that these were related to wider cultural patterns of inequality, for example the disadvantages commonly experienced by women. In turn it was argued that many of the characteristic patterns were not simply developed from within the family but reflected these wider cultural factors. For example, a commonly observed pattern was that many fathers occupied a distant, disengaged position in families with the women making repeated attempts to involve them and criticizing their lack of involvement. Rather than simply seeing this as an example of family ‘dysfunction’, correctable by an ‘expert’ therapist it was suggested that, particularly in western cultures, this pattern was a direct product of patterns of gender and family socialization.

Similarly the family life cycle has attracted critical attention, especially on the grounds that it takes an overly normative view of family development and focuses on the nuclear family which, in its pure form, is not now the most common arrangement. The experiences of stepfamilies, for example can involve complex overlapping of life cycle stages. A new couple may find themselves in a courtship, romantic phase, while at the same time having to deal with adolescent children from previous marriages. There is also the danger of ignoring the diversity of choices people may feel are available about forms of family life. It is possible that adults may choose to live in a single-parent arrangement or a commune, but such choices are less available to a child and, as Haley (1973) argues, in extreme cases the parents’ ‘eccentric’ choices can have considerable ramifications for the child in terms of being rejected by his or her peers and becoming stigmatized and labelled in various destructive ways.

**Gender and shifting inequalities of power**

Relationships in families may be considered a matter of give and take – but who gives and who takes varies during the course of a relationship. The balance of power can be seen to be determined by global considerations, such as the general balance of power between men and women, access to jobs, education and so on and also by local conditions – the relative balance of power between partners. One way of conceptualizing power is in terms of the resources that each partner possesses (Blood and Wolfe 1960; Homans 1961). The most obvious and objective resources are income, education, physical strength and occupational status. But there is also a range of relative resources, such as physical attractiveness, love, affection, humour, emotional dependency, skills and so on. The latter are more open to negotiation
and are to some extent constructed within the relationship, so that one partner may have considerable power because the other is deeply in love with, is emotionally dependent upon, or feels inferior to them, or even greatly enjoys their cooking. Which resources are dominant and how they are to be employed is, however, also to some extent dependent on culturally shaped sets of obligations. For example, partners are ‘supposed’ to provide for each other financially, emotionally and physically. Failure to provide, to withhold or abuse these basic resources may be taken as grounds for complaint or for ending the relationship.

Gender differences in resources are also partly culturally determined. For example in western cultures women have generally been valued if they possess beauty, charm, and nurturing and supportive attributes. However, many of these not only have little exchange value but are short-lived. Beauty especially has been, and perhaps continues to be seen as a central resource. Consequently women have been encouraged to emphasize their looks in contrast to substantial abilities and skills. Western culture tends to define female beauty as youthful, fit and slim. As women age this resource inevitably diminishes. Likewise, a woman’s ‘resource’ is determined by her role as a wife and mother, but as children grow up she is less needed to care for them. The value of the role of wife may also be transient and lost through separation or divorce, in that it is contingent on being in a relationship and being appreciated in that relationship. Indeed, many women who have described their relationships as egalitarian are shocked to realize the extent of their inequality and dependence when that relationship disintegrates. At this point they may become painfully aware that much of their power was contingent on the wishes of their partner, and the particular nature of their relationship (Williams and Watson 1988; Dallos and Dallos 1997).

A number of researchers and therapists (Homans 1961; Haley 1976a; Madanes 1981) have suggested that satisfaction in relationships is related to an equitable distribution of rewards in the relationship. The power each partner possesses lies in the range of resources they have available and which can be applied to influence their partner or other members of the family. It is suggested (Haley 1973; Carter and McGoldrick 1980; Hesse-Biber and Williamson 1984) that the distribution of power in a nuclear family alters during the family life cycle. Not only do men and women have access to different resources but this changes during their lives. Typically, it can be argued that men and women have relatively equal power during courtship. Even if there are differences, their effects may be less marked since structures of dependence arising from living together have not been established. With the birth of a first child, and incrementally with the birth of each additional child, a woman’s power is likely to decrease. It is common for a woman to stop working or reduce her commitment to work. She
thus becomes increasingly dependent upon a husband, and the more children she has the longer she may need to withdraw from a job or career, thus losing out on experience, promotions and so on. In contrast a husband is likely to be based outside the home. He may take on extra work to help with the finances and this may even help his career to develop, thereby exacerbating the power inequalities in the relationship. As the children start school, and when they leave home, a woman’s power may increase if she is able to return to work. At the same time a man’s career may be starting to level off. As a couple move towards retirement the balance of power may become more equal, but cultural norms may still perpetuate power inequalities.

