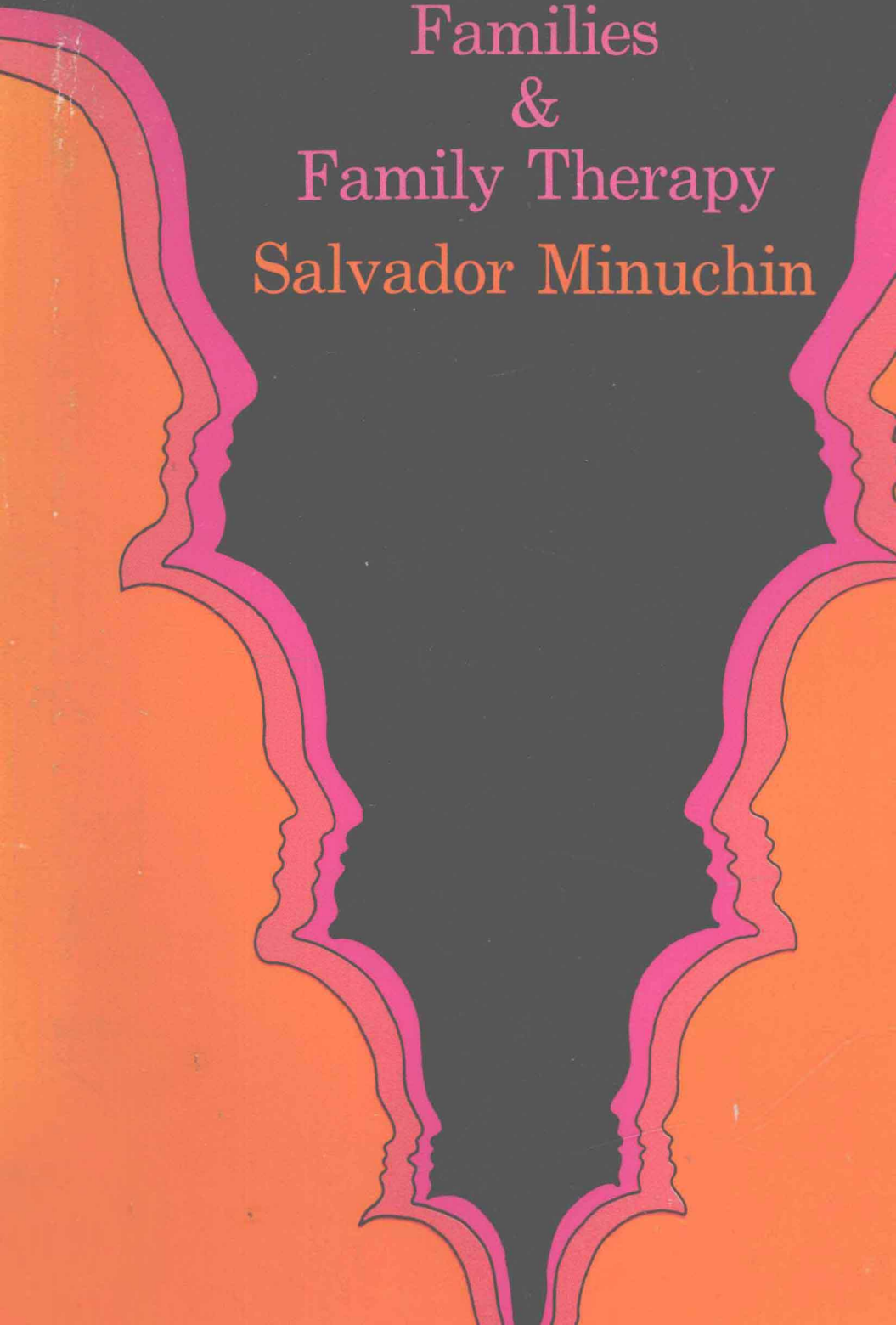
# Families & Family Therapy

Salvador Minuchin



# FAMILIES & FAMILY THERAPY

by Salvador Minuchin

HARVARD UNIVERSITY PRESS, CAMBRIDGE, MASSACHUSETTS

# Families and Family Therapy

To my father and mother,
who taught me the meaning of families,
and to my wife and children,
who enlarged my experience.

