

# Introduction

There have been many advances in the field of family therapy since the fourth edition of this book appeared 8 years ago. These have included new ways of working with families and new theoretical underpinnings for the work family therapists do. Previously accepted ideas have been re-examined and, sometimes, questioned. Family therapy is, as it has always been, a field that is in a continuing, but creative, state of flux.

There is no one way of helping families that are confronting problems. Not only do families' problems differ, but so also do the societies and cultures within which they exist. Recent years have seen an increasing acknowledgement by family therapists – reflected in many articles appearing in the family therapy journals – that flexibility and sensitivity to culture are essential to effective work in this field. And it is not only culture and societies' norms to which we must be sensitive. There are also specific problems that require special consideration and, often, special therapy techniques. Examples are families in which there are one or more members with substance abuse problems; those with 'acting out' adolescents; those in whom there are members with attachment disorders; and those attempting to deal with the aftermath of an episode of infidelity on the part of a marital partner. So, one size does not fit all.

Are there, in spite of the above considerations, some basic principles that are widely applicable? I believe there are, and in this edition of *Basic Family Therapy*, as in previous ones, I have tried to set these out as clearly as I can. My aim is to provide a clear, easy-to-read and readily understandable introduction to the subject. As the volume of available information on family therapy increases, I believe there is more need than ever for an eclectic introduction to the subject.

It is not possible to learn family therapy from a book. There can be no substitute for supervised practice. What a textbook such as this can offer is a basic orientation to the field and a guide to further reading. The ever-expanding literature on family therapy can be confusing to the newcomer. Moreover, many books on the subject are written from a particular theoretical viewpoint and/or reflect the work of a particular, often charismatic, therapist. These can be valuable contributions to the field, but they also have the danger of being one-sided.

I have aimed to be eclectic in my discussion of the family therapy field as it is today. There are various views of eclecticism. Some consider it a euphemism for a muddled approach based on unclear theoretical

foundations. I do not see it this way. We need to have at our disposal a range of methods of intervening in families with different problems and aims. Families vary in the interventions to which they will respond positively. I have therefore tried to outline some of these. All the schools of therapy have something to contribute to the work we do with families. I have tried to define what each has to contribute. While every therapist must have a theory of change, and a clinical approach, I also offer, in Chapter 13, a method of working with families that the new therapist may find useful. In due course each therapist will develop her or his personal style and way of working.

The book has been extensively rewritten for this edition. Not only are new therapeutic techniques and theories discussed, but there is new material on cultural issues; on special therapeutic challenges; and on research, 'evidence-based' practice and the evaluation of outcomes. But perhaps one of the biggest changes, certainly since the first edition, is the increased emphasis on family therapy as a collaborative activity involving therapist and family as partners in the quest for solutions to the family's problems. No longer is the therapist someone who 'does' something, from a position of authority and as a person with special expertise, to bring about the desired changes; he or she is instead a partner in a joint enterprise, a trend that is occurring in many areas of medicine.

It is an ethical imperative that all of us who practise family therapy keep up to date with advances in the field and the latest research. In view of the quantity of new knowledge that becomes available month by month, this presents a challenge. We must continually examine the available literature so that we can evaluate the evidence for the effectiveness, or otherwise, of various possible clinical approaches. In Chapters 17 and 18 I have outlined ways of approaching what may seem to be a daunting task. A glance on a regular basis through at least a selected few of the many available family therapy journals need not take up a lot of time. You may then choose to read in full those articles that are of particular interest to you. Many journals are available online so you may not have to leave your office or home to do this.

Philip Barker

## Chapter 1

# The Development of Family Therapy

Family therapy emerged during the second half of the twentieth century, as an often potent means of helping individuals and families with a variety of problems. Until the 1950s the emphasis of psychiatrists and other psychotherapists was on the psychopathology and treatment of individuals. Even group therapy had as its main aim the resolution of the problems of the individuals in the group. While the importance of patients' environments was not denied, the current family environment of those seeking treatment was not looked upon as a possible focus for intervention.

The second half of the twentieth century also saw an increasing interest in larger systems in areas other than family therapy. By way of example let us see how this change affected the science of physics. Gleick (1988, page 6), in his book *Chaos*, wrote:

'The mainstream (of physics) for most of the twentieth century has been particle physics, exploring the building blocks of matter at higher and higher energies, smaller and smaller scales, shorter and shorter times. Out of particle physics have come theories about the fundamental forces of nature and about the origin of the universe. Yet some young physicists have grown dissatisfied with the direction of the most prestigious of sciences. Progress has begun to seem slow, the naming of new particles futile, the body of theory cluttered . . . the field had been dominated long enough, they felt, by the glittering abstractions of high-energy particles and quantum mechanics.'

Gleick (1988, page 7) goes on to say that:

'Understanding nature's laws on the terms of particle physics left unanswered the question of how to apply those laws to any but the simplest of systems. Predictability is one thing in a cloud chamber where two particles collide at the end of a race around an accelerator. It is something else altogether in the simplest tub of roiling fluid, or in the earth's weather, or in the human brain.'

