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A REVIEW OF LITERATURE ON THE HISTORY, THEORY AND PRACTICE OF CONJOINT FAMILY THERAPY

by

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ABSTRACT

Pertinent literature related to the practice of conjoint family therapy was reviewed. The purpose was to promote an understanding of the historical development, theoretical background, and the nature of the current practice of conjoint family therapy. The work of current theorists and practitioners was discussed at length.

It was found that the development of conjoint family therapy began with dynamic research on the pathological individual, particularly the schizophrenic. Therapists eventually recognized the importance of information concerning the pathological individual's primary group, the family. With this recognition came the development of early forms of family treatment.

The initial practice of family therapy revealed several interesting phenomena in relation to the pathological individual's family. The frequent existence of pathology in other family members was revealed. Further, the disappearance of pathological functioning in one family member often led to the appearance of symptoms in another. Finally, it was discovered that the manifestation of symptoms in the pathological individual was directly correlated with certain patterns of family interaction.

The latter discovery initiated numerous studies that culminated in the development of a communicational model of family functioning. This model is the theoretical basis for the practice of conjoint family therapy.

The researcher recommended that additional studies be conducted to determine the long-range effects of this approach to treatment. It was suggested that more emphasis upon this practice be placed in graduate programs designed to train personnel in helping professions. Widespread adoption of conjoint family practice was also suggested to avail this form of treatment to any families desirous of this approach to therapy.

CHAPTER I

INTRODUCTION

> Troubled families are everywhere today. Family relations are out of kilter. After an upset, the family seems less able to bounce back and regain its balance. Unlike Humpty Dumpty, however, it may well pull itself together. But at what cost: And will it ever be the same again?. . .
>
> The issues are crucial: What is the present condition of the human family? How did it get that way: How would it like to be? The social disorders of family living magnify the vulnerability of family members to emotional and mental disorder. What can we do about it?
>
> The development of a method of psychotherapy for the whole family is at least a partial answer. (Ackerman, 1966, pp. vii-viii.)

Family therapy is a relatively new development in the realm of psychotherapeutic practice. Since many schools of family practice appeared on the scene at one time, a number of forms of family therapy are available today.(Haley, 1962). Foley (1974) classifies these different forms of family therapy into four main groups: (1) multiple impact therapy, (2) network therapy, (3) multiple family therapy, and (4) conjoint family therapy. These four different types of therapy contain important differences related to approach.

Multiple impact therapy refers to an approach in which a team of therapists work intensively with a family for a period of two to three days. Various combinations of family members and individual family members are treated simultaneously. Network therapy includes treatment of not only the nuclear family, but also includes neighbors,

friends, relatives, and any other persons who are significant to the family. Multiple family therapy is an approach in which a number of families are treated at the same time by a therapist. Conjoint family therapy involves primarily treating the nuclear family, with the therapist's focus of attention on the interactional patterns of the members of that family.

If Ackerman's position (1966) is indeed true, and family therapy does provide some solution to the apparent social and psychological problems experienced by families today, these four basic methods of treatment serve a very important purpose. However, since family therapy is a relatively novel practice, it requires much more investigation and attention by personnel in the helping professions.

The researcher hopes that the following study on one of these approaches to treatment, conjoint family therapy, will help draw attention to the growing importance of this practice. In addition, it is hoped that the study will provide a useful understanding of the nature and development of conjoint family therapy for the benefit of counseling practitioners.

STATEMENT OF THE PROBLEM

The problem of this study is to research the growth and development of conjoint family therapy, investigate the underlying theory of this form of treatment, and present several techniques used

by current practitioners.

PURPOSE OF THE STUDY

The purpose of this study is to research pertinent literature related to the development and practice of conjoint family therapy. The author feels that as a novel, yet effective form of therapy, conjoint family practice merits considerable attention.

Furthermore, numerous advantages of this form of therapy have been elaborated by various authors. Thorman (1971) cites the following advantages:

1. Family therapy is economical.
2. Diagnosis is more comprehensive.
3. Treatment is more comprehensive.
4. Subsequent illness may be avoided.
5. Preventing pathology in other family members.
6. Family is strengthened.

Because of these advantages, family therapy will very likely become commonly accepted and practiced widely in the near future. It is a purpose of this study to bring to awareness the historical development, theoretical basis, and current treatment practices of conjoint family therapy, in an attempt to demonstrate its usefulness and viability to personnel of the counseling profession.

GENERAL QUESTIONS OF THE STUDY

In an attempt to solve the problems of this study, a review of pertinent literature was made in answer to the following questions:

1. What historical research studies were pertinent to the growth and development of conjoint family therapy?

2. What is the theoretical basis for the practice of conjoint therapy?

3. Based on the theoretical model, what are some current techniques practiced by conjoint family therapists?

LIMITATIONS

This study was limited essentially to a review of literature on conjoint family therapy. Since this form of practice is relatively new to the realm of psychotherapy, literature on this subject is not abundant. The author discovered that only a limited number of researchers have completed studies relevant to the practice of conjoint family therapy.

DEFINITION OF TERMS

For the purposes of this study, the following definitions of terms will apply:

1. Identified patient: The member of the family who manifests

pathological symptoms.

2. Pathology: A diseased or abnormal mental condition.

3. Pathogenic: Pertaining to conditions which lead to pathology.

4. Schizophrenia: A psychosis that is characterized by the severe breakdown of integrated personality functioning and disturbances in thought and behavior.

5. Schizophrenogenic: Pertaining to conditions which lead to schizophrenia.

6. Conjoint Family Therapy: A form of therapeutic practice in which the therapist meets with a family with the purpose of focusing on the patterns of communication in that family.

7. Symbiosis: A close association or union, especially where this is advantageous to both parties.

SUMMARY

Families today are experiencing an increasing number of difficulties of both a social and psychological nature. Conjoint family therapy represents an effort to meet and deal with these problems. As a novel approach to treatment, however, conjoint family therapy has received relatively little attention and investigation.

