conjoint family therapy

virginia satir

third edition/revised and expanded

Conjoint Family Therapy

Third Edition

by Virginia Satir

SCIENCE AND BEI

Palo Alt

Library of Congress Number 82-061781

ISBN 8314-0063-3

Editing and design by Rain Blockley
Cover design by Lois Stanfield
(Original cover design by Nord Graphic Art Studio)
Typesetting by ComCom
Printed in the United States of America

PREFACE

Welcome to the third edition of *Conjoint Family Therapy.* This edition is both a revision and a vehicle for new material. Parts One through Three (the original book) are largely unchanged except for chapter XII, "Using a Family Life Chronology"—which has been expanded and modified slightly—and chapter XV, "Integrating Models and Disciplines," which has been updated.

Part Four presents two new chapters. The first, "When I Meet a Person," is a subjective account of my initial interview with a family. The chapter answers many of the questions I am often asked, and I think therapists will find it of great interest. It also is a bridge to my later book, *Peoplemaking.* The communication stances and patterns that I describe in *Peoplemaking* play an important role in my initial perceptions of this family. Recognizing these communication postures helps me to design appropriate exercises or interventions. Once the family members are aware of their own stances, they have opened the door to change.

The second new chapter describes a new dimension in my family therapy experience. Just as this book originally grew out of the then revolutionary idea that individuals could be treated in the presence of their families, "Involving the Larger System" recounts a project in which sixty families were treated within the context of their *community.* Since the project's sponsor, the state of Virginia, is still conducting follow-up

studies, my account is not a final analysis. Instead, it captures my excitement about the approach and about the work I did with the nine other members of my team. The project's results will have many implications for family therapists, and readers may want to consider using this "larger systems" approach if they have the opportunity.

An "Author's Note" and a new bibliography complete this new edition. The note describes my other training materials and how they can be used in conjunction with this book. It also provides information on Avanta, a training program I created.

* * * * *

This book grew out of demands for teaching materials for a course in Family Dynamics which I taught to psychiatric residents at the Illinois State Psychiatric Institute in Chicago from 1955 to 1958. Since that time, many of my colleagues from the fields of medicine, psychiatry, psychology, social work, nursing, education, anthropology and sociology have expressed interest in my training programs in family therapy and have encouraged me to expand my initial training outlines and put them in book form. This book is the result, and represents the conclusions I have reached to date on the difficult and challenging subject of conjoint family therapy.

Many major contributions have been made to the use of the family as a therapeutic unit by people who saw behavior as a result of interactional experience in addition to intra-psychic forces. I was one of many who experimented with observing the person labeled "schizophrenic" *in the presence of his family,* rather than by individual treatment alone.

The germ of my particular theory and practice grew out of a new appraisal of the meaning of relatives' calls to me about the "patient" I was seeing. These calls were ostensibly in the form of complaints about the patient, or about my handling, or reports about things they thought I should know about. In traditional psychotherapeutic practice, I had been taught to view any attempt by a relative to communicate with the therapist as a potentially dangerous obstacle to the treatment relationship. As I began to try to understand the meaning of these calls, I saw that there were at least two messages conveyed in them: one about the pain or trouble that the relative observed in the patient, and one about the pain and trouble in himself.

The next step was to see that the call contained not only an offer of help to the patient, but also a request for help for the relative disguised as a threat. It was then impossible not to

recognize that there was an essential relationship between a patient and his family. While I had known this at some level, it was now explicit. Furthermore, it became clear that any individual's behavior is a response to the complex set of regular and predictable "rules" governing his family group, though these rules may not be consciously known to him or the family. From this point of view, we can begin to stop seeing relatives' activities only as dangers, and look at them as forces for growth and indications of the power of interactional transactions in relation to shaping the behavior of the individuals that are a part of that family system.

Most family therapists today agree more or less on how the family systems operate. However, there are now wide differences in ways of modifying these systems. In fact, today—thirty years after family therapy began—we hear talk of "schools" of family therapy. This is reminiscent of the days when a student of human behavior had to choose whether he or she would follow Freud, Jung, or Adler. At that time (forty years ago), it was considered unprofessional to use any ideas that were not part of one's "leader's" methods or approach. It was bad to be eclectic. We are not quite so rigid today. The last word on family therapy has yet to be spoken. It behooves all of us to continue being students. My recommendation is that we free ourselves to look anywhere and to use what seems to fit. This makes each of us a continually growing entity.