We need only substitute 'psychotherapists' for 'physicists', 'individual psychotherapy' for 'particle physics', and 'family systems' for the various systems mentioned in the last sentence above, to get some idea how it is that family therapy has emerged as a major treatment modality. Working

with individuals, and studying individual psychopathology, can carry us only so far. In child psychiatry, for example, it is commonplace to meet children who are perfectly behaved at home and exceedingly difficult at school; or fine with their grandparents but troublesome with their parents; or 'good' with one parent and 'bad' with the other. To explain such discrepancies we must consider not only the individual subject but also the systems of which that person is a part.

Understanding individuals tells us little about how they will behave in social situations of different sorts. Family therapists tend to see human problems in the context of their clients' environments, especially their families, although the wider systems of which families are a part are gaining increasing attention. They concentrate on interpersonal processes, rather than on those occurring within the minds of the individuals in the families they treat. We might think of them as traffic engineers whose job it is to see that vehicles travel smoothly on highways. Therapists with an 'intra-psychic' orientation would correspond to mechanics, whose concern is the internal workings of vehicles.

The fact of the matter, of course, is that good treatment may require both approaches, or at least the taking into account of both sets of factors. While the two types of therapy require different skills and training, and are based on different theoretical systems, the therapist should ideally have skills in both areas.

Among the first to point out the importance of the family in the therapeutic endeavour were Christian Midelfort who, in 1957, published *The Family in Psychotherapy*; and Nathan Ackerman, whose book *The Psychodynamics of Family Life* (1958) marked an important point in the development of family therapy. Ackerman pointed out that while psychiatrists had 'acquired adeptness in the retrospective study of mental illness, in the minute examination of family histories . . . they (had) not yet cultivated an equivalent skill in the study of family process here and now' (Ackerman, 1958, page 89). He went on to say that, by acquiring skills in working with whole family groups, we would come to have 'a new dimension to our insights into mental illness as an ongoing process that changes with time and the conditions of group adaptation'. Prophetic words, indeed!

## The early years of family therapy

Prior to the Second World War, the response of psychiatrists to the difficulties their patients appeared to have in adapting to their family and social environments was often to remove patients from their families in order to ensure recovery in a setting away from the possible adverse effects of their family environments. This was often in a psychiatric hospital far away from their families; or if psychoanalysis was to be the treatment used, the transference relationship with the therapist was supposed to replace that with

the actual family member(s) with whom the subject was believed to have difficulty.

After the publication of *The Psychodynamics of Family Life*, Ackerman's thinking developed gradually. His second book, *Treating the Troubled Family* (1966), is indeed a book about the treatment of 'the family as an organic whole'.

Other pioneers include John Elderkin Bell who, however, did not publish descriptions of his work until the early 1960s (Bell, 1961, 1962). His book *Family Therapy* did not appear until 1975.

In the 1950s several groups embarked on the investigation and/or treatment of subjects with schizophrenia and their families. In 1952 Gregory Bateson obtained a grant to study communication and its different levels. He was joined in 1953 by Jay Haley and John Weakland and by a psychiatrist, William Fry. In 1954 the group embarked on a 'Project for the Study of Schizophrenia'. Don Jackson joined this group as a consultant and as the supervisor of psychotherapy with patients with schizophrenia. The work of this group had a profound influence on the thinking of many family therapists. Bateson and his colleagues introduced the concept of the 'double-bind', discussed in a later section.

The Mental Research Institute (MRI) was founded by Don Jackson, in Palo Alto, California, in 1959. Although Jackson acted as consultant to the Bateson group, the MRI was a separate entity. It contributed much to the development of family therapy, and continued after Bateson's group disbanded in 1962.

Theodore Lidz (Lidz & Lidz, 1949) began studying the families of patients with schizophrenia at Johns Hopkins Hospital, Baltimore, in 1941, later moving to Yale University. He introduced the concepts of *schism*, the division of the family into two antagonistic and competing groups; and *skew*, whereby one partner in the marriage dominates the family to a striking degree, as a result of serious personality disorder in at least one of the partners.

Lyman Wynne started to study the families of schizophrenics shortly after he joined the staff of the National Institute of Mental Health in 1952. In 1972 he became Professor in the Department of Psychiatry at the University of Rochester, New York, and continued to study schizophrenic families until his retirement. He introduced the concepts of *pseudo-mutuality* and *pseudo-hostility*.

Pseudo-mutuality (Wynne et al., 1958) arises when an individual feels the need for a relationship with someone, perhaps because of painful earlier experiences of separation anxiety. A person in a pseudo-mutual relationship tries to maintain the idea or feeling that he or she is meeting the needs of the other person; in other words that there is a mutually complementary relationship. Those involved in pseudo-mutual relationships are predominantly concerned with fitting together at the expense of their respective identities. Genuine mutuality, by contrast, thrives upon

divergence, the partners in the relationship taking pleasure in each other's growth. Each has a real wish that the other achieve fulfilment of desires and expectations. In pseudo-mutuality there is dedication only to the sense of reciprocal fulfilment, not to its actuality. With pseudo-hostility (Wynne, 1981), the apparent emotional relationship, in this case hostility, is a substitute for a true, intimate relationship, which is absent. Wynne and his colleagues concluded that the families of 'potential schizophrenics' are characterized by pseudo-mutuality and consequently have rigid, unchanging role structures which they cling to as essential.