This study is an attempt towards the partial resolution of this situation by its focus on the nature and development of conjoint family

practice. Personnel in the helping professions who deal with family-related difficulties can derive considerable benefit from a working knowledge of this unique form of therapy.

CHAPTER II

HISTORY AND THEORY

INTRODUCTION

The course of development of conjoint family therapy was a process covering many years of research and study. To understand this form of therapy as it is currently practiced, it is necessary to review the events that led to its establishment, the theoretical concepts on which it is based, and the techniques with which therapists implement this theory in practice.

To this end, the following review will be divided into three separate sections. The first section reviews the developmental history of conjoint family therapy. The second section discusses the theory upon which this approach to therapy is based. Finally, the third section presents selected techniques elaborated by present practitioners.

A DEVELOPMENTAL HISTORY

In order to understand how and why conjoint family therapy appeared upon the scene of psychotherapeutic practice, it is necessary to explore the background of events that led to its development.

Numerous reasons have been suggested by various authors for the creation of family therapy. Ackerman reports:

> In considerable part family therapy evolved to fill a void in the armamentarium of therapeutic procedures. With increasing

> clarity we recognize that there has been something lacking and also something artificial in psychoanalysis, in traditional group therapy, and in child therapy. In each of these the disturbed person is removed from the life context in which his disorder developed. Each of these procedures side-steps the direct observation of family processes and direct influence on them. If it is within the family setting that the person falls ill, then why not use the family to make him well again? (p. 9)

Rebner (1972) concurs with Ackerman that family therapy developed mainly out of disenchantment with the effectiveness of more traditional forms of therapy. He adds that family therapy grew out of the therapist's need to know more about the individual and his immediate environment. In time, therapists discovered the usefulness of knowledge in reference to the people who were important in shaping the personality of the identified patient, without getting this information secondhand. Practitioners realized that seeking this information solely from the patient would result only in the knowledge of that patient's <u>perceptions</u> of his environment and his significant others (Haley, 1959b). Naturally, it was concluded that a less distorted account of these subjects could be acquired by the therapist himself in the family therapy session. Thus, the practice of treating the entire family came into being.

Furthermore, the beginnings of family treatment revealed another previously unrecognized phenomenon. Rebner (1972) describes it as follows:

> They (the therapists) began to observe that the person for whom help was originally sought, was by no means the only member in the family who manifested psychopathology. Other members were "as sick as" the identified patient, if not "sicker." (p. 62)

Also noted was the fact that the appearance and disappearance of the identified patient's symptomatology was "directly correlated with the transactions of the individual with others in the family. It became obvious, therefore, that the healthy or pathological functioning of the patient, or for that matter any individual in the family, was very much correlated with the effects of other members in the family upon that individual." (Rebner, 1972, p. 62). Growing importance was also placed upon the increasing opportunity to help the identified patient with less time and more efficiency in the family setting.

Besides the above-mentioned reasons, however, Rebner claims that the practice of family therapy grew from interest in dynamic research and therapy with the individual. In this section of Chapter II, the course that leads from this particular research and therapy with the individual, specifically the schizophrenic individual, to the practice of conjoint family therapy will be discussed.

The first known case of any type of family treatment occurred in 1909 with Freud's classic case of "Little Hans," whom he treated through dealing with his father.

However, Freud's conception of the personality as an intrapsychic phenomenon prevented further work with families.

As the tenets of Freudian psychoanalysis were extremely prevalent among early practitioners and theorists, the concept of the family gained little recognition until 1938, when Ackerman wrote on the

"Unity of the Family." In this paper, Ackerman recognized the family as having its own social and psychological life, and suggested that it may have a place in the treatment of individual disturbance. (Jackson and Satir, 1961).

Foley (1974) sees Ackerman as a bridge between the intrapsychic psychology of Freud, and the communication theorists of today. Since communication theory forms the basis of conjoint family therapy, Ackerman's work was extremely important in the development of this approach to therapy. Ackerman's work opened up a decade of significant research leading to the development of family therapy.

Consequently, this discussion of the developmental history of conjoint family therapy begins with the 1940's. Much of the information that follows has been summarized from Zuk and Rubenstein (1965).

Beginning research in this area focused mainly upon establishing a relationship between parental traits and pathology in children. One such study by David Levy appeared in 1943. Levy showed a correlation between an over-protective attitude in mothers, and a deprivation of love in these women's childhoods. This deprivation was concluded to be responsible for their trying to regain from their children what they had missed in their own childhoods.

In 1948, Fromm-Reichmann described the schizophrenogenic mother as aggressive, domineering, insecure, and rejecting. The father in these families was described as inadequate, passive, and quite

indifferent.

A year later, Tietze described mothers of schizophrenic children as rejecting and rigid.

Reichard and Tillman, in a study done in 1950, classified parents in three ways: one, schizophrenogenic mothers - overtly rejecting type; two, schizophrenogenic mothers - covertly rejecting type; and three, schizophrenogenic fathers - domineering, sadistic type.

That same year, Gerard and Siegel discovered an exclusive attachment to their mothers in ninety percent of the cases observed.

In 1955, Thomas, in a study of the mother-daughter relationship of eighteen black schizophrenics, found that the mothers were unable to tolerate verbal expressions of hostility from their daughters. Further, they were excessively punitive with their daughters after puberty. The majority of these girls' fathers were either dead or separated from their mothers.

Galvin (1956) discovered a pattern of over-controlling by means of appeals to pity, shame, and guilt in the mothers of schizophrenic children.

In 1943, Rosenzweig and Bray found in a study of three-hundred fifty-six male hospitalized schizophrenics that thirty-nine percent had experienced the death of a sibling. Subsequent studies by Ellison and Hamilton (1949), Lidz and Lidz (1949), and Wahl (1954, 1956) showed some correlation between the appearance of schizophrenia and the

absence of a family member due to death or divorce.

