Individual and Family Therapy

CLINICAL PRACTICES OF FAMILY THERAPISTS

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In the thirty years since T.S. Eliot first dramatized the innovation of family therapy (see chapter 2), the numbers of family systems theories, family training programs, and family therapists have been increasing at an unimaginable rate. This uncontrolled development is characteristic of what Kuhn (1962) described in *The Structure of Scientific Revolutions* (see chapter 1) as a revolution's

> pre-paradigm period when there is a multiplicity of competing schools. . . . This is the period during which individuals practice science, but in which the results of their enterprise do not add up to a science as we know it. . . . With respect to normal science, then, part of the answer to the problem of progress lies simply in the eye of the beholder. Scientific progress is not different in kind from progress in other fields, but the absence, at most times, of competing schools that question each other's aims and standards makes the progress of a normal scientific community far easier to see. . . .Once the reception of a common paradigm has freed the scientific community from the need constantly to re-examine its first principles, the members of that community can concentrate exclusively upon the subtlest and most esoteric of the phenomena that concern it. [pp. 162-163]

Most pioneers of the family therapy revolution have until now favored the openness and unstructured development of this multiplicity of schools. But the proliferation has now come to haunt the profession. Sooner or later a discipline must develop professional standards, credentialing procedures, training accreditation and legitimized theories. To begin to address these questions an American Family Therapy Association has now been formed

with Murray Bowen as its first president. At the same time, AAMFT, the American Association of Marriage and Family Therapists (formerly the American Association of Marriage Counselors), a large, older organization with an altogether different history and tradition, has recently been recognized by the Department of Health, Education, and Welfare as the national accrediting body for training institutions for marriage and family therapy. In an attempt to avert a collision between these organizations, Donald S. Williamson, president of AAMFT, suggested in a recent memorandum (1979) that "the two organizations are twin wings of a single movement which has now naturally and irretrievably fused as far as theory, therapeutic biases, and professional personnel are concerned. From the beginning the commitment to perceive and understand human behavior in inter-relational terms and to generate treatment interventions from this framework has been the incipient bond between these two traditions and communities."

This bit of rhetoric attempts to gloss over differences for the sake of political harmony. In my view the field is far from having achieved sufficient consensus to warrant a credentialing and accrediting status. For the time being it seems best for the traditional disciplines of psychiatry, social work, psychology, and psychoanalysis to continue their already difficult tasks of giving credentials and accrediting while family systems concepts, theories, and techniques are introduced as they are developed and researched. We

must try to clarify what the various "schools" of family therapy do have in common and in what important ways they differ. I shall in this chapter survey the clinical approaches of some major contributors to the family systems approach from the perspective of the underlying premise of this book, i.e., that the polarization of individual/intrapsychic and family/interpersonal approaches is an artificial one. We need to understand in what ways the individual approach affects individuals and family systems as we need to know how the family systems approaches affect change in families and individuals.

FREUD'S AND HALEY'S UNCOMMON THERAPIES: COMPARING THE BEGINNINGS OF PSYCHOANALYSIS AND FAMILY THERAPY

The Beels and Ferber (1969) review of the field of family therapy was the first and is still the most comprehensive attempt at comparing the various family therapists' approaches. Before describing major differences in techniques, the authors correctly note what unifies all the schools of family therapy, "the goal of changing the family system of interaction" with .. individual change occurring as a by-product of system change" (p. 283).

It is natural and understandable for therapists to want to change the individuals and families who come to them for help. In the prepsychoanalytic period, reviewed in chapter 5, we noted how Freud, while experimenting with hypnosis, was also eager to actively change and "cure" the individual

disturbances referred to him.

In his 1893 paper "A Case of Successful Treatment by Hypnotism," Freud dramatically intervened in a strategic way that had obvious and immediate ramifications along both intrapsychic and transactional pathways, and it has much in common with some of the recent developments in family systems therapy.

Almost ninety years ago Freud was consulted by the family of a young woman in her mid-twenties who was unable to feed her newborn infant. The woman vomited all her food, became agitated when it was brought to her bedside and was completely unable to sleep. After a thorough abdominal examination, Freud hypnotized her, using ocular fixation, and suggested away her symptoms. Cured for a day she then relapsed as anticipated by her husband, who in fact feared her nerves would altogether be ruined by hypnosis. A second hypnosis was attempted the following day.