Wynne et al. (1958) also introduced the idea of the 'rubber fence'. He described how the psychological boundary to the family moves, if it has to, to keep the individual family members confined within the system. The boundary itself, though it may move, is quite impervious to outsiders and new information. A consequence is that the children do not have normal and necessary experiences with people outside the family. Instead, there is a continual effort to maintain the family as a self-sufficient social system. The 'rubber fence' prevents members from psychologically leaving, even though the feelings and ideas acceptable within the family may constantly shift (Singer and Wynne, 1965).

Carl Whitaker, a psychoanalytically trained psychiatrist, had started experimenting with the treatment of family groups before he took up the Chair of Psychiatry at Emory University, Atlanta, in 1946. With John Warkentin and Thomas Malone he continued this work, developing his own distinctive approach to family therapy. Nichols (1984) later described Whitaker as 'strong-willed and colorful . . . dynamic and irreverent'. After resigning his university appointment in 1955, he continued in practice in Atlanta until 1965, developing his own, highly personal approach to therapy (Whitaker, 1958).

Ivan Boszormenyi-Nagy, another psychoanalyst turned family therapist, founded the Eastern Pennsylvania Psychiatric Institute in Philadelphia in 1957. With his colleagues, James Framo, David Rubenstein, Geraldine Spark and Gerald Zuk, Boszormenyi-Nagy developed an approach to family therapy that paid particular attention to its multigenerational aspects. He proposed the concept of 'invisible loyalties'. This was the title of a subsequent book of which he was co-author. He was one of a number of therapists who came to feel that work should not be limited to the nuclear family or to current transactions. Multigenerational linkages and the wider family system began to be taken increasingly into account.

Like Whitaker, Boszormenyi-Nagy and his colleagues made extensive use of co-therapy, the practice of having two therapists in the room with the family being treated. Boszormenyi-Nagy, together with Framo, edited the book *Intensive Family Therapy* (1965), the contributions to which surveyed much of the contemporary family therapy scene.

Two other important early pioneers were Murray Bowen and the British psychiatrist Ronald Laing. Bowen (1960) developed the concept of

schizophrenia as a process requiring three generations to develop. Typically, he said, the grandparents were 'relatively mature but their combined immaturities were acquired by one child who was most attached to the mother' (Bowen, 1960, page 354). When such a child married an equally immature spouse the same process was repeated in the next generation. The result was one child who was very immature while the others were much more mature. Bowen believed that such a child is liable to develop schizophrenia in an attempt to adapt to the demands of growing up.

Laing also studied the families of schizophrenics. His findings concerning the first 11 patients and their families were reported by Laing and Esterson (1964) and his ideas were also set out in a chapter entitled 'Mystification, confusion and conflict' (Laing, 1965). He placed great emphasis on the concept of *mystification*. The term can be used both to describe the *act* of mystification and the *state* of mystification. The state of mystification is one of being befuddled and clouded. The mystified person feels masked from situations and finds them obscure. The act of mystification is what is done by others to bring about this state in a person. The person may or may not be aware of being befuddled, and so may not *feel* mystified.

Laing believed that some mystification occurs in everyday life. People sometimes deny the experience of others and replace it with their own. A mother may use a 'straight' way of telling her son to go to bed, saying for example that it is bedtime or that it is her function to determine when he should go to bed; or she may use a 'mystifying' way saying, for example, 'I'm sure you feel tired, darling, and want to go to bed, don't you?' Here a command is dressed up as an expression of solicitude and concern. It attributes to the child feelings, such as fatigue, which he may not have.

Mystification is a means whereby one person tries to control another. The person who is trying to achieve control does not use direct means, but instead attributes opinions, feelings or values to the other person. An example is to be found in the following quotation from Laing (1965, pages 349–50):

*Mother:* I don't blame you for talking that way. I know you don't really mean it.

*Daughter:* But I do mean it.

*Mother:* Now, dear, I know you don't. You can't help yourself.

*Daughter:* I can help myself.

*Mother:* No, dear, I know you can't because you're ill. If I thought for a moment you weren't ill, I would be furious with you.'

Laing links his concept of mystification with the ideas of Wynne and Lidz. He considers that it functions to maintain stereotyped roles at the expense of reality, rather as pseudo-mutuality and pseudo-hostility were considered to do. It also serves to fit other people into a set mould as described by Lidz et al. (1958). The imperviousness to children's needs and the masking of disturbing situations in the family, both of which

are described by Lidz and his colleagues, are common concomitants of mystification.