Johnson, Griffin, Watson and Beckett (1956) found frequent instances of physical or psychological assault by parents of latent schizophrenics upon their children. Johnson and Szurek demonstrated that antisocial behavior in children resulted from superego defects in their parents in a study done in 1954.

The first actual practices of family psychotherapy involved using the technique of group psychotherapy with schizophrenic patients and their parents (Bauer and Gurevitch, 1952; Kirby and Priestman, 1957; and Ross, 1948).

Conjoint group psychotherapy with schizophrenic daughters and their mothers was practiced by Abrahams and Baron in 1953. During these sessions, the mothers' emotional dependence on their daughters was noted. The mothers' need to feel superior often resulted in their sacrificing of their daughters to feelings of worthlessness.

In 1956, Szurek and Berlin reported positive results from treating one hundred schizophrenic children simultaneously with their parents.

At this same period in history, research on the marital relationship was flourishing. Oberndorf (1938) and Mittelmen (1956) described numerous patterns of neurotic interaction between spouses.

The following therapists were early practitioners of concurrent marriage therapy: Moreno (1954), Neubeck (1954), Whitaker (1958), and

Wolf (1950). Concurrent marriage therapy involves the treatment of both spouses.

A number of studies showing pathogenic symbiosis between mother and child were conducted by Hill (1955), Kanner (1949), Limentani (1956), and Mahler (1952). These studies recognized a tie between pathology in the child and his relationship with his mother.

In summarizing the research and therapeutic developments of this period, Zuk and Rubenstein make the following statements:

> A major effort was made to relate certain abnormal traits in parents with the same or other abnormal traits in offspring; emphasis was on dyadic relationships. Parallel developments in therapeutic technique were taking place which made it practicable to consider an approach in which the pathologic family system would itself become the central object of attention, rather than pathology in the individual family member or in the dyadic relationship between family members. (p. 7)

Recognition that the family itself was the source of pathology was a major milestone in the development of conjoint family therapy. Haley (1959b) noted that in the study of schizophrenia, the idea that family difficulties were caused by the schizophrenic member has evolved to the idea that the families themselves are pathogenic. This concept made family therapeutic practice a reality.

Josselyn (1953), Richardson (1948), and Spiegel and Bell (1959) all recognized the value of treating the entire family group.

Midelfort (1957) treated families together in a group psychotherapy situation. Midelfort encouraged the relatives of families in

treatment to attend these group sessions. He believed that therapeutic results could be acquired through family members' interacting in a loving and affectionate way with the patient. Midelfort also maintained that therapists with similar ethnic and religious background to that of the patient would be most facilitative in therapy.

Midelfort's most valuable contribution to the development of family therapy was his recognition that the symptoms of the identified patient are expressive of family pathology, suggesting the presence of other disturbed members.

Bowen (1959, 1960) in his research with schizophrenics came upon this same theory. He agreed with Midelfort in the belief that the schizophrenic reaction was indicative of pathology in the entire family. In his work with the families of schizophrenics, Bowen had the families live in hospital wards for up to two and one-half years. During this time, he found the parents of the schizophrenics as demanding of the clinicians' attention as the patients.

In these studies, Bowen also introduced the concept of "emotional divorce" with which to describe the marital relationships he found typical of parents of schizophrenics. These relationships were characterized by the maintenance of emotional distance between marital partners.

Another concept stressed by Bowen (1959, 1960) is that of projection in the mother-child relationship. In cases where projection

occurs, the mother forces her own sense of inadequacy and helplessness onto the child, and subsequently reacts to the child not for himself, but for the image of herself she has managed to project onto him. The mother and child are then entangled in a pathogenic, symbiotic relationship, and any growth or attempts at independence by the child are considered very threatening by the mother. She will respond to these threats by attempting to force the child back to his previous state of helplessness.

Bowen also observed an interesting pattern of behavior in the family which centered on the marital pair. It was found that when the parents became responsive to each other, the child's condition would improve. If the marital relationship became strained, however, the child's condition would also deteriorate; thus, a pattern of family pathology was established.

Another pattern of family pathology was described by Brodey (1959). This pattern is circular in nature, and occurs when the parents of the schizophrenic use him as a battleground on which to try and resolve their conflicts. The patient's role in this pattern is to then sabotage this attempt at resolution by taking the focus of attention away from his parents, and placing it upon himself.

Studies of the schizophrenogenic father were also being conducted at this time. Lidz and Lidz (1949) discovered that often the father's influence was just as harmful as the mother's. They concluded

that potentially schizophrenic children might have been saved from pathogenic symbiosis with the mothers had the father been more stable.

Ellison and Hamilton (1949), Frazee (1953), and Hadju-Gimes (1940) all reported that a number of the fathers of the schizophrenic children they studied were cruel and rejecting.

Lidz, Cornelison, Fleck and Terry (1957) described five types of schizophrenogenic fathers: one, fathers disappointed in marriage who try to mold their daughters to satisfy their needs; two, fathers who were hostile towards their sons with whom they felt under pressure of competition for the attention of their wives; three, fathers with grandiose, exalted self-concepts; four, pathetic, self-absorbed fathers who were considered failures in life; and five, passive fathers who submitted to their wives' authority.

With the late fifties and early sixties came the development of a new research orientation which focused mainly upon the family system, and the intrafamilial environment.

In 1960, Lidz and Fleck related pathology in the marital relationship with the presence of schizophrenia in the child. They maintained that the mother may convey to her child the anxieties she feels out of concern over her husband. In addition, Lidz and Fleck suggested that a parent may reject a child if he feels that child binds him to an unwanted marriage.

Pathogenic marital relationships were classified into two main

types by Lidz, Cornelison, Fleck and Terry (1957). The first of these types, called "marital schism," is typified by overt scrapping with the families remaining together, regardless. "Marital skew" involves covert disagreement under a mask of surface harmony. These two types of marital relationships pave the way for the seduction of children by one spouse or the other into a pathogenic alliance.