> I told the patient that five minutes after my departure she would break out against her family with some acrimony: what happened to her dinner? did they mean for her to starve? how could she feed the baby if she had nothing to eat herself? and so on.
>
> When I returned on the third evening, the patient refused to have any further treatment. There was nothing more wrong with her, she said: she had an excellent appetite and plenty of milk for the baby, there was not the slightest difficulty when it was put to her breast, and so on. Her husband thought it rather queer that after my departure the evening before she had clamored violently for food and had remonstrated with her mother in a

> way quite unlike herself. But since then, he added, everything had gone all right, [p. 120]

We can only speculate as to the basis of this remarkable "hit-and-run," symptomatic cure. It is commonplace in many family therapies to encourage more open expression of feelings among family members and to "prescribe" behaviors. Such interventions are rarely welcome and require the tactful handling of family resistances. Was the intervention successful due to the "abreaction" of her "strangulated affects," a formulation developed with Breuer (1893) and/or due to the anxiety in herself and the family members created by the uncharacteristic, rule-breaking expression of her suppressed hostility.

In his discussion of the mechanism of his patient's disorder, Freud demonstrated his earliest plummeting into dynamic psychic determinism. It was the beginning of an unparalleled voyage into the depths of psychic functioning. He postulated the presence in his patient of "distressing antithetical ideas," that is, ideas running counter to intentions. The patient had every intention of feeding her child. However, "counter intentions in neurotics are removed from association with the intentions and continue to exist as a disconnected idea, often unconsciously to the patient" (p. 122). These novel formulations of unconscious motivations and of ambivalence were the beginnings of the elaborate and comprehensive theory of mental functioning that was to become psychoanalysis.

The case however, even as unelaborated in details as this one, suggests the presence of ongoing interpersonal conflicts, as well as intrapsychic forces. In her regressed state, unable to feed her baby, she simultaneously identified with the ungiving mother and the unfed child, thus acting out with her child her ambivalence conflict with her own mother. That she was not allowed expression of her conflict in the family setting is implied in her becoming "unlike her (usual) self" in the rebellious attitude set off by Freud's suggestion. That her husband may have expected her dysfunctioning is suggested by his prediction that her nerves would be altogether ruined by hypnosis.

In getting his patient to remonstrate with her mother in a way quite unlike herself and thereby losing her symptoms, Freud had achieved an optimum family therapy goal: changing the family system of interaction. In this instance Freud was intervening in what Plaley, in his recent book *Uncommon Therapy: The Psychiatric Techniques of Milton Erickson, M.D.* (1973), would call an overinvolved dyad (pp. 36-37). By inducing her anger Freud could help the patient begin to disengage from her intense overinvolvement with her mother and gain control over her symptom of vomiting. The intervention also participated in the paradoxical component Haley has noted in all hypnotic therapy. "The hypnotist directs another person to spontaneously change his behavior. Since a person cannot respond spontaneously if he's following a directive, the hypnotic approach poses a

paradox. The way the subject adapts to such a conflicting set of directives is to undergo a change and behave in a way described as trance behavior" (p. 21). Freud's intervention was doubly paradoxical in that he told the patient who was vomiting all her food to angrily ask for more food if she was to feed the baby she had said she was unable to feed. This element demonstrates the point made by Don Jackson about the ambiguity regarding the patient's ability or inability to control his symptoms. Before Freud such symptoms were seen as manipulative and as manifestations of malingering. Freud introduced the idea of unconscious ideas motivating symptoms (Freud and Breuer 1895) and later explored the role of secondary gain in symptom formation (1905, pp. 42-44). This question of secondary gain is, I believe, one of the major points of linkage between psychoanalytic theory and family systems theory, which more recently has come to see symptoms as induced or expected of the identified patient by the immediate context.

The case is almost identical in family structure to the one Haley uses to illustrate illness in the childbirth phase of the family life cycle (pp. 185-188). In fact, it coincides in its family aspects with almost every case of postpartum illness I have seen. In addition to the regression in the identified patient, there is an uncanny collusive participation of the husband and either or both sets of grandparents. In their eagerness to take over the nurturing function of the new mother, they compound and reinforce the patient's maladaptation.