Laing (1965) also refers to Searles' (1959) description of six ways 'to drive the other person crazy'. Searles was another early student of the families of schizophrenics, and Laing pointed out that all six of the processes Searles describes are mystifying, involving, as they do, things which undermine the other person's confidence in his or her own emotional reactions and perception of reality. The six ways are:

- (1) Repeatedly drawing attention to areas of the subject's personality of which the subject is unaware.
- (2) Stimulating the person sexually in situations in which sexual gratification would have disastrous consequences.
- (3) Exposing the person to stimulation and frustration, either simultaneously or in a rapidly alternating pattern.
- (4) Relating to the person simultaneously at levels which are unrelated, for example sexually and intellectually.
- (5) Switching 'emotional wavelengths' while discussing the same topic, for example talking in a humorous way and a serious way about the same thing.
- (6) Switching from one topic to another while maintaining the same 'emotional wavelength', for example talking about a matter of life and death in the same vein as a trivial matter.

## The 1960s

Most of the pioneers mentioned above continued their work with families in the 1960s, although Bateson's group disbanded in 1962. The pioneers were joined by many new entrants to the family therapy field.

Jackson, at MRI, continued to develop his methods of treating families. Although he had psychoanalytical training, increasingly he concentrated on the study and treatment of interpersonal processes. He introduced the term 'behavioural (or communicational) redundancy', to describe the way family members, and others in ongoing relationships, develop repetitive patterns of interaction – patterns that therapy must sometimes help alter if the changes clients seek are to occur. He also wrote about homeostatic mechanisms (the means whereby families maintain relatively set ways of functioning); complementarity/symmetry; *quid pro quo* processes; and the double-bind. He distinguished between families' 'norms' – rules that are not overtly acknowledged, but can be observed when the functioning of families is studied; 'values' – rules that are consciously acknowledged; and 'homeostatic mechanisms' – rules about how the family's norms and values are to be applied. These 'rules about rules' he dubbed *metarules*.

Jackson's work appeared in a number of papers, some written with John Weakland (Jackson & Weakland, 1959, 1961; Jackson, 1961, 1965). Jackson

was also co-author of *Pragmatics of Human Communication* (Watzlawick et al., 1967), which set out much of what had been discovered at the MRI concerning human communication, especially in families. He died in 1968.

Jay Haley, an original member of Bateson's group, made major contributions to the growth of family therapy during the 1960s. He was much influenced by the work of Milton Erickson, which he later described in the book *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson* (Haley, 1973). *Strategies of Psychotherapy* (Haley, 1963) set out Haley's early position, and a series of publications have since traced his development as one of the most continually creative of the fathers of family therapy (Haley, 1967, 1976, 1980, 1984).

Haley developed a directive approach to therapy with families. He also stressed the importance of the hierarchical structure of the family, seeing many family problems as due to confused or dysfunctional hierarchies. He believed that the therapist must be in charge of the treatment, rather than allowing the family members to take over. He does not hold the attainment of insight by clients in high regard. For him, the main need is to get the family to *do* something – something that will help them change their habitual, but dysfunctional, ways of interacting.

In the 1960s, Murray Bowen expanded the range of his clinical work, so that he treated the families of children with problems other than schizophrenia. In doing so he discovered that many of the processes which he and others had observed in the families of schizophrenics were also to be found in other families. He described what he called the *undifferentiated ego mass*, observing that in many families with problems, members often seemed to lack separate identities (Bowen, 1961).

In the mid-1960s Bowen experienced an emotional crisis. He came to understand this as related to unresolved issues in his own family which, it turned out, were not in his current nuclear family, but in his family of origin. His came to understand his problems as the result of the process of *triangulation*. Triangulation occurs when a third member is drawn into the transactions between two people, often a marital couple. Instead of communicating directly with each other the couple communicate through the 'triangulated' third person, who may be a child. Thus one spouse may voice complaints about the other to a child, who is then faced with the problem of whose side to take, or whether to take either parent's side, and indeed how to react generally. This child may develop undue anxiety, antisocial behaviour or other problems. At the same time, the parents' issues remain unresolved.

Apparently, Bowen believed that such unresolved problems existed in his family of origin. Eventually he returned to his family in Pennsylvania and managed to 'detriangulate' himself, a process which he described in a paper published anonymously (Anonymous, 1972), though its authorship soon became known. This paper is included in the volume *Family Therapy in Clinical Practice* (Bowen, 1978), which includes all Bowen's major publications.

Ackerman continued as a leader of the family therapy movement throughout the 1960s. In 1961, with Jackson, he co-founded *Family Process*, the first journal devoted to family therapy. He made many other contributions to the family therapy literature (Ackerman, 1961, 1966, 1970a, 1970b, 1970c). He died in 1971, and is commemorated in the name of the Ackerman Institute in New York City.

During the 1960s, Wynne and Boszormenyi-Nagy continued to work along lines similar to those they had pursued in the 1950s.

Virginia Satir, a charismatic and enormously talented therapist with a forceful personality and strong views, joined Jackson shortly after he founded MRI. Her book *Conjoint Family Therapy* (1967) influenced many therapists. She emphasized the communication of feelings in families and, more than many family therapists, was interested in the personality and development of the individuals in a family and the psychodynamic processes behind their behaviour.