In this vein, I want to emphasize that I offer this book as a conceptual frame around which to organize your data and your impressions, rather than something to be memorized and followed as though it were a recipe. It is a suggested path. The best approach to any situation will be determined by its particular circumstances. It is very important that therapists be flexible and free to adopt whatever is necessary and appropriate under those circumstances.

This book is primarily intended to prepare students for effective family therapy work and to refresh "old pros" about parts that are easy to forget. For this reason, I kept the informal outline format of the training manual from which this book originated. At this point, family therapy has been further explored. We are much farther along in both our knowledge about how family systems operate, and I hope that the book may also serve as a catalyst for innovations in both clinical practice and research.

Virginia S. Satir

ACKNOWLEDGMENTS

No man develops by himself. The evolution of this book and the ideas contained herein present a concrete example of this fact. Therefore, to all persons with whom I have had the experience of an interaction throughout my lifetime, I extend thanks for the enrichment they have given me.

Opportunities for clarification of my thinking have been many and rich through the questions of people who have elected to be in my training seminars or who have invited me as a consultant all over the United States and four other continents. To the persons who have sought my treatment services during the past forty-one years, I wish to extend special thanks. Without them, I would have had no way of knowing whether my ideas had any particular relevance.

For the encouragement I received while teaching at the Illinois State Psychiatric Institute, Chicago, Illinois, I should like to thank Dr. Kalman Gyarfas, then director of the Institute, and Miss Pauline Peters, director of social work at Chicago State Hospital, where the newly formed Institute was then housed.

My original ideas were greatly expanded and altered through my intimate professional association with Dr. Don Jackson, Gregory Bateson, Jay Haley, John Weakland, Dr. William Fry, Dr. Jules Riskin, Dr. Robert Spitzer, and others at the Mental Research Institute, Palo Alto, California.

To my many other colleagues who were also engaged in the exciting work of studying family interaction and its

relationship to the development of health and illness, I wish to express my appreciation for their willingness to offer me the findings of their research. Among these many persons were: Dr. Murray Bowen, Dr. Warren Brodey, Dr. Victor Freeman, Dr. S. Minuchin, Dr. E. Auerswald, Dr. Otto Pollak, Dr. Eric Berne, and Dr. S. I. Hayakawa.

In addition, I should like to acknowledge the generous financial help given me for the first edition by the following foundations: the National Institute of Mental Health for their Small Grant and Training Grant; Mrs. H. L. McIntyre for her gift from the Robert C. Wheeler Foundation, and the Louis W. and Maud Hill Family Foundation for their grant to the Family Project.

The first edition would never have come into being without the able assistance of Barbara Francisco, who spent many hours over a two year period listening to tapes of my teaching and treatment sessions in order to pull the material together. To Lynn Hoffman, who lent her excellent editorial skills to putting the manuscript in its final form, and to Camille Ball, who volunteered her help in typing the manuscript, I give special thanks. I wish also to thank Dee Barlow Krueger for her contribution to the preparation and writing of the Revised Edition.

Since the original publication of this book, I have traveled widely and shared experiences with many people. My thanks go to all of them, and particularly to Ruth Topping, Fritz Perls, Michael Murphy, and Richard Price.

As my experience worldwide has continued to deepen, broaden, and lengthen, I have been privileged to be in contact with the emerging leaders in the field of holistic health, which is opening up vistas never before dreamed of. Brugh Joy, M.D.; Ken Pelletier, Ph.D.; Irving Ogle, M.D.; Norman Shealy, M.D.; Carl Simonton, M.D., and Stephanie Simonton; Elisabeth Kubler-Ross, M.D.; Al Huang; Stan Grof, M.D.; Bob Ornstein, Ph.D.; Lama Govinda; Alyce and Elmer Green, Ph.D.s; Jack Schwarz; Ida Rolf; Fredrik Lionel; Karl Pribram; and Marcel Vogel are outstanding among the people who have especially touched me in ways that informed and stimulated me toward new discoveries and possibilities.

I want to extend special thanks to Robert Spitzer, M.D., and his capable editor, Rain Blockley, for literally riding herd on me to carve out the time to do this revised edition.

Finally, I feel a deep gratitude for the support and stimulation of the members of Avanta and of the International Human Learning Resource Network (IHLRN), who have joined in the dream of how to help people become more fully human.

KEY TO ABBREVIATIONS

The following abbreviations have been used throughout the text.