Another group of researchers were also able to identify and describe a pathogenic relationship within the family. Wynne, Ryckoff, Day and Hirsch (1958) coined the term "pseudomutuality" to describe this particular relationship. The discovery of pseudomutuality was made as the researchers experimented with a novel form of treatment. Schizophrenic patients were given intensive psychotherapeutic treatment as hospital inpatients, while their parents were treated concurrently as outpatients.

In the pathogenic relationship discovered, family members were characterized by an obsession with fitting into formal familial roles at the expense of individual identity. Members appeared to be striving for an outward appearance of uniformity. Children in these families were punished for attempts at independence, and rewarded for dependence. An ideal family relationship seemed to be the main preoccupation of those families in which pseudomutuality was identified. The researchers pointed out that pseudomutuality can appear in any family; however, its presence in the families of schizophrenics is especially intense

and enduring.

In 1956, a study by Bateson, Jackson, Haley and Weakland laid the foundation for conjoint family therapy by developing a comprehensive theory of schizophrenia based on a communicational model. In this paper, the cornerstone of communication theory, the double bind, was elaborated. The introduction of this concept paved the way for the development of new methods of therapy and research which culminated in the practice of conjoint family therapy.

In summary, the early development of family therapy brought about a distinct change in practitioners' conception of psychotherapy. They began to see the value of understanding the individual in terms of the operations of his family. The importance of the intrapsychic was diminished, as family interaction drew attention in therapeutic practice.

A statement by Haley (1971) bears this out:

> By the end of the 1950's it was becoming clearer that family therapy was a different concept of change, rather than merely an additional method of treatment to be added to individual and group therapy. The focus of family treatment was no longer on changing an individual's perception, his affect, or his behavior, but on changing the structure of a family and the sequences of behavior among a group of intimates. (p. 4)

A THEORETICAL BASIS

As stated in the previous section, the introduction of the concept of the double bind was a major factor in the development of communications theory, the basis of conjoint family therapy. This concept was elaborated by Bateson, Jackson, Haley and Weakland (1956).

In this study, Bateson, et. al. researched the nature, etiology, and therapy of schizophrenia. The approach to the problem was based on Russell's Theory of Logical Types. It was discovered that schizophrenic communication was typified by an inability to recognize logical types, causing difficulties in the ability to communicate clearly.

Bateson, et. al. maintained that in order for a person to develop this maladaptive pattern of thought and speech, "he must live in a universe where the sequences of events are such that his unconventional communicational habits will be in some sense appropriate." (p. 253)

These "sequences of events" that reinforce unconventional communication patterns and consquently give rise to difficulties in logical typing are called "double binds."

Bateson, et. al. explained that there are five necessary conditions for a double bind situation to occur: (1) two or more persons, one of which is designated as the "victim;" (2) repeated experience, so that the victim comes to expect the double bind situation; (3) a

primary negative injunction, which may assume either of two forms: (a) "Do not do so and so, or I will punish you, or (b) "If you do not do so and so, I will punish you; (4) a secondary injunction that conflicts with the first injunction at a more abstract level, and is also enforced by threat of punishment; and (5) a tertiary negative injunction that prohibits the victim from escaping.

Perhaps the most frightening aspect of this phenomenon is the intense grip it has on the victim once he has learned to perceive his world in terms of double binds. Once this learning has taken place, the complete set of five factors is no longer necessary for the victim to manufacture a double bind situation out of any communication. The authors state: "Almost any part of a double bind sequence may then be sufficient to precipitate panic or rage. The pattern of conflicting injunctions may even be taken over by hallucinatory voices." (p. 254)

There is another aspect of communication that must be examined before an understanding of the double bind experience is possible. This aspect is the different levels of meaning involved in communication. As explained by Satir (1967), a clear understanding of what is said involves attending not only to the words, but also to gestures, facial expressions, body posture and movement, tone of voice, and even the dress of the speaker. Further, the context of the communication must also be taken into consideration: questions such as when, where, with whom, and under what circumstances does the communication take

place will also affect the meaning.

Besides all of the above-mentioned factors, the receiver of the communication must also be aware of his own interpretation system.

Satir (1967) stresses that a communication will always carry with it at least two levels of meaning. The first of these, the denotative level, is the literal content of the message. The second level, metacommunication, is a "comment on the literal content as well as on the nature of the relationship between the persons involved...a message about a message." (p. 76)

The most important facet of metacommunication lies in the fact that it is impossible for human beings not to metacommunicate. Metacommunication takes place every time communication takes place.

Furthermore, there are two ways to metacommunicate: nonverbally and verbally. Nonverbal metacommunication can take a multitude of forms: smiling, frowning, grimacing, and stiffening are examples of nonverbal metacommunication.

Verbal metacommunication takes place when a denotative statement is made concerning a communication. For example, "It was only a joke" is a statement of verbal metacommunication.

Metacommunicative handicaps are prevalent among established victims of the double bind. In explaining the nature of communication in the double bind situation, Bateson, Jackson, Haley and Weaklend (1956) state the following:

> (1) When the individual is involved in an intense relationship; that is, a relationship in which he feels it is vitally important that he discriminate accurately what sort of message is being communicated so that he may respond appropriately.
>
> (2) And, the individual is caught in a situation in which the other person in the relationship is expressing two orders of message and one of these denies the other.
>
> (3) And, the individual is unable to comment on the messages being expressed to correct his discrimination of what order of message to respond to, i.e., he cannot make a metacommunicative statement. (p. 254)

Bateson, et. al. suggested that this is the type of pathogenic situation that occurs between the pre-schizophrenic and his mother. More specifically, when an individual has spent his life in a double bind relationship, his way of relating to people after a psychotic break would have a definite systematic pattern. He would not be able to indicate, by means of metacommunication, his intended meaning in communication.