Haley's emphasis upon employing, as foci of psychiatric intervention, the difficulties attendant upon the transitions in the family life cycle is the very considerable contribution of his book. He illustrates again and again the participation of other family members in the identified patient's illness. The families are, in fact, having difficulty carrying out the functions of their stage of development. By highlighting the stages of family development, he lays the groundwork for the next theoretical step of linking these stages developmentally with one another as Erik Erikson (1950, pp. 219-234) did so elegantly within the framework of individual psychology (see chapter 3). Perhaps as we develop our family theories further, we can go beyond the miraculous- sounding strategies outlined in*Uncommon Therapy*. Haley's need, however, to debunk insight, intrapsychic forces, the unconscious, and long-term intensive therapy, none of which is centrally relevant to the management of family crises or psychiatric emergencies, mars his otherwise excellent book. Psychoanalysis is not the indicated therapy in crises. Because its theories were probably overutilized when no other theories or models were available is no reason to discard its hard-won insights.

As imaginative as the miraculous-sounding strategies described by Haley are, they nonetheless sound like attempts to outsmart the patient and terminate the contact as quickly as possible. This approach leaves unanswered the question of how long-lasting the changes brought about will be and what the bases of these changes are. In this regard, Freud observed

that his patient relapsed with the birth of her next child. He went beyond his uncommon hypnosis of the 1890s to develop the even more uncommon therapy of psychoanalysis. Not to ask these questions concerning follow-up and the dynamics of change is to relegate such therapeutic innovations to the long list of successful, uncommon faith healers that have marked the history of psychotherapy. The history of psychotherapy is replete with illustrations of symptom alleviation from the days of Aesclepius to the fads of the 1960s and 1970s (see Buckley and Sander 1974). The advancement of psychotherapy as a science rests upon the greater insight gained into the processes — biological, psychological, and social — of symptom formation and "abnormal behavior." The family systems paradigm assumes that significant portions of human behavior and experiences are (to degrees never fully realized) overdetermined by the social field and has demonstrated that as a modality it too can achieve symptomatic improvement. But to embrace behavioral change as a raison d'etre of family therapy will doom its further development.

The importance of and for many the centrality of the social field has been rediscovered by the family therapy movement. The most radical exponents of this view have been the communications school of family therapists, which include Don Jackson, Paul Watzlawick, John Weakland, Jay Haley, and more recently Mara Palazzoli and Salvador Minuchin. They are all indebted to Gregory Bateson; the title of his recent collection of writings (*Steps to an Ecology of the Mind* 1975) marks the pole toward which the

systems theory purists are traveling. It was this group that first described the concept of the double bind (Bateson, Jackson, Haley, and Weakland 1956) and saw schizophrenia as a manifestation of profoundly disturbed, rule-governed communication processes between people. It is this group that has written most lucidly about communication in family systems (see especially Watzlawick et al. 1967) and that has developed a model that is primarily change oriented. This emphasis is in striking contrast to a principle of psychoanalytic treatment, most recently restated by Gedo (1979), that "the analyst should not approach his or her clinical work with the personal need to be a healer; to require patients to improve is an illegitimate infringement on their autonomy" (p. 649).

It is one of the ironies in the history of the family therapy revolution that in the eagerness to do away with "the medical model" the most radical family therapists have incorporated the underlying attitude of that very same model, that is, the active intervention and change of a dysfunctioning entity, be it an individual or a family. We see this trend most elaborated in the work of Minuchin, to whom we now turn.

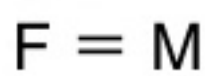
MINUCHIN'S STRUCTURAL FAMILY THERAPY

Significantly influenced by the communications theorists just mentioned, Salvador Minuchin has risen to national prominence as the

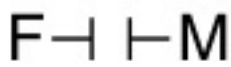
proponent of the structural family therapy approach. This theory, developed at the Philadelphia Child Guidance Clinic, forms the framework for a therapy that is, as stated on the second page of his *Families and Family Therapy* (1974), "directed toward changing the organization of the family." He reiterates that "structural family therapy is a therapy of action. The tool of the therapy is to modify the present, not to explore and interpret the past" (p. 14). Clearly his framework is established in diametrical opposition to what he imagines is the individual psychoanalytic approach. It is a common misunderstanding to think that psychoanalytic treatment begins and ends with the past. The present transference relationship, which repeats the past, is the actual focus of the unfolding work.