The second chapter of *Conjoint Family Therapy* is entitled, 'Low self-esteem and mate selection'. It explores how people, whose views of themselves are poor, depend on what others think of them. They present a 'false self' to the world, rather as Winnicott (1960) defines the term. People with low self-esteem are liable to marry other similar people. Each partner is deceived by the psychological defences of the other – that is by the false self the other presents to the world. At the same time each has fears of disappointment and difficulty in trusting others, including, of course, their respective mates. Satir suggests that this can lead to serious marital difficulties.

A major figure to emerge in the United States during the 1960s was that of Salvador Minuchin. A native of Argentina, and a psychoanalytically trained psychiatrist, he went to work with young delinquents at the Wiltwyck School for Boys in New York City. He soon realized the limitations of current methods of treating these young people and their families, mostly urban slum families. Along with a group of colleagues, he developed methods of working with them. His innovative approach, published in *Families of the Slums* (Minuchin et al., 1967), was probably responsible for his being offered the directorship of the Philadelphia Child Guidance Clinic. Under his direction, this became one of the world's foremost family therapy centres.

Minuchin was largely responsible for the development of the 'structural' school of family therapy. Structural therapists are interested in how families are organized in sections, or subsystems, and in the boundaries between these parts; also in the boundaries between the family unit being studied and the wider community. Therapists using this model see family problems as related to their structure. There may be a structure which does not permit satisfactory functioning, for example a lack of an appropriate boundary between the parental and the child subsystems. The structural approach is already evident in *Families of the Slums* (Minuchin et al., 1967),

but was set out in perhaps its classic form in *Families and Family Therapy* (Minuchin, 1974).

Minuchin also advocated the use of the one-way observation screen. Until the advent of family therapy, therapists rarely watched each other work. Even therapists in training limited themselves to reporting to their supervisors what they believed had happened during their therapy sessions. Family therapists opened up the process, both by the common practice of having observers watch and listen through one-way observation screens, and by the use of videotapes which enable therapy to be reviewed, if necessary, repeatedly.

Although most of the early family therapists worked in the United States there were important developments elsewhere. A 'family psychiatric unit' was established at the Tavistock Clinic, London, in the late 1940s. Under the direction of Henry Dicks (1963, 1967), the staff of this unit worked mainly with marital couples who were having problems in their relationships. Another British pioneer of family therapy was Robin Skynner, who made two noteworthy contributions to the family therapy literature before the 1970s (Skynner, 1969a, 1969b). In Germany, family therapy had made enough progress that Horst Richter could, by 1970, publish his book *Patient Familie*. This was later translated into English and published as *The Family as Patient* (Richter, 1974). In Montreal, Canada, Nathan Epstein led the 'family research group' at the Department of Psychiatry of the Jewish General Hospital. This developed into one of the earlier systems for describing the functioning of families, the 'Family Categories Schema' (Epstein et al., 1968).

## The 1970s

Family therapy came of age in the 1970s. It was increasingly accepted in major psychiatric centres. Family therapists began to address themselves to a wider range of disorders, and there was less emphasis on people suffering from schizophrenia and their families.

Many new centres for the study and development of family therapy were established in the 1970s, and many new books appeared. Peggy Papp (1977) edited *Family Therapy: Full Length Case Studies*, which presented the work of 12 prominent family therapists, including herself. Each contributed an account of the treatment of a family. The book provides a snapshot of family therapy in the 1970s, and illustrates the diversity of approaches used by therapists at that time. Lynn Hoffman's (1981) *Foundations of Family Therapy* surveyed the state of family therapy as the 1970s came to an end.

The Philadelphia Child Guidance Clinic, under Salvador Minuchin's leadership, became one of the world's leading family therapy centres. The child guidance clinic was closely associated with the Children's Hospital of

Philadelphia. This facilitated the joint study of children with psychosomatic disorders and their families and led to the book *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin et al., 1978).

Haley spent several years at the Philadelphia Child Guidance Clinic before going to Washington, DC, where, with his wife, Cloe Madanes, he founded the Family Institute of Washington, DC. Also established in Washington, DC, by Murray Bowen, was the Georgetown Family Center.

During the 1970s Murray Bowen continued to refine his theory, renaming the 'undifferentiated family ego mass' the 'nuclear family emotional system'. He ceased treating the families of schizophrenics, applying his methods instead to a wider range of problems, not usually involving a psychotic family member. Wynne, on the other hand, continued to study people with schizophrenia and their families and built up a team of researchers at the University of Rochester (Wynne et al., 1978). They also addressed the issue of the relative 'invulnerability' of some children by studying the presence of healthy communication patterns and other aspects of healthy family functioning that may coexist with disturbed family relationships. These might reduce the risk of severe psychopathology and promote healthy or even superior functioning in the offspring.

