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The Quest for Survival
A Training Program for Family Diagnosis and Treatment

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It is quite fitting that I preface my presentation about the teaching of conjoint family therapy by an acknowledgment of the debt that all of us owe to the first teachers of psychotherapy, who began their work in this city. What I am about to describe today is a training program for family therapy which integrates these early teachings on individual psychopathology with the added dimensions of anthropology, sociology, communication, and learning theory, applied to the total family group as a productive treatment unit. As a prelude to the discussion of the training program, I should like to present a brief description of its content.

Conjoint family therapy, as we have defined it, is a therapeutic approach in which the whole family, where there is an emotionally disturbed, a socially disturbed, or a mentally ill member, is seen together as a group. This is based on the theory that the ill member, whom we designate as the Identified Patient (I.P), by means of his symptom is sending a message about the "sick" condition of the family of which he is a member.

The basic assumption underlying our diagnostic and treatment efforts is that since the symptom relates to a sick family situation, rather than only to its "sick" member, the diagnosis and treatment then must include a thorough study of the whole family. This means that the family, rather than the individual member or members, is the unit of treatment. Interaction between and among family members becomes the primary focus. The psychotherapeutic tools are in many ways quite different from those used in therapy on a one-to-one basis.

All of the pioneer work in family therapy in the United States was done with families of the schizophrenic patient. The first published article, by Dr. NATHAN ACKERMAN, appeared as early as 1934. However, the bulk of the published material has come since 1954. At this point several groups in the United States have become identified with

research about and treatment of families, among them, NATHAN ACKERMAN in New York; LIDZ and FLECK ET AL., at Yale; MURRAY BOWEN and associates, N.I.M.H.; GALOOSHIAN ET AL., in Galveston; OTTO POLLAK, Philadelphia; GREGORY BATESON, DON JACKSON ET AL., in Palo Alto. The Mental Research Institute in Palo Alto, under the direction of Dr. DON D. JACKSON, has been expanding the conjoint family approach to include other symptoms such as delinquency, asthma, school problems of children, and marital problems, with future plans for work with alcoholics and drug addicts.

The primary operating principle in the analysis of the family process is that the interaction between the father and the mother as husband and wife provides the premise upon which the child develops his rules for who and how he shall be and determines his behavior. The kind of communication about this interaction determines the clarity with which the child perceives this interaction, and in turn determines his chance to get a consistent message about the rules that he is to follow.

An analysis of the specific family homeostasis, as it exists in the present, is based on the development of the present family, beginning at the time of the meeting of the parents and continuing through to the present. Emphasis is placed on three points in the development of the family:

1. The time of the meeting and the subsequent courtship, through the decision to marry and including the marriage ceremony, which gives data about circumstances, bases of decisions about choosing each other, the individual expectations of each other as life partners and the nature of the communication utilized by the couple at that time.

2. The time from the marriage to the birth of the first child, which gives data pertaining to the interrelationship that ensued and data concerning the fulfillment of the expectations that each held for the other and the consequent communication. All of this gives a picture of the husband-wife relationship of the partners in the marriage.

3. The time of the birth of the first child to the present, including subsequent births. This gives data relative to how the parental role was integrated with the marital role in order to accommodate the presence of a child or children, and the consequent communication between all of the members of the family constellation that follows.

We emphasize an understanding of the precise life experiences in the respective families of origins which we see as developing the perceptions by which the husband and wife in the present family live by and on which they form the expectations of their marital partners.

The treatment philosophy of family therapy is based on the following:

The therapist acts as an expert in human relationships, and he behaves in accordance with his own humanness as well as that of the family with which he works. He is direct and clear at all times and works for directness and clarity with the family members in terms of their communication with him and with each other. His techniques are geared toward continual ego enhancement of all family members.

The therapist continually focuses on the reality and the identification of discrepancies that have hitherto made distortion of reality a necessity. The goal of the therapist is to achieve clear, appropriate, and reality-oriented communication among all family members.

The ear of the therapist is alert for discrepancies, that is, statements that do not fit the facts, like "Here is your swimming suit—do not go near the water".

The practice of family therapy allows no room for the therapist to make assumptions about data that are not confirmed. Clear and direct communication enables each member of the family to get a consistent message. If everyone has a clear and mutally understood message, the consequent action on the part of each member of the family may be expected to have some degree of reality related response so that confusion, surprise, and misunderstanding are minimized.

In September 1960, the Mental Research Institute received a three-year grant from the Hill Foundation to train qualified clinical practitioners in the field of psychiatry, psychology, and social work in order to become family therapists. In each year for three years, twelve such practitioners were to be selected for training. Each group of twelve practitioners, whom we refer to as "trainees", would represent an equal division among the three disciplines and an equal number of men and women. Further, each trainee would have been fully trained in his discipline and would have had experience. The next criterion concerned the "intestinal fortitude" of the individual trainee; that is, "the ability to look at a naked soul without flinching". The practice of family therapy requires that the therapist be competent, intelligent, and properly trained; that he be sturdy, courageous, flexible, spontaneous, and above all, he must be hopeful.