Given this incredibly difficult situation, the victim must make a choice of how to respond to communication directed at him. Bateson, et. al. described three alternative courses. In the first alternative, the victim becomes obsessed with the idea that every statement contains a hidden meaning that is potentially detrimental to him. Thus, he searches constantly for meanings behind the communications he receives, and only succeeds in becoming extremely confused.

Should the victim engage in the second alternative course of action, he will accept the literal or denotative meaning in all

communication, and simply disregard the accompanying metacommunication. He will follow each injunction explicitly and make no attempt to make sense of the messages he receives.

In the third course of action, the victim chooses to ignore all communications and withdraw from his surrounding environment. He believes that since he cannot interpret the meaning of communication, the best thing to do is to block it from his awareness.

Clearly, those victims that choose these alternatives do so because they are unable to follow the course of action that would help them to decipher meanings; that is, to discuss the messages of others. Indeed, because of handicaps in their ability to metacommunicate, they resign themselves to schizophrenia and other types of pathology.

Thus, the work of Bateson, et. al. shows a direct connection between dysfunctional communication patterns in the form of the double bind, and the occurrence of schizophrenia in families where this pathogenic communication takes place.

Since that original study, a great deal of research has been done that is based upon the work of Bateson, et. al., that affirms their original hypothesis. A review of these studies to 1961 was completed by Watzlawick (1963), whose treatment of the double bind represents a comprehensive study of articles both American and European in origin. Although he found the double bind to have received a great deal of attention in the United States, European theorists, with the

exception of the British, showed little interest. Watzlawick hypothesized that an interactional theory had no place among European theorists who have traditionally followed organistic and intrapsychic psychologies.

A more recent article by Bateson, Jackson, Haley and Weakland (1963) provides a review of the research these authors have conducted since the presentation of their original study in 1956. They point out that the concept of the double bind was only a part of a larger framework, a general communicational approach to human behavior.

Foley (1974) claimed that of all communication theorists, Jackson, Haley and Satir are the most recognized and influential. Foley mentions that the three have much in common in reference to theoretical position. All stress the importance of interaction in the development of personality; the intrapsychic remains functionless in their conceptual framework.

Foley differentiated these theorists by pointing out the separate aspects they stress along with the basic communicational model. Jackson emphasizes the cognitive aspects of communication; Haley, power and communication; and Satir, emotion and communication.

Jackson gives special attention to the role of thinking in his approach to family therapy. There is a strong emphasis on the idea that what one thinks influences what one does (Foley, 1974).

This is clearly indicated by Jackson's descriptions of his own

therapeutic interventions. Jackson and Yalom (1965) demonstrated one such intervention called "prescribing the symptom." In this case, the "well" sibling of a schizophrenic was asked to help his brother out by becoming more of a problem in the family. This intervention had the effect of showing other family members how much of a problem this sibling was in fact, and took the onus off the schizophrenic for being the only source of his family's difficulties. By making changes in the family's thinking toward the schizophrenic member, the family's behavior towards him subsequently changed. The schizophrenic member was able to make considerable progress as a result.

Foley (1974) differentiated Haley from the other communication theorists by linking his work in communication with the concept of power. The acquisition and use of power are central in his particular approach to therapy.

Haley (1962) applies this concept of power in his treatment methods. He maintains that the only way for a therapist to succeed is to retain control of what happens in therapy. If the family members gain control, they will only perpetuate their current destructive system of interaction.

A method of retaining control suggested by Haley is for the therapist to present himself as an expert adviser, and then not offer any advice. The therapist takes charge of what is to happen by emphasizing how the family must take the initiative for solving problems.

The family is then placed in a paradoxical situation where their usual attempts to take charge are encouraged by the person who actually is in charge. The therapist can enforce this action by using silence as a technique.

According to Haley (1959a), all communication represents a maneuver to define the relationship between the sender and the receiver. The receiver is given the choice of whether to accept or reject the relationship offered by the sender. He can accept the sender's definition of the relationship, challenge the sender by redefining the relationship, or accept the sender's definition with the qualification that he is letting the sender get by with this maneuver. In the intervention technique used above, the therapist always retains control of the relationship he has with his clients by consistently acting as the definer of the relationship.

To sum, Haley sees all relationships as being power struggles, with communication being the means by which a person attempts to define his position in relation to others.

Foley (1974) differentiates Virginia Satir from other communication theorists by pointing out her emphasis upon feeling. Her main concern in therapy is how one feels toward himself and others.

Self-esteem is particularly important, for the level of self-esteem a person feels will determine the effectiveness of his communication with others. A low level of self-esteem will result in

dysfunctional communication (Satir, 1967).

Though they may differ with respect to their approach and/or focus in therapy, all communication theorists subscribe to the tenets of the basic communicational model. This model is outlined by Ferber and Beels (1973). These authors list the following items as axioms that govern human communication:

1. All behavior is communicative. It is impossible not to communicate.

2. Messages have "report" and "command" functions. Depending upon the context of the statement, a communication can either report the speaker's message or give a command to the receiver.

3. Command messages define a relationship.

4. In families, command messages are patterned as rules.

5. Change and stability. Families consistently try to maintain an emotional balance. Any attempt by family members to redefine relationships within the family causes instability.

6. Inability to change rules is pathology. The system is considered pathological when the rules are set in such a manner so as to preclude change. The double bind is an example of this type of rigidity.

To summarize, the introduction of the double bind was the first building block in communications theory, which forms the basis of conjoint family practice. Since the introduction of the double bind, much research has been completed and new theoretical conceptions concerning the role of family interaction as related to family pathology have been developed. These conceptions have culminated in a communicational model

for family therapeutic practice.

Although conjoint family therapy was developed by research and study of the schizophrenic, primarily, its benefits are not limited to the families of schizophrenics.

Satir (1967) points out that the families of delinquents often react in similar fashion to treatment of their "identified patients." Also, Thorman (1971) points out that family therapy has been used in treating not only families of schizophrenics, but also families of children and adolescents manifesting behavior disorders.