In Canada, Epstein and his colleagues made the Department of Psychiatry at McMaster University, Hamilton, Ontario, an important centre for the practice and teaching of family therapy. With colleagues he developed, from the Family Categories Schema, the McMaster Model of Family Functioning (Epstein et al., 1978) and, later, the McMaster Model of Family Therapy (Epstein & Bishop, 1981).

The 1970s saw important developments in Europe, especially Italy and Great Britain. In Milan, Italy, Mara Selvini Palazzoli played a major role in setting up the Institute for Family Study. This was founded in 1967 but had its main impact in the 1970s. She was one of four psychoanalytically trained psychiatrists who became the 'Milan Group'. The others were Gianfranco Cecchin, Giulana Prata and Luigi Boscolo. They were much influenced by the work of the Palo Alto therapists, especially Bateson, and by Watzlawick and his colleagues. They found that families often came for help, yet seemed determined to defeat the attempts of their therapists to help them change. They proposed the term 'families in schizophrenic transaction', for such families and described them, and their treatment, in the book *Paradox and Counterparadox* (Palazzoli et al., 1978a; the book was originally published in Italian in 1975).

Among the contributions to family therapy made by the Milan group were: their techniques of 'circular interviewing' and 'triadic questioning', whereby the therapist asks a third family member about what goes on between two others; their concept of developing hypotheses about the functioning of a family in advance of the interview and then devising questions to test the hypotheses; developing a better understanding of how the 'symptom' is connected to the 'system'; and their way of structuring each

therapy session. The latter comprised a five-part 'ritual' consisting of a pre-session discussion, the interview, the intersession discussion, the intervention and the postsession discussion.

In Rome, Maurizio Andolphi started working with families early in the 1970s, and in 1974 founded the Italian Society for Family Therapy. By 1979 he was able to publish an excellent systems-based book, *Family Therapy: An Interactional Approach*.

In Britain, Skynner, in 1976, published *One Flesh: Separate Persons* (published in the USA as *Systems of Family and Marital Psychotherapy*). This provided a view of family therapy as seen by a British psychiatrist trained in the Kleinian school of therapy. Important work was also being done at the Family Institute in Cardiff, Wales. The first director of this institute, Sue Walrond-Skinner (1976), published *Family Therapy: The Treatment of Natural Systems*, a book addressed primarily to social workers. Brian Cade and Emilia Dowling were among the other members of the staff of this institute who were responsible for placing it in the forefront of family work in Britain. Walrond-Skinner (1979) also edited the book *Family and Marital Psychotherapy*, with contributions by 11 British family therapists, giving a wide-ranging view of the British family therapy scene at that time.

Another British pioneer of the family approach to psychiatric problems was John Howells, a child psychiatrist turned family therapist, who founded the Institute of Family Psychiatry in Ipswich. He distinguished his approach as 'family psychiatry', rather than 'family therapy'.

Mention must be made here of Milton Erickson. Erickson was not a family therapist. He was an unconventional but creative psychiatrist who made much use of hypnosis in his practice of psychotherapy. He studied hypnotic phenomena throughout his long career and published extensively on hypnotherapy. He greatly influenced Haley who wrote *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson* (Haley, 1973), a fascinating description of how Erickson worked.

Erickson's importance in the development of family therapy is due to his interest in the interpersonal processes in which his patients were engaged, and his use of strategic and solution-focused methods of treatment. Traditional psychodynamic psychotherapy explores and aims to resolve the repressed conflicts of individuals. The objective of the family therapist is rather to get the family members to *do* something different, to interact with each other in a different way; this was how Erickson approached many of the clinical problems with which he was confronted. Moreover, he found, as family therapists have too, that telling people what to do does not always work. Instead indirect, or 'strategic', methods, including paradoxical ones, may be needed.

*Conversations with Milton H. Erickson, MD*, Volumes II and III (Haley, 1985a, 1985b), consist of transcriptions of conversations between Erickson and, in most cases, Jay Haley and John Weakland. These took place in the

1950s and early 1960s and make it clear that Erickson had by that time developed many innovative, strategic ways of helping families change. Erickson's influence on the mainstream of family therapy has mainly been indirect, however. He himself wrote little on the subject and his innovative ideas were spread mainly by those who studied with him, notably Haley and Jackson.

The 1970s also saw an explosive development of the family therapy literature. Books not so far mentioned include *Family Therapy: Theory & Practice* (Guerin, 1976), *The Family Life Cycle* (Carter & McGoldrick, 1980) and the first two editions of this book (Barker, 1981a, 1986). Many new journals joined *Family Process*.

## The 1980s

The 1980s saw something of a *rapprochement* between the various schools of family therapy. Many of the pioneers were charismatic characters with strongly held views, and in family therapy's early days it was hard to discern a body of knowledge which all, or even most, family therapists would accept. Increasingly, however, a middle ground was defined, if not precisely, as therapists of the various previously distinct schools began to accept and use the concepts and techniques of others.