To better understand his revolutionary stance, we would do well to look at the patient population out of which his theories evolved. His earliest contribution was a result of his work in a project at the Wiltwyck School for Boys, which culminated in *The Families of the Slums* (1967). The delinquents treated in that project came from very "disorganized" families that required "restructuring." The treatment formats developed emphasized the necessity of creating appropriate role boundaries for the family's subsystems, be they for spouse, parent, or sibling. Common in the early treatment strategies was the tendency to use the one-way screen to demarcate family subsystems. A grandmother, for example, who tended intrusively to control a family's interaction, might be asked to stay behind the one-way screen while the

mother and father discussed their child-rearing difficulties. In this early work we see the beginnings of what was to become the structural family therapy notation system. Healthy families include a gratifying spouse/parent affiliation



in contrast to a conflictual relationship



that in turn related to “overinvolvement” of a parent and child.

Boundaries tended to be rigid (_____), with detachment,

diffuse (. . . . . .), with enmeshment, or

clear (_ _ _ _ _).

While we may look at this work today and see it as the application of common sense, in the fifties and early sixties, the mental health professions, for reasons explored in the next chapter, were reluctant to adopt a family systems approach while attempting the near impossible individual treatment of the casualties of these disorganized families (see Meers 1975 for a psychoanalytic discussion of this clinical population).

Families of the slums are not the only families in need of structural support or change, and this accounts for much of the success and wider popularity of Minuchin's approach. At this stage in our social history, as we noted in the second chapter, the structure and functioning of American families are changing rapidly. The high divorce and remarriage rate has created many families where parenting roles become highly fragmented. Minuchin's diagrammatic and programmatic approach is easily taught to trainees who attempt to help families establish appropriate role boundaries, alliances, and coalitions. A trainee in one of my seminars, after reading Minuchin's book, had the parents of a family, after two sessions, move into the parental bedroom, which had been given over to the children.

Beyond the ubiquitous sociological upheavals the structural family

therapy approach also appears relevant to patients with severe psychosomatic illnesses (see Minuchin 1978) and often with families of behaviorally symptomatic children. Minuchin and his coworkers have repeatedly exposed the ineffectiveness and inappropriateness of the individual treatment approach when families are functioning in a manifestly malignant manner.

The case reports and edited teaching tapes that have been produced over the years by the Philadelphia Child Guidance Clinic as well as such publicity as a recent lead article in the New Yorker (Malcolm 1977) have established the Minuchin approach as a leading school in the family therapy movement.

We should nonetheless ask whether this approach is any further in its development than psychoanalysis in its early days. In a teaching tape titled "A Modern Little Hans" (also briefly discussed in *Families and Family Therapy*, 1974, p. 153), the approach is used to cure a young boy's dog phobia by "restructuring" the family. The initial ("before") structural diagram of the family is like that of many in which the child is the identified patient.

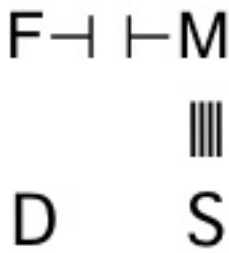


Fig. 1

There is a marked marital conflict and an overly close relationship between the mother and the identified patient. The obvious solution for the structural therapist is to arrange a closer relation between the boy and his father and foster improvement in the marital relationship.

> In "A Modern Little Hans," a child comes into therapy with a dog phobia that is so severe he is almost confined to the house. The therapist's diagnosis is that the symptom is supported by an implicit, unresolved conflict between the spouses, manifested in an affiliation between the mother and son that excludes the father. His strategy is to increase the affiliation between the father and son before tackling the spouse subsystem problems. Therefore, he encourages the father, who is a mailman "and therefore an expert in dealing with dogs," to teach his son how to deal with strange dogs. The child, who is adopted, in turn adopts a dog, and the father and son join in transactions around the dog. This activity strengthens their relationship and promotes a separation between mother and son. As the symptom disappears, the therapist praises both parents for their successful handling of the child. He then moves to work with the husband-wife conflicts, [p. 153]

The cure is accomplished in a short period of time, leading to an “after” treatment diagram:

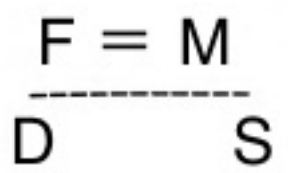


Fig. 2

There is no mention in the tape or case report that father, mother, and daughter are all visibly overweight. It is sufficient that the dog phobia has been cured.