CHAPTER III

TECHNIQUES IN CONJOINT FAMILY THERAPY

The techniques used by practitioners of conjoint family therapy vary in form and style; however, they are all bound by one main factor: the focus of the therapist is fixed on communication within the context of the family system.

One of the earliest attempts to implement this form of therapy in practice was an experiment conducted by Jackson and Weakland (1961). The purpose of this experiment was to test the viability of using conjoint family therapy to treat the families of schizophrenics. Although the authors were hesitant to state prematurely that family therapy proved more effective than other forms of current practice, they were able to report very promising results. Six out of seven previously hospitalized patients showed a noticeable improvement in the area of social adaptation and independence. Seven out of nine young schizophrenics who were rarely hospitalized showed noticeable improvement in that they were either able to return to school and change from failing to passing grades or they were able to begin work or at least go out unaccompanied. Two schizophrenics who had been confined to their homes after hospitalization also showed noticeable improvement by their ability to go out unaccompanied.

In addition to these results concerning improvement in the identified patients, the researchers were also able to report that more

than half the fathers in the families were judged improved by the therapists, as were the mothers (in two cases, however, the mothers were judged to be worse). Limited data on siblings also demonstrated fifty percent improvement of the population, with only one sibling being judged as worse. Out of this experiment by Jackson and Weakland (1961) came some important considerations for technique in the practice of conjoint family therapy. It was discovered by the researchers that families entering conjoint therapy will tend to dwell on the symptoms of the identified patient, without recognizing that they, too, have much to gain in therapy.

The therapists in this experiment wished to dispel the idea that the only source of difficulty in the family was the identified patient. They wished to demonstrate to the family that they were members in a system that was functioning in a harmful, destructive manner.

To this end, the therapists began treatment with a statement that the purpose of family therapy was to work together on understanding one another so that everyone could get more out of family life. This statement implies that all members were involved in the family's unhappiness, and that much of the unhappiness is due to lack of understanding, which is attributable, naturally, to difficulties in communication.

Clearly, the goals of the therapists in the experiment were to alter the destructive patterns of communication (notably the double

bind) in which the family was bound. In doing so, they found the following techniques most valuable: directly making explicit the communications of the family members and using implication and interpretation to clarify family messages.

In conclusion, Jackson and Weakland's early application of communication techniques to resolve difficulties in family interaction was a major landmark in the establishment of conjoint family therapy.

Mosher (1969), as a practitioner of conjoint family therapy, is also deeply concerned with the application of communication theory in practice. In his article, Mosher explains the technique he has developed for doing just that. His therapeutic goals are to teach the family to interact in a clear, consistent manner. He wishes to enable his patients to communicate in such a manner so that they are unhampered by difficulties in understanding or in maintaining the focus of attention. His emphasis in therapy is on the structure and process of the family's communication patterns. Content plays a less important role in Mosher's treatment.

Mosher's technique involves three distinct phases of therapy: diagnostic evaluation, treatment, and termination. In the phase of diagnostic evaluation, Mosher establishes the following items: evidence of a peculiar or pathogenic communication pattern in the family, the structure and function of this pattern, the development of pathology in the identified patient and the ways in which pathology is maintained in

the family.

Once these items have become established, Mosher begins the treatment phase. Mosher's techniques in treatment are designed to teach the family to communicate clearly. Firstly, Mosher clarifies inherently unclear statements. These statements are probed and dealt with until everyone shares their meaning. To do this Mosher uses several techniques. The first of these involves asking the speaker directly to expand and clarify the statement. In a second technique, he asks others what they understood the speaker to say, and then compares their understandings with the speaker's meaning. A third technique is asking the speaker to predict what others would think he meant by his statement, and then to compare with the others what they actually understood.

Further, Mosher does not allow any disruptions in the focus of attention. He permits no introductions of unrelated material into the family's discussions. He does not tolerate inattention, and discourages disruptive behavior. Upon the occurrence of such behavior, Mosher turns the discussion toward understanding the motivation behind the disruption.

Finally, Mosher deals directly with invalidating statements. Invalidating statements are those that disqualify the statements of the previous speaker, and are common in the conversations of schizophrenogenic families. Mosher describes several techniques he uses in dealing with such statements. One technique is to restate the previous speaker's

statement, and ask the invalidating responder to compare his statement with that of the original speaker. A second technique is used when the speaker changes his point of view as a result of an invalidating statement. In this case, Mosher points out the incongruity between the speaker's original statement and his changed statement. A third technique is to ask some other family member who is not the target of invalidation to comment on the interaction.

To sum, Mosher's techniques in conjoint family therapy are indeed a clear application of communications theory in practice. He seeks to locate destructive patterns in family communication, and alter them as they occur.

Another therapist using basically the same approach is Isaac Rebner (1972). In his article on conjoint family practice, Rebner states the following premise:

> The level of psychic integration and adaptation of the individual can best be observed, understood, and changed when it is considered as a structural and functional expression of the dynamic transactions within and among the significant family members. (p. 62)

Rebner's work with families also follows a three-phase treatment plan, similar to that of Mosher. Rebner emphasizes that once the structure and function of family interaction patterns are understood, the therapist must set specific goals to guide his course in treatment. Therapy consists of dealing with the family's communication process in relation to these goals.

An important aspect of Rebner's therapy is the setting in which it takes place. Rebner maintains a family office that looks much like a typical family living room. He claims that the family members can relax and interact more spontaneously in an atmosphere similar to their natural habitat.

Speck (1967) takes this concept one step further. He advocates conducting therapy sessions in the homes of the families. Speck argues that conducting therapy in the home offers a very definite diagnostic advantage; that is, it allows the therapist to construct a more accurate picture of family interaction. Office dress and manners are unnecessary in the home; family members can move about as they please without interrupting as in an office.

In addition, the therapist is considered the intruder in the home, and this will tend to reduce any feelings of inferiority family members might experience toward him.