Four trainees, two men and two women, come in together for seven hours once a week for forty weeks. Each training day is divided into three parts: a didactic seminar, a treatment session with a family, and the observation of an ongoing family session. The equal male-

female ratio is maintained to give the highest heterosexual balance. Since all our treatment sessions are carried on in front of a one-way mirror, one trainee treats while the other observes. In this way, the two other experiences of training for treatment and for consultation are incorporated into the program. All sessions are tape recorded. These recordings are utilized to facilitate the compilation of research data, to facilitate training, and to clarify further the communication patterns for the family itself. The director of training sits in on the observation and occasionally sits in on the treatment session. Where it has been possible to do so, the director of training conducts family sessions in order that the trainee may observe the technique of an experienced family therapist.

At the outset of training, so that the maximum of learning and growth is possible, the trainees are asked to consciously follow the rule that one must be free to comment on and question anything that he sees or anything that he hears relating to the family, other trainees, or the training staff, and that these comments must be received only as comments on what is done and said, rather than who says it or who does it. This means that all comments need to be expressed freely, which gives a constant feedback to the other members of the group. Because all of the trainees agreed to the "rule", there was free expression and consequently less need for hurt feelings about critical comments. Evaluation at this point indicates the success of this "ground rule". The trainees report ease and an accelerated pace in learning, much growth in their feelings of personal adequacy, and consequently improved performance in their therapeutic endeavor as well as in their daily lives.

The goals of the training program are the following:

1. *Practice* to develop family therapists.

2. *Consultation* to develop consultants in family therapy and to facilitate in-service training in their respective agencies.

3. *Research*—to become oriented to research so that continued and increased knowledge concerning family processes, the diagnosis of family pathology, and treatment of family disordered interaction so that larger numbers of clinicians may be available to collect and to publish data concerning the family.

The problem of each trainee was three-fold. (1) How to integrate the theoretical base of family therapy with an already learned individual approach, which at the outset appeared as though it had little in common with what was already known by the trainee; (2) how to adjust tradi-

tional concepts of etiology of emotional deviation to fit new evidence that was constantly emerging as whole families were being seen and the processes of family homeostasis were becoming clear; (3) how to regain the confidence that the therapist previously had in his former therapeutic role, but which was no longer present.

As one would most certainly expect, this created a period of confusion and uncertainty. Each trainee needed to incorporate new knowledge to adjust himself to behave in a new way as a therapist, and to think differently about the cause and the cure of emotional disturbance and social and mental disorder. This required changes in his philosophy about the etiology of behavior deviation and symptom development. It meant adding and integrating an understanding and an ability to diagnose the interactional basis for behavior deviation in addition to the individual intrapsychic determinants that came from his previous training. This obviously called for learning about interaction and communication theory, and developing skill to identify, label, and analyze the "here and now". This also called for emphasis on diagnosing health as well as illness and becoming familiar with the evolutionary character of family development. It called for greater attention to specific detail whereby the specific meaning of behavior within the family became more precise and discriminating. This frequently led to complete changes in the diagnostic picture as would have been previously seen.

After one year of operation, the results of the training program are reported by the trainees as follows:

1. The personal psychological growth and insight into themselves as people;
2. Active enthusiasm about the results of their therapeutic endeavors;
3. The acquisition of hope about so called untreatable cases;
4. Confidence in their ability to analyze and understand about the relationship of family interaction to development of health and illness.
5. The development of an attitude of discovery and of exploration, minimizing the stereotyped expectations of the clinical picture.

All the trainees reported that their experiences brought them closer to the commonality of man and moved them towards thinking that was less dichotomized concerning health and illness. Further, there was an awareness in the trainees of the inherent good intentions of man, and a belief in the existence and the operation of the intelligence of man as an effective means of changing behavior toward health.

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Summary

This is a presentation of a training program in family diagnosis and treatment given to psychiatrists, psychologists, and social workers who work in a variety of settings; state hospitals, out-patient clinics, probation departments, and family service agencies.

This training program illustrates the teachability of the theoretical framework and demonstrates that treatment is applicable to any setting where people with psychiatric and social symptoms come for help.

Zusammenfassung

Darstellung eines Übungsprogramms für Diagnose und Behandlung von Familien, ausgegeben an Psychiater, Psychologen und «social workers», welche in mannigfaltigen Milieus arbeiten wie staatlichen Spitälern, Polikliniken, Fürsorgestellen und Familiendienst-Vermittlungsstellen. Dieses Übungsprogramm illustriert die Lehrbarkeit des theoretischen Gerüstes und demonstriert, dass Behandlung in jedem Milieu anwendbar ist, wo Bevölkerung mit psychiatrischen und sozialen Symptomen Hilfe sucht.

Résumé

Il s'agit d'un programme visant le diagnostic et le traitement des familles, à l'usage des psychiatres, psychologues et travailleurs sociaux qui travaillent dans: des hôpitaux d'état, cliniques externes, sections de criminologie et dans les agences familiales.

Ce programme illustre le fait qu'on peut enseigner le bases théoriques de ce genre de travail et démontre qu'il est applicable à n'importe quel genre de service où les patients avec des difficultés psychiques et sociales viennent chercher aide.

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