The structural family therapists tell us that a family structure such as that in Fig. 1 is pathogenic, as it interferes with the child’s development of autonomy. Such a generalized theory tells us little of the more discrete aspects of development. Why after all should the modern Little Hans have been fearful of dogs? It is, of course, fascinating that the case lends itself, as intended, to comparison with the original Little Hans case, for there too, by having the father, though not by therapeutic design, treat his own son, Freud was increasing the “affiliation” between those oedipal rivals.

The family structures of each little Hans complicate development by threatening the fulfillment of oedipal wishes and undermining autonomous strivings. Figure 1 symbolizes the realization of the intrapsychic oedipal wishes. Dogs, the animals presumably threatening his father on his postal route, may well have been a repository simultaneously of the child's aggressive impulses (by projection) as well as the feared retaliation from his father (through displacement). The symptom, of course, like Little Hans's horse phobia, kept him home with mother, thereby further reinforcing the phobia. We see that family systems data can potentially enrich our understanding of how intrapsychic reality relates to the realities of family interaction.

For better or for worse one of the consequences of the family systems revolution involves turning the privacy and confidentiality of individual therapy into a far more public and often dramatic affair. Reflecting this change, the courts have just recently questioned the therapist's privilege of confidentiality in the family therapy context on the ground that by its very structure it is not confidential (*Psychiatric News*, 5/4/79). The one-way screen, with its multiple observers, as well as videotape replay are testimonies of the technological changes that have turned the world of therapy literally inside out. "The One-Way Screen," the title of Janet Malcolm's *New Yorke*r account (1977) of Minuchin and the family systems revolution, describes her direct observations of family therapy interviews conducted at

the Philadelphia Child Guidance Clinic.

The family, a couple in their forties with a young fifteen-year-old daughter who has been deteriorating and is about to be hospitalized are referred for family therapy. The family is treated by a trainee, while Minuchin directs and orchestrates the therapy by phoning in suggestions and at other times entering the interview room with observations, pronouncements, and "attacks":

> Mr. Braun began to complain about his wife. He said that she "screamed and hollered." Mrs. Braun began to cry. He went on to report that she had said she couldn't take it anymore and was going to leave. Mrs. Braun, through her tears, accused her husband of leaving everything to her; it was all too much for her, she said.
>
> In the observation room, Minuchin listened to the argument and then said, "*I'm going to attack the mother again.*" He reentered the treatment room and said sternly to Mrs. Braun, "I am concerned about what you are saying. I am concerned that when you leave here today your daughter will go crazy again. And I think the reason she will do it is to save your marriage. Children sometimes act in very weird ways to save their parents' marriage." He turned to the girl and said, "Yvonne, I suggest that you go quite crazy today, so that your parents can become concerned about you. Then things will be O.K. between them. You seem to be a good daughter, so you will go crazy, and your father will support your mother in taking care of you, and things will be O.K." To the parents, he went on, "I think that your daughter is trying to save your marriage. It is a bizarre thing to say, I know. But sometimes children are so protective of their parents that they sacrifice themselves. I think that Yvonne has kind of perceived that you are at the deep end, and she is saving you by being crazy, so you will organize yourselves." He started to leave, and then, pausing in the doorway, he said to the girl, "You're a good daughter, and if you see a danger, go crazy."

> The parents started talking about their marriage, and Lee [the therapist] told the girl that she could leave if she wanted to, since what her parents were saying didn't concern her. "Do you think you'll go crazy when you get home?" Lee asked her. [p. 40]

How are we to understand such interventions as helpful? Those investigators who have studied, whether individually (e.g., Lidz 1965) or conjointly (e.g., Wynne et al. 1958), the family members of seriously disturbed adolescents have described the severest disturbances in object relations and communication patterns involving the entire family. The very fact of bringing such families for treatment rather than specifying an identified patient allows the examination and often the amelioration of an organismic family process in which one member sacrifices himself for the sake of the psychological stability of one parent (see chapter 3) or, as Minuchin suggests in this case, for the stabilization of the parents' marriage. This intense pathological triangling and family undifferentiatedness has been noted by many students of the family, and the process can be temporarily interrupted by family treatment. In the present case Malcolm visits the family a month or so after they ended their brief treatment and notes that while the acute problem has been relieved, the chronic relational disturbances remain.