I.P.	—	Identified Patient
Th	—	Therapist
H	—	Husband
W	—	Wife
F	—	Father
M	—	Mother
S	—	Son
D	—	Daughter

References cited are included in the numbered bibliography. In the text, these sources are indicated by their respective bibliography numbers (in parentheses) for easy reference.

CONTENTS

PART ONE: FAMILY THEORY

CHAPTER I

Why Family Therapy?

1. Family therapists deal with family pain.

   a. When one person in a family (the patient) has pain which shows up in symptoms, all family members are feeling this pain in some way.

   b. Many therapists have found it useful to call the member who carries the symptom the "Identified Patient," or "I.P.," rather than to join the family in calling him "the sick one," or "the different one," or "the one who is to blame."

   c. This is because the therapist sees the Identified Patient's symptoms as serving a family function as well as an individual function.

2. Numerous studies have shown that the family behaves as if it were a unit. In 1954 Jackson introduced the term "family homeostasis" to refer to this behavior (39).

   a. According to the concept of family homeostasis, the family acts so as to achieve a balance in relationships.

b. Members help to maintain this balance overtly and covertly.

c. The family's repetitious, circular, predictable communication patterns reveal this balance.

d. When the family homeostasis is precarious, members exert much effort to maintain it.

3. The marital relationship influences the character of family homeostasis.

   a. The marital relationship is the axis around which all other family relationships are formed. The mates are the "architects" of the family.

   b. A pained marital relationship tends to produce dysfunctional parenting.

4. The Identified Patient is the family member who is most obviously affected by the pained marital relationship and most subjected to dysfunctional parenting.

   a. His symptoms are an "SOS" about his parents' pain and the resulting family imbalance.

   b. His symptoms are a message that he is distorting his own growth as a result of trying to alleviate and absorb his parents' pain.

5. Many treatment approaches are called "family therapy" but differ from the definition which will be presented here, since they are oriented primarily to family members as individuals rather than to the family as a unit as well. For example:

   a. Each family member may have his own therapist.

   b. Or family members may share the same therapist, but the therapist sees each member separately.

c. Or the patient may have a therapist who occasionally sees other family members "for the sake of" the patient.

6. A growing body of clinical observation has pointed to the conclusion that family therapy must be oriented to the family as a whole. This conviction was initially supported by observations showing how family members respond to the individual treatment of a family member labeled as "schizophrenic." But further studies showed that families with a delinquent member respond in similar ways to the individual treatment of this member. In both cases it was found that:

   a. Other family members interfered with, tried to become part of, or sabotaged the individual treatment of the "sick" member, as though the family had a stake in his sickness.

   b. The hospitalized or incarcerated patient often got worse or regressed after a visit from family members, as though family interaction had a direct bearing on his symptoms.

   c. Other family members got worse as the patient got better, as though sickness in one of the family members were essential to the family's way of operating.

7. These observations led many individually-oriented psychiatrists and researchers to re-evaluate and question certain assumptions (109, 110, 114, 140, 142, 146, 162).

   a. They noted that when the patient was seen as the victim of his family, it was easy to overidentify with and overprotect him, overlooking the fact that:
      — Patients are equally adept at victimizing other family members in return.
      — Patients help to perpetuate their role as the sick, different, or blamed one.

   b. They noted how heavily transference was relied on in order to produce change.
      — Yet perhaps much of the patient's so-called transference was really an appropriate reaction to the

therapist's behavior in the unreal, noninteractive, therapeutic situation.
— In addition, there was a greater chance that the therapeutic situation would perpetuate pathology, instead of presenting a new state of affairs which would introduce doubts about the old perceptions.
— If some of the patient's behavior did represent transference (that is, his characteristic way of relating to his mother and father), why shouldn't the therapist help the patient deal with the family more directly, by seeing both the patient and his family together?

c. They noted that the therapist tended to be more interested in the patient's fantasy life than in his real life. But even if they were interested in the patient's real life, as long as they saw just the patient in therapy, they had to rely on his version of that life or try and guess what was going on in it.

d. They noted that in trying to change one family member's way of operating they were, in effect, trying to change the whole family's way of operating.
— This put the burden of family change-agent on the patient all by himself rather than on all family members.
— The patient was already the family member who was trying to change the family's way of operating, so when he was urged to increase his efforts, he only received a more intense criticism from the family. This also led him to feel even more burdened and less able.