A final consideration in conducting therapy in the home is that it averts hospitalization of the identified patient. If hospitalization is avoided the complications of placing the identified patient in an unnatural, artificial environment are also avoided. Speck stresses the importance of focusing on family interaction as it happens within the natural family environment.

Another family therapist whose work is typified by a focus on family interaction is George Thorman. Thorman (1971) sees effective

communication as vital to progress in family therapy. The ability of a family to achieve therapeutic goals is contingent upon their ability to communicate clearly. Because of this belief, Thorman maintains that providing models for communication is one of the therapist's chief objectives in treatment.

To achieve this objective, Thorman advocated a technique of active intervention in therapy. Active intervention is used to challenge and confront the family as prevailing destructive patterns of communication occur. The therapist uses active intervention to control digressions away from touchy subjects, identify confusing responses, and clarify the interaction process.

A further type of active intervention was elaborated by Jackson and Yalom (1965). This intervention is called the therapeutic paradox, and is used under special circumstances in the process of therapy. In a case described by Jackson and Yalom, treatment was at a standstill because most of the family's energies were spent in preserving its present pathological system of interaction and maintaining the identified patient's sickness.

The therapists decided to use the technique of the therapeutic paradox to attempt to break this destructive pattern. They asked the family what problems might arise for them if the identified patient improved.

This question is a therapeutic paradox, for in answering it,

the family "cannot win." Since they wish to demonstrate their cooperativeness, they must answer the question and come up with some problems. Further, any problems they enumerate can be considered as barriers to the recovery of the identified patient; the family is forced to accept the fact that they must change before the patient can recover. In other words, by being cooperative with the therapist, they must admit that they are a major part of the patient's, and subsequently, the family's pathology.

In the case cited by Jackson and Yalom, this technique proved effective. Family patterns of interaction were altered, and the identified patient was able to progress considerably.

Perhaps the most influential practitioner of conjoint family therapy, today, is Virginia Satir. In her book, Conjoint Family Therapy (1967), Satir clearly indicated her acceptance and utilization of the communicational model. She defined the "dysfunctional person" as one who "has not learned to communicate properly." (p. 92) Accordingly, her concept of therapy is as follows: "If illness is seen to derive from inadequate methods of communication (by which we mean all interactional behavior), it follows that therapy will be seen as an attempt to improve these methods." (p. 96)

Satir has very definite conceptions of the therapist's part in the treatment of families and elaborates upon them in her chapter on the "Role and Technique of the Therapist." According to Satir, the

first task of the therapist will be to make the family comfortable, reduce their fears, and show them that he has a definite direction for therapy. He must use his abilities to give his patients a sense of competence and productiveness by asking appropriate questions; in other words, questions the patient is mentally and emotionally prepared to answer. The therapist must also give honest, open feedback, and seek information in the same matter-of-fact, nonjudgmental manner.

Satir puts special emphasis upon the self-esteem building function of the therapist. She maintains that dysfunctional communication is a product of the patient's low level of self-esteem, and it is therefore necessary to elevate this level to facilitate clear communication. To do this, the therapist must make statements indicating that he values the patient as a human being, and recognizes him as an equal.

In order to facilitate the process of therapy, Satir elaborates on several methods she uses to reduce threat. Firstly, she sets definite rules for interaction. All family members must attend therapy sessions, no interrupting during discussions is permitted, no one is allowed to speak for anyone else, and all interaction must be heard by everybody. Secondly, Satir reduces threat by structuring the interviews. Goals are set; the number of therapy sessions is limited. The therapist functions within this structure as an impartial figure. He does not take sides with any one family member. Thirdly, Satir reduces

threat by decreasing the need for defenses and using caution when handling delicate material.

When the initial groundwork for conjoint family therapy has been laid, Satir takes a firm course of action in reeducating the patients towards healthier functioning. She demonstrates to the patient that he is a responsible person, capable of accounting for his own deeds. Further, she teaches clear, direct methods of communication so as to replace previous dysfunctional patterns with useful, healthy ones.

Beels and Ferber (1969) provide an excellent summary of Satir's therapy:

> Satir is determined to teach the family a new language, with which they can resolve the communication problems that she sees as the root of their trouble. To do this, she makes herself the embodiment of clarity and perception in communication, using simple words, keeping up a running explanatory gloss on what she is doing, and arranging encounters between family members according to her rules...basically she is a teacher of a method of communication. The treatment is accomplished when the family has learned it, and the deepening of their relationship is a by-product. (p. 287)

In conclusion, conjoint family practitioners may differ in their respective approaches to therapy, and forms of intervention into the family system. However, they hold in common the belief that difficulties in communication are at the root of family problems, and that the solution to these problems involves changing prevailing patterns of destructive family interaction. Several techniques used by various

therapists were discussed and found to be based upon the communication theory which was elaborated in the previous section.

CHAPTER IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

SUMMARY

The growth and development of conjoint family practice began with the study of individual pathology and how it was related to traits identified in the families of these individuals. Researchers placed special emphasis upon connecting parental traits with pathology in children. Eventually, descriptions of both pathogenic mothers and fathers were elaborated.

The second phase in the development of conjoint family practice arrived with the recognition that the family was the source of individual pathology. With this recognition came numerous experimental studies on various modes of treating the families of patients.

Noted in these studies were frequent observations that the identified patient was often not the only family member that was pathological. Further, it was observed that specific family patterns of interaction were correlated with the appearance of the identified patient's symptoms.

One group of researchers began the intensive study of these patterns of interaction, which culminated in the development of the theory of the double bind.

The introduction of this theory led to more studies on family

patterns of interaction, and eventually a communicational model for the treatment of families was elaborated. This model serves as a basis for the practice of conjoint family therapy in its current state.

Several techniques used by practitioners of conjoint family therapy were presented. It was discovered that approach to treatment depended largely on the style of the individual therapist. Nevertheless, conjoint family practitioners all share in common the communicational theory of family interaction. Thus, the separate techniques used by conjoint family practitioners are similar in focus and purpose. The most important therapeutic goal in conjoint family practice is to alter destructive patterns of family communication in an attempt to free the family towards healthier functioning.