**Normative assumptions of life cycle models**

Families exist within a cultural context and one of the key ways that this regulates family life is through a set of normative assumptions about how family life should progress through a number of key stages. The family life cycle model suggests an image or norm of what people believe family life ‘should’ be like. Inherent in this image are beliefs about the form that the family should take; how a family should develop, solve problems, communicate with each other, how the members should feel about each other and when it is appropriate for children to leave and start a new family of their own. In one sense the concept of the family life cycle merely maps out a formal set of assumptions that people in a given society hold about a particular form of family life.

At the same time the concept of the family life cycle embodies the ideological assumptions and imperatives that designate the nuclear family as a goal to be striven for, especially in terms of offering the most satisfactory form of nurturance for children. Given the high rates of divorce now prevalent in most western societies, this model potentially serves as a form of implicit condemnation for many stepfamilies who may feel obliged to contort themselves into a nuclear family configuration. As with many models in the social sciences, attempts to describe and categorize phenomena, such as the stages that families are likely to proceed through, can lead to the model becoming prescriptive. It has been proposed in contrast that we fully acknowledge diversity and talk of life cycles plurally rather than of one superior or normal version. This necessitates that we recognize that events such as divorce be ‘viewed as normal rather than abnormal phases of the family life cycle and that this can be reframed in positive terms, such as a couple being “ready for a new relationship” or children “being the lucky possessors of two families instead of one”’ (Morawetz 1984: 571).
The first phase – 1950s to mid-1970s

Key texts


The following are four skills or techniques that can be seen to be derived from the first phase of systemic family therapy. They are included because they embody some of the core contributions of that phase and also because they are of enduring value. Many therapists continue to employ these skills, perhaps adapting them to suit their own styles and to fit with their contemporary views and preferences.

### Family sculpting

#### Background

Family sculpting is a technique developed by David Kantor and Fred and Bunny Dahl and used extensively by Virginia Satir, Peggy Papp, Maurizio Andolfi and others whereby a physical arrangement of family members is made (either by a family member or by a therapist) symbolically depicting how the one sculpt director thinks and feels relationships are, have been or how, at a given time, the family sculpt director would like relationships to be in the family.

#### Usefulness and relevance

The process of sculpting can be used to show existing relationships or change communication patterns and/or as an attempt to restructure family relationships. Sculpting is thus a tool enabling family members to comment on past, present and future relationships – how relationships are experienced, what changes family members or therapists would like to achieve, and to get in touch with the psychological distances and the feelings and emotions they arouse. Sculpting is a useful and powerful tool which can be used in a number of different ways according to the needs of the therapeutic processes. It is useful both in therapy and in training therapists.

#### Exercise

A family member or therapist is invited (or a therapist negotiates permission) to sculpt the family (to make a living picture of relationships) at a time when symptoms emerge or at a future time when symptoms have disappeared. People are asked to remain silent,
to notice their feelings as they are arranged in the sculpt. Family members are then invited to comment on what feelings they have about the positions they have been allocated or chosen. When everyone in the sculpt has had the opportunity to say how they feel, the director of the sculpt then invites everyone to move to a position they would prefer and find more comfortable in relation to other family members. The exercise ends with each person being invited to comment on changes they and others would have to make to become and remain more comfortable both physically and emotionally with themselves and in their relationships with other people in the sculpt.

Sculpting of the family situation can be undertaken by the client/s only or in collaboration with the therapist – or the therapist may wish to sculpt how they experience the family situation as described by the client.

**Sculpting with stones – an alternative to sculpting with people**

The stones (or other objects, such as sea shells, marbles, pieces of fruit etc.) may be selected to represent family members according to their size, colour, texture and so on. They may be given names and then arranged and discussed in an analogous way to the work with actual family members. The objects and their arrangements may be interspersed with some humour and all members of the family invited to participate and manipulate the stones according to their ideas about the relationships between the family members. Sculpting with stones involves touch and can arouse powerful feelings with the client/s. It is important to ensure trust is established in the client/therapist relationship and that the clients know there will be sufficient time to work with and through any intense feelings that may be aroused.