THE BOWEN THEORY: THE DIFFERENTIATION OF SELF

The popularity of Bowen's theory is comparable with that of Minuchin's, and Bowen, like Minuchin, has trained large numbers of practitioners whose

thinking and approach mark them as Bowenians. Bowen too has developed a deceptively simple schema, the key concept of which is the differentiation of self from the undifferentiated family ego mass (1978). Bowen's theory must also be understood, in part, as stemming from a specific clinical experience. In the 1950s Bowen began to study families of schizophrenic patients at the National Institute of Mental Health. In these early studies the whole family was often hospitalized. Any clinician who has worked with families in which the schizophrenic process is operative will recognize the aptness of the concept of the undifferentiated family ego mass, as these family members often speak and act as if they had but one skin. Ego boundaries are hard to recognize. Bowen's descriptions can immediately be correlated with the individual paradigm's emphasis on intrapsychic self-object undifferentiatedness and symbiotic (rends. Bowen demonstrated that this is as much a relational as an intrapsychic process.

The problem with the concept is that it is overgeneralized. While differentiation of the self should go on throughout the life cycles of individuals and families, this developmental concept becomes a kind of catchall explanation, perhaps comparable to psychoanalysis's early emphasis upon the oedipal conflict as the common denominator of all neuroses.

Nonetheless, for a number of reasons, Bowen's approach, though he would probably deny it, has more in common with the psychoanalytic

paradigm than the other schools of family therapy. His emphasis upon the importance of self-differentiation parallels the ultimate goal of a psychoanalysis.

The psychoanalyst attempts through the analysis of the transference to undo the neurotic distortions that have been internalized over the years. Bowen eschews or deflects such transference developments in therapy and does much of his therapy by having his "clients," with his coaching, work directly with members of their family of origin. This approach often diffuses marital conflicts that became the arena for displaced struggles with parents and siblings. This approach may also reduce the guilt associated with attempts to resolve conflicts by "leaving home." In other words, you must go home again. There is much that Bowen has in common with Boszormenyi-Nagy in this regard, whose book *Invisible Loyalties* (1973) traces somewhat moralistic ally the subterranean, cross-generational loyalty ties, which are so often disrupted. The presence and degree of unconscious guilt would probably limit this approach in certain cases.

Bowen, with his emphasis upon generational transmission of emotional disorders, introduces an historical perspective that is absent in the communications and structural schools. He appreciates that the process of change is not a simple one achieved by a quick strategy. His disavowal of the medical model by refusing to call his clients "patients" is an awkward

semantic evasion. Whether those seen in psychotherapy are called patients, clients, or students is less material than the actual nature of the therapeutic interaction, which is not determined primarily by labels. In psychoanalysis, for example, a patient's view of himself as "patient" and his view of "cure" are analyzed for their associated unconscious meanings. What Bowen does emphasize, in this position, is his primary orientation to research, which has much in common with psychoanalysis. He feels as do most psychoanalysts that such an orientation goes further in "helping" patients than the active-change methods of almost all other individual and family approaches. Like the analyst he refuses to collude and collaborate in the clients' attempts to satisfy transference demands, and he is similarly criticized for this stance of technical abstinence.

CARL WHITAKER: EXISTENTIAL ENIGMA

In Napier and Whitaker's *The Family Crucible* (1978) we have a most readable and controversial introduction to the field of family therapy. The experience of working with families is conveyed through the depiction of a composite of families the authors have seen. What emerges is a very recognizable, American, middle-class version of "Everyfamily."

The dramatic portrayal of this family's struggles, as well as the therapists' "war" against its resistances to change, alternate with remarkably

lucid and jargon-free "theoretical" chapters. Family homeostasis, the inevitable tendency toward triangulation, the role of the families of origin, marriage as an attempt to heal past wounds, are ideas developed out of the "clinical" material. As in most good novels, the universality of family conflicts is convincingly presented, and again we can trace the roots and manifestations of pathology.

The portrayal of this family is as naturalistic as its treatment is controversial. Most schools of family therapy, while in accord with the overall viewpoint, will also find issues with which to quarrel. Followers of Bowen will question the degree of involvement of the therapists. The structuralists will question the retention of an intrapsychic perspective. The interventions, however, are so graphically presented that one can readily compare and contrast one's own theory and approach. Discussion is thus easily stimulated, making this book an excellent teaching vehicle.