8. Aside from all these observations, once therapists started to see the whole family together, other aspects of family life which produced symptoms were revealed, aspects which had been largely overlooked. Other investigators of family interaction were making similar discoveries. As Warren Brodey sees it, the mates act differently with the normal sibling than they do with the symptomatic sibling (27):

> . . . the parents in the presence of the "normal" sibling are able to relate with a freedom, flexibility, and breadth of awareness that one finds hard to believe, considering the limitations that exist in the

relationship between the parents when involved with the symptomatic sibling. The pathological ways of relating seem to be focused within the relationship with the symptomatic member. One wonders how this has come about.

9. But those psychiatrists who became increasingly devoted to family therapy were not the first to recognize the interpersonal nature of mental illness. Sullivan and Fromm-Reichmann, along with many other psychiatrists, psychologists, and social workers, were pioneers in this area of discovery. The Child Guidance movement was another important development which helped break the tradition of singling out just one family member for treatment (41).

   a. Child Guidance therapists included both mother and child in treatment, even though they still tended to see mother and child in separate treatment sessions.

   b. They also increasingly recognized the importance of including the father in therapy, though they found him hard to reach, and generally failed to engage him in the therapy process.
      — Therapists reported that the father felt parenting was his wife's job more than his; if the child acted disturbed, his wife was the one who should be seen.
      — The Child Guidance therapists, being mother-child oriented anyway, tended to agree with the father's reasoning, so they could not easily convince him that his role in the family was important to the health of his child.
      — Child Guidance Clinics remained primarily focused on "mothering," even though they increasingly recognized the importance of "fathering." And whether or not they included the father in their thinking, they continued to focus on the husband and wife as parents of the child rather than as mates to each other. Yet it has been repeatedly noted how critically the marital relationship affects parenting. Murray Bowen writes, for example (25):

> The striking observation was that when the parents were emotionally close, more invested in each other than either was in the patient, the patient

improved. When *either* parent became more emotionally invested in the patient than in the other parent, the patient immediately and automatically regressed. When the parents were emotionally close, they could do no wrong in their "management" of the patient. The patient responded well to firmness, permissiveness, punishment, "talking it out," or any other management approach. When the parents were "emotionally divorced," any and all "management approaches" were equally unsuccessful.

10. Family therapists have found it easier to interest the husband in family therapy than in individual therapy. This is because the family therapist is himself convinced that both architects of the family must be present.

    a. Once the therapist convinces the husband that he is essential to the therapy process, and that no one else can speak for him or take his place in therapy *or* in family life, he readily enters in.

    b. The wife (in her role as mother) may initiate family therapy, but once therapy is under way, the husband becomes as involved as she does.

    c. Family therapy seems to make sense to the whole family. Husband and wife say: "Now, at last, we are together and can get to the bottom of this."

11. Right from the first contact, family therapists operate from certain assumptions about why a family member has sought therapeutic help.

    a. Usually the first contact is made because someone outside the family has labeled Johnny as disturbed. This first contact will probably be made by an anxious wife (we will call her Mary Jones), acting in her role as mother of a disturbed child, Johnny. The child is disturbed, so she, the mother, must be to blame.

    b. But Johnny was probably exhibiting disturbed behavior long before he became labeled disturbed by someone outside the family.

c. Until the outsider (often a teacher) labeled Johnny as disturbed, members of the Jones family probably acted as though they did not notice Johnny's behavior; his behavior was appropriate because it served a family function.

d. Usually some event has occurred which has precipitated symptoms in Johnny, symptoms which make the fact that he is disturbed obvious to outsiders. These events are:
   — Changes from outside the nuclear family: war, depression, etc.
   — Changes in the two families of origin: sickness of a grandmother, financial distress of a grandfather, etc.
   — Someone enters or leaves the nuclear family: grandmother comes to live with the family, the family takes on a boarder, the family adds to its membership with the birth of another child, a daughter gets married.
   — Biological changes: a child reaches adolescence, mother reaches menopause, father is hospitalized.
   — Major social changes: a child leaves home to attend school, the family moves to a new neighborhood, father gets a job promotion, son goes to college.

e. These events can precipitate symptoms because they require the mates to integrate the changes. This requirement puts an extra strain on the marital relationship because it calls for a redefinition of family relationships and thus affects family balance.

f. The family homeostasis can be functional (or "fitting") for members at some periods of family life and not at other periods, so events affect members differently at different times.

g. But if one member is affected by an event, all are to some degree.

12. After the first contact with Mary Jones, the therapist may speculate about the relationship between Mary and her husband, whom we will call Joe. If it is correct to assume that a dysfunctional marital relationship is the main