**Further reading**


An introduction to family therapy

Family tree and time line (or family life chronology)

Background

The challenge of organizing often vast amounts of information about family members gleaned by practitioners during sessions when family members are encouraged to share their stories has led to the development of family trees and time lines as a way to record significant information in formats that are accessible and usable for clients and therapists alike.

Family trees or genograms are maps providing a picture of family structure over several generations, with schematic representation of the main stages in the family life cycle. The format most generally used was established by Murray Bowen (Carter and McGoldrick 1980) and included names and ages of all family members, dates of birth, marriage, divorce, separation and death information about three or more generations.

Time lines can be used to ensure family trees remain useful and uncluttered and to show changes in occupation, location, life course, illness and other predictable and unpredictable life events.

Usefulness and relevance

Family trees or genograms and time lines are useful diagnostic tools and can provide a benign shared experience for family members often disclosing, for the first time, information with high emotional intensity. Thus working together on a family tree or time line can also be both cathartic and therapeutic for family members, providing an opportunity for ideas, thoughts and feelings hitherto undisclosed to be shared.

As with any effective therapeutic intervention, therapists need to be sensitive to nuances of family members’ verbal and non-verbal behaviour indicating their vulnerability while involved in creating family trees or time lines.

Exercise 1

Therapists and clients are invited to identify a time in family life that is a snapshot of family process; this should be at a significant point, for example at the point of referral for professional help, at a life cycle transition point such as leaving home, death of parent or spouse, etc.

The family tree is drawn showing, where possible, up to three or four generations. Themes to look for and explore may include
separation, loss, conflict, closeness, communication, power and family beliefs, myths and legends; explanations and responses to crises and life changes can be described. Using large sheets of flip-chart paper for this exercise enables (if necessary) many people to work together and the sheet can be saved for later therapy sessions and new information added as appropriate.

**Exercise 2**

Therapists can complete a time line or ask clients to do so showing the flow of events and crises in a client’s life that influence or contribute to symptom formation.

Information will be provided on:

1. the client’s view of and feelings about significant events;
2. the client’s responses to professionals’ views/enquiries;
3. the discrepancies between 1 and 2;
4. for the professionals, data for assessment of symptoms and indicators for treatment.

Useful questions to ask are:

- **What** is the problem? What brings you here today? What are the consequences of the problem for the client’s life and relationships?
- **Where** do you think it comes from? Can we look for explanations?
- **When** did you first notice it?
- **How** would you like us to be able to help?
- **Who** else knows about the problem? Who else understands about the problem? Who is affected by the problem?
- **Why** is it happening now?

**Further reading**


An introduction to family therapy

Date commenced: ________________

Client na/Name: ________________  Significant others* ________________

* network of family, friends, professionals and others

I keep six honest serving men,
(They taught me all I knew)
Their names are What and Where and When
And How and Why and Who.

(R. Kipling, Just So Stories)

Figure 1.9 Time line
Reframing

Background

Reframing is an important art and skill associated with many therapeutic approaches whereby alternative and equally plausible explanations for the symptomatic or complained about behaviour are offered to clients in order to introduce a difference in communication patterns and open up possibilities for more choices for clients. Thus a teenager father can be blamed for impregnating a girl or praised for his potency; an anorexic girl can be relabelled as stubborn and determined not sick. A classic example of the opportunities offered by reframing is Langbridge’s adage, ‘Two men look out through the same bars: one sees the mud, and one the stars’. Similarly the optimist says of a cup, it is half full, while the pessimist says it is half empty.

Usefulness and relevance

Since therapists deal with clients’ subjective images of reality, the possibility of investing a dire and depressing situation with new meanings so that clients begin to believe there is a way out of their impasse is an invaluable skill. The ability to reframe or develop new and different and acceptable meanings for and with clients is what enables therapists to create a context for change and work with clients towards developing an understanding of the underlying meaning of their problem.

Exercise

Therapists form a group, trio or pair and give one another several examples of the most dreaded blaming statements from clients. Each person in turn has to think of three non-critical and preferably humorous reframes for each of the statements made. Fluency in this exercise can lead to playfulness in social conversation. So, for example, the statement, ‘I had great difficulty getting here today because there was a train strike’ can be reframed as, ‘I am
someone who perseveres and overcomes obstacles when I want to get somewhere.’

**Further reading**