New concepts and techniques continued to emerge. These included the 'narrative' approach, and the technique of 'externalizing' problems of the creative Australian therapist, Michael White (White & Epston, 1990); various cognitive approaches to treating family problems (Epstein et al., 1988); and the 'systematic family therapy' of Luciano L'Abate (1986). In *Milan Systemic Family Therapy* (Boscolo et al., 1987), two of the original members of the Milan group, with Lynn Hoffman and Peggy Penn, set out a method of therapy developed from that presented in *Paradox and Counterparadox* (Palazzoli et al., 1978a). Minuchin's contribution in the 1980s was *Family Kaleidoscope* (1984). Beautifully written, it presented this great family therapist's views of the contemporary family and how families may be helped.

The 1980s also saw a great interest in brief, solution-focused therapy. *Patterns of Brief Family Therapy* (de Shazer, 1982) was influential in this. It describes the work of the Brief Family Therapy Centre in Milwaukee, Wisconsin, and is presented as a 'practical integration of Milton Erickson's clinical procedures and Gregory Bateson's theory of change'. It describes a quite stylized approach to therapy, employing a therapy team, one member being the 'conductor', the person who goes into the room with the family, the others being the observers behind the one-way screen. The team, observers and conductor, devise interventions, which are often tasks for the family to perform that may enable the family see their problems in a different light. In other words the problems are 'reframed'.

During the 1980s, books appeared focusing on various particular aspects of family therapy such as ‘transgenerational patterns’ (Kramer, 1985); ‘doing therapy briefly’ (Fisch et al., 1982); the use of rituals (Imber-Black et al., 1988); ‘families in perpetual crisis’ (Kagan & Schlosberg, 1989); and the use of family systems principles in family medicine (Glenn, 1984; Henao & Grose, 1985) and in nursing (Wright & Leahey, 1984, 2005); the families of adolescents (Mirkin & Koman, 1985); and the alcoholic family (Steinglass et al., 1987).

An important contribution was Michael Nichols’ book *The Self in the System: Expanding the Limits of Family Therapy* (1987). ‘If people were billiard balls,’ Nichols says, on page x, ‘their interaction could be understood solely on the basis of systemic forces. The difference is that human beings interact on the basis of conscious and unconscious expectations of each other.’ In advocating for the inclusion of consideration of family members’ personal experience in the family therapist’s thinking, Nichols takes further the ideas of Kirschner and Kirschner (1986).

## The 1990s and the early years of the new millennium

Family therapy now has a well established place among the psychotherapies. The rather uncritical enthusiasm of some of the pioneers has given way to a more balanced view of its place in the therapeutic scheme of things. There has also been an ongoing re-examination of many of the ideas and assumptions that previously characterized the field.

Steinglass (1996), writing as the journal *Family Process* entered its 35th year of publication, mentioned family therapy’s ‘ups and downs’. He used its approach to major mental disorders as an example. He pointed out that during the 1960s and 1970s family therapists were ‘hot on the trail’ of family factors that might cause or contribute to schizophrenia, but they largely abandoned this as evidence of genetic factors emerged. Yet during the 1990s, they were back working with patients with schizophrenia and their families, psychoeducational family therapy now being viewed as important.

Some of the assumptions made, implicitly if not overtly, during the 1960s have been questioned. For example, free and open communication within families was assumed to characterize healthy functioning. But an in-depth examination of the question of secrets in families (Imber-Black, 1993) showed that this is not a simple issue. Some secrets are ‘functional’ and the borderline between pathological secrecy and appropriate privacy is not always clear.

In the book *Therapy as Social Construction* (McNamee & Gergin, 1992) a series of writers questioned many of the traditional views of the process of therapy. The editors wrote of how they saw that there had been ‘a generalized falling-out within the academic world with the traditional

conception of scientific knowledge' (page 4). The concept of the scientist, or the therapist, being the 'expert' who will solve people's problems has come to be questioned. The solutions of many of our problems must come from within, so many came to contend.

But family therapy theories come and go. Thus the concept of the 'functionality' of symptoms and the behaviour of family members was popular in the early days of family therapy, but later fell into disrepute. But now it is being suggested that it may have a place and needs to be revisited (Roffman, 2005). New approaches to therapy have continued to be developed. The use of the 'reflecting team' (see Hoffman, 2002, pages 149–168) is but one example.

During the 1990s interest increased in the application of cognitive behavioural methods in family therapy. In *Understanding and Helping Families: A Cognitive-Behavioral Approach* Schwebel and Fine (1994) described and discussed the 'cognitive-behavioral family model' (CBF). The basis of this approach is the assumption that the 'experiences, thoughts, emotions and behaviours (of individuals) are heavily shaped by the manner in which they cognitively structure their world' (page 30). Therapy aims 'to help participants become aware of and correct' their unhealthy cognitions.

In Chapter 3 (pages 36–55) of their book Schwebel and Fine describe the *family schema*. In CBF this term describes 'all the cognitions that individuals hold about their own family life and about family life in general' (page 50). These cognitions are 'the guidance system that directs the individual's family related behaviour' (page 55). Since that was written the application of cognitive-behavioural techniques in family therapy has received increasing attention (Dattilio, 2005; Dattilio & Epstein, 2005).