Unfortunately the authors misunderstand the place of Freud, and their discussion of him is full of distortions. Freud was not "the source of the entire psychotherapeutic movement" (p. 30). Actually, psychoanalysis as repeatedly noted in this book represents the latest and most fully developed theory and practice of individual treatment, a modality that goes back to man's beginnings when his diseases were responded to by "healing" the individual sufferer. Nor did Freud "avoid seeing that his disturbed patients were

members of disturbed families" (p. 41). He just candidly expressed his inability to deal with families (see chapter 5). In relation to Freud's "scornful attitude toward humanity" (p. 43) — more correctly a pessimistic outlook — one sees little to warrant Napier's optimism or his quest for a "science of the higher person" (p. 43). Napier disdains the instinctual bases of psychoanalytic theory, incorrectly implying that they preclude examination of man's creativity and achievements. He thus joins the current wave of "repression" and repudiation of the findings of the Freudian revolution (cf. Jacoby 1976).

Despite the book's manifestly antipsychoanalytic bias, unconscious processes are introduced repeatedly. The emphasis upon the repetition of familial disturbances across generations (p. 119) and the appreciation of transference (p. 107) are testimony to psychoanalytic concepts, i.e., the repetition compulsion (p. 159). Although the authors note the importance of identifications in this process, the dynamic of guilt in the perpetuation of selfdestructive neurotic interaction is omitted. Here Napier and Whitaker share with many family therapists an aversion to "why" questions. Why are family systems so difficult to change? Why do so many individuals and families persist in self-defeating patterns? Psychoanalysis, while shying away from family treatment, has some compelling answers to such questions. Separation anxiety, for example, certainly contributes to what the authors call "family-wide symbiosis" (p. 88) and what Bowen calls the "undifferentiated family ego mass" and Minuchin sees as family "enmeshment." Further, the

authors' essential interventions involve the Oedipus situation. First they disengage the family's adolescent daughter and later the son from oedipal triangles that are aggravated by the parents' conflictual marriage.

> For Don [the son] was indeed the victim of a family process which created in him the fantasy that he was older, smarter, and stronger than he actually was. Without meaning to, his parents had trained him in a kind of subtle delusional thinking about himself, one that implied that he could beat his father in a contest of strength and that he could be his mother's substitute mate. [p. 179]

Don is disabused of this fantasy of physical strength in the "therapeutic moment" of a spontaneous but "unconsciously" enacted wrestling match with Whitaker.

Napier and Whitaker repeatedly and actively enter the therapeutic exchange with an explicit acceptance of the role of surrogate, "symbolic" parents. They see themselves as a "professional marriage" (p. 91), offering warmth (p. 10), parenting (pp. 11, 185) with toughness (p. 20), caring (p. 210), and presenting "maybe a superior model" of parenting (p. 80). With interpretations, confrontations, advice, and "just being with the family," they try to interrupt the cycles of disappointment and of blaming "the other" for inadequacies in "the self" (p. 197); by sparking a renewal of the marriage, they attempt to free the children to develop more naturally.

Napier and Whitaker thus become "real objects" to their patients in

ways that psychoanalytic therapists usually reserve for sicker patients. While they, after many years of experience and their own eight personal therapies, may know the right dosage of such personal involvement, many students will take their model too literally, thereby infantilizing their patients.

On the other hand, although their "parenting" therapy is quite pervasive, the authors repeatedly insist, especially in their excellent chapter on divorce, that the family members must take ultimate responsibility for their own lives. This seeming contradiction is potentially confusing to both patients and students. When Whitaker asks the family to turn to the therapists for help rather than to each other, the father poignantly asks, "Where does that leave us when you guys aren't around?" (p. 121). That is something, of course, we will never know with this fictionalized family, as we rarely know with most real families.

One does feel by the end, however, that this "family" has learned better ways of approaching their problems. The authors, unlike so many therapists these days, do not make grand claims of success. They acknowledge that the work of growth and change is difficult and interminable and that the family or individual members may again come for help in the future with similar or new problems. The appropriateness of family treatment for this kind of crisis is most convincing.

The book written by Napier describes the work of a pioneer family therapist who, unlike Bowen and Minuchin, has not founded a school because, wary of the pitfalls of theory, he refuses to write about theory, and his approach is so idiosyncratic and "existential" that it is virtually unteachable.

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