CONCLUSIONS

On the basis of the research presented, the following conclusions are merited:

1. The pathology of an individual is directly connected with destructive patterns of interaction and communication in that individual's family.

2. The striving of the family system to maintain an emotional equilibrium can result in the perpetuation and maintenance of pathology in the family.

3. The presence of an "identified patient" within the family

system does not contraindicate the possibility of pathology in other family members.

4. Since destructive patterns of interaction are responsible for the appearance of pathology in the family, the most appropriate approach to therapy is direct intervention in the family's communication system.

5. Conjoint family therapy represents a positive development in psychotherapeutic practice as limited research results demonstrate it is a viable, effective approach to treatment.

RECOMMENDATIONS

The recentness of the development of conjoint family therapy necessitates the suggestion of the following items:

1. Extensive research and study of conjoint family therapy should be conducted to promote a better understanding of the application of communications theory in practice. The researcher recognizes that the absence of studies demonstrating the long-term results of this form of treatment are precluded due to its recent creation and development. However, such studies are essential to determine the true value of conjoint family practice.

2. Much more emphasis on family treatment is needed in university graduate training programs related to therapeutic practice.

3. Widespread adoption of this approach to therapy should be made in mental health clinics accessible to the general population, with the intent of making conjoint family therapy available to all families desirous of this form of treatment.

REFERENCES

Ackerman, N. Treating the Troubled Family. New York: Basic Books, Inc., 1966.

Ackerman, N., F. Beatman, and S. Sherman. Expanding Theory and Practice in Family Therapy. New York: Family Service Association of America, 1967.

Bateson, G., D. Jackson, J. Haley, and J. Weakland. "Toward a Theory of Schizophrenia," Behavioral Science, 1956, 1, 251-264.

_____. "A Note on the Double Bind--1962," Family Process, 1963, 2, 154-161.

Beels, C., and A. Ferber. "Family Therapy: A View," Family Process, 1969, 8, 280-318.

Bloch, D. Techniques of Family Psychotherapy. New York: Grune and Stratton, 1973.

Coleman, J. Abnormal Psychology and Modern Life. Glenview, Illinois: Scott, Foresman and Company, 1972.

Erickson, G., and T. Hogan. Family Therapy. Monterey, California: Brooks/Cole Publishing Company, 1972.

Ferber, A., M. Mendelsohn, and A. Napier. The Book of Family Therapy. Boston: Houghton Mifflin Company, 1973.

Foley, V. An Introduction to Family Therapy. New York: Grune and Stratton, Inc., 1974.

Haley, J. "An Interactional Description of Schizophrenia," Psychiatry, 1959a, 4, 321-332.

_____. "The Family of the Schizophrenic, A Model System," Journal of Nervous and Mental Disease, 1959b, 129, 357-374.

_____. "Observation of the Family of the Schizophrenic," American Journal of Orthopsychiatry, 1960, 30, 460-467.

_____. "Wither Family Therapy?" Family Process, 1962, 1, 69-100.

Haley, J. "A Review of the Family Therapy Field." In J. Haley (Ed.), Changing Families. New York: Grune and Stratton, Inc., 1971.

_____. "Family Therapy," International Journal of Psychiatry, 1971, 9, 233-242.

_____. Uncommon Therapy. New York: Ballantine Books, 1973.

Haley, J. and L. Hoffman. Techniques of Family Therapy. New York: Basic Books, 1973.

Jackson, D. "The Question of Family Homeostasis," The Psychiatric Quarterly Supplement, 1957, 31, 79-90.

_____. "Family Interaction, Family Homeostasis and Some Implications for Conjoint Family Psychotherapy." In D. Jackson (Ed.), Therapy, Communication, and Change. Palo Alto: Science and Behavior Books, Inc., 1968.

_____. "Family Therapy in the Family of the Schizophrenic." In D. Jackson (Ed.), Therapy, Communication and Change. Palo Alto: Science and Behavior Books, Inc., 1968.

_____. "Interactional Psychotherapy." In D. Jackson (Ed.), Therapy, Communication, and Change. Palo Alto: Science and Behavior Books, Inc., 1968.

Jackson, D., and V. Satir. "A Review of Psychiatric Developments in Family Diagnosis and Family Therapy." In N. Ackerman, F. Beatman, and S. Sherman (Eds.), Exploring the Base for Family Therapy. New York: Family Service Association of America, 1961.

Jackson, D., and J. Weakland. "Schizophrenic Symptoms and Family Interaction," Archives of General Psychiatry, 1959, 1, 618-621.

_____. "Conjoint Family Therapy: Some Considerations on Theory, Technique, and Results," Psychiatry, 1961, 24, 30-45.

Jackson, D., and I. Yalom. "Conjoint Family Therapy as an Aid to Intensive Psychotherapy." In D. Jackson (Ed.), Therapy, Communication, and Change. Palo Alto: Science and Behavior Books, Inc., 1968.

Mosher, L. "Schizophrenogenic Communication and Family Therapy," Family Process, 1969, 8, 43-63.

Rebner, I. "Conjoint Family Therapy," Psychotherapy: Theory, Research, and Practice, 1972, 9, 62-66.

Satir, V. Conjoint Family Therapy. Palo Alto: Science and Behavior Books, Inc., 1967.

Speck, R. "Family Therapy in the Home." In N. Ackerman, F. Beatman, and S. Sherman (Eds), Expanding Theory and Practice in Family Therapy. New York: Family Service Association of America, 1967.

Thorman, G. Family Therapy: A Handbook. Los Angeles: Western Psychological Services, 1971.

Zuk, G., and D. Rubenstein. "A Review of Concepts in the Study and Treatment of Families of Schizophrenics." In I. Boszormenyi-nagy and J. Framo (Eds.), Intensive Family Therapy. New York: Harper and Row.