Another development has been increased attention to spiritual issues. These have come to be seen by many as an important consideration when working with families (Hodge, 2005).

Family therapy is also being applied to an ever-widening range of family types and ethnic groups. For example, the September 2005 issue of *Contemporary Family Therapy* was devoted to 'Treating Indian Families: In India and Around the World'.

*Nurturing Queer Youth: Family Therapy Transformed* (Fish & Harvey, 2005) addresses the issue of working with *sexual minority youth*. The authors prefer this term or, more simply *queer youth*, to terms such as *gay*, *lesbian*, *bisexual* and *transgendered* because they consider the former terms to be more inclusive. They point out that young people are 'coming out', to themselves, to their families and to their wider environment at ever younger ages. Fish and Harvey discuss the challenge of working with such young people and their families.

The second edition of *Family Therapy in Changing Times*, by Gill Gorell Barnes (2004) takes a broad look at the diversity of family forms created by such things as:

- New cohabitation and marriage patterns
- The choice by some of lone parenthood
- Divorce and repartnering
- Gay and lesbian parenting
- Migration
- Cultural diversity

The book discusses methods of working with families affected by such circumstances.

The family forms that Barnes considers are but a few of the many that exist around the world. Religious practices and cultural traditions vary enormously. For example, in the Muslim faith the sexes worship separately, whereas Christian couples can worship together (Hünler & Gençö, 2005). In some countries polygamy is accepted and indeed, as this is written, King Mswati II of Swaziland has 11 wives and two fiancées. By the time you read this he will probably have more, though among the Swazi population at large, three is the usual maximum number of wives. (Perhaps we should hope that the king does not seek family therapy!)

The 1990s saw the emergence of the 'post-modern' approach to therapy. This was well described in Harlene Anderson's (1997) book *Conversation, Language, and Possibilities*. The 'post-modernists' reject the concept of the therapist as the expert with the skills and knowledge to promote change in the family so that it becomes more 'functional'. Instead, therapy becomes a collaborative endeavour involving family and therapists as equals. Anderson (1997, page 32) writes:

'In the modern perspective therapy constitutes a dominant cultural-truth-informed, *therapist-led endeavour* and yields *therapist-determined possibilities*. These truths determine and actualize a priori, across-the-board diagnoses, goals and treatment strategies.' (Anderson's italics)

Anderson (1997, Chapters 5 and 6) goes on to provide one of the clearer descriptions of the post-modern approach to therapy. No longer is the therapist 'an objective, neutral, and technical expert who is knowledgeable about pathology and normalcy and who can read the inner mind of a person like a text' (page 93). This is in contrast with the collaborative approach in which the focus 'is on a relational system and process in which client and therapist become conversational partners in the telling, inquiring, interpreting, and shaping of the narratives' (page 95). Anderson continues:

'A client brings expertise in the area of content: a client is the expert on his or her life experiences and what has brought that client into the therapy relationship. When clients are narrators of their stories, they are able to experience and recognize their own voices, power and authority. A therapist brings expertise in the area of process: a therapist is the expert in engaging and participating with a client in a dialogical process

of first-person storytelling. It is as if the roles of therapist and client were reversed: *The client becomes the teacher. A therapist takes more of an “I am here to learn more about you from you” stance.*’ (page 95)

Out of such collaboration, solutions to the client’s problems are expected, by the post-modern therapist, to emerge.

Lynn Hoffman is a talented writer who has been intimately involved in the family therapy scene since 1963, when she was engaged to edit Virginia Satir’s *Conjoint Family Therapy. Family Therapy: An Intimate History* (Hoffman, 2002) which recounts, as Hoffman puts it on page xi, her ‘journey from an instrumental, causal approach to family therapy to a collaborative, communal one’. It is, however, more than this, providing an insightful, if somewhat selective, account of the development of family since 1963.

## Summary

Family therapy has developed since the Second World War as a new way of dealing with the human problems that were previously dealt with by one of the various forms of individual or group psychotherapy. It was based on a new conceptualization of how these problems come to exist. Formerly they were thought to be mainly the result of intrapsychic processes, or the ‘psychopathology’ of individuals, which was believed often to have its roots in early childhood experiences.

The family approach, by contrast, is based on the belief that these problems are related to the current interactions taking place between the individuals in the family and, sometimes, between these individuals and other social systems. It also takes into account multigenerational and extended family factors.

Initially, family therapists worked mainly with patients suffering from schizophrenia and their families, but they have come to apply their methods to the full gamut of psychiatric disorders. In its early days family therapy was divided quite sharply into schools of thought and practice. These divisions are now less clear, and a common body of knowledge has emerged and continues to expand. Family therapy methods are nowadays being applied to an ever increasing number of cultural and ethnic groups and family forms.

Recent years have seen the development of ‘post-modern’ approaches, in which therapy is seen more as a collaborative endeavour between clients and therapist. This is in contrast with the ‘modern’ approach, in which the therapist plays the role of ‘expert’ who has the training, skills and insights to intervene so as to resolve clients’ problems.