# Acknowledgments

This book owes a lot to an informal seminar that was held twice a day for thirty to forty minutes over more than two years as Jay Haley, Braulio Montalvo, and I were driving to and from the Philadelphia Child Guidance Clinic. Many of the ideas presented here emerged from our discussions, for which I am deeply grateful. I especially thank Braulio Montalvo, whom I consider my most influential teacher. He has the rare capacity to receive an idea and then give it back enlarged. At many times during our ten years of working together he has redirected my thinking, and has always enriched it. I have also benefited from the assistance of Frances Hitchcock, who for seven years helped me to clarify my ideas and to turn them into prose.

Many of my colleagues at the Philadelphia Child Guidance Clinic made contributions to this book, bouncing ideas back and forth with me. I especially want to mention the faculty of the Institute of Family Counseling, and in particular, Jerome Ford, Carter Umbarger, Marianne Walters, and Rae Weiner.

This book began as a series of lectures presented to groups in the United States, Sweden, and Holland. I wish to thank my students of the Group Psychotherapy Association in Holland, who contributed examples and shared their views. Mordecai Kaffman, M.D., kindly interviewed the Israeli family especially for this book. Finally, thanks are due to Lyman Wynne for his helpful suggestions in reviewing the manuscript and to Virginia LaPlante for her work in editing the book.

## A NOTE ON THE TRANSCRIPTS

The transcripts in this book have been edited to protect the privacy of the families interviewed. When necessary, meanings have been clarified.

Before the presentation of the transcripts, references are sometimes made to the families involved, as examples of various points. This anticipatory device is used to familiarize the reader with the cases, so that when he reaches the full account of each session, he need give less attention to content and more to the therapeutic process.

The Smith, Dodds, and Gorden family interviews have been made into movies, with analysis provided by Braulio Montalvo. They are titled "I Think It's Me—Difference Display As a Contextual Event" (Chapter 9), "Affinity" (Chapter 10), and "A Family with a Little Fire" (Chapter 11). Information on these films is available from the Philadelphia Child Guidance Clinic, 1700 Bainbridge Street, Philadelphia, Pennsylvania 19146.

Salvador Minuchin, M.D.

# Contents

# 1 Structural Family Therapy

Robert Smith, his wife, his twelve-year-old son, and his father-in-law are sitting with me for their first consultation with a family therapist. Mr. Smith is the identified patient. He has been hospitalized twice in the past seven years for agitated depression and has recently requested rehospitalization.

*Minuchin:* What is the problem? . . . So who wants to start?

*Mr. Smith:* I think it's my problem. I'm the one that has the problem. . .

*Minuchin:* Don't be so sure. Never be so sure.

*Mr. Smith:* Well . . . I'm the one that was in the hospital and everything.

*Minuchin:* Yeah, that doesn't, still, tell me it is your problem. Okay, go ahead. What is your problem?

*Mr. Smith:* Just nervous, upset all the time. . . seem to be never relaxed. . . I get uptight, and I asked them to put me in the hospital. . .

*Minuchin:* Do you think that you are the problem?

*Mr. Smith:* Oh, I kind of think so. I don't know if it is caused by anybody, but I'm the one that has the problem.

*Minuchin:* . . . Let's follow your line of thinking. If it would be caused by somebody or something outside of yourself, what would you say your problem is?

*Mr. Smith:* You know, I'd be very surprised.

*Minuchin:* Let's think in the family. Who makes you upset?
*Mr. Smith:* I don't think anybody in the family makes me upset.
*Minuchin:* Let me ask your wife. Okay?

The consultation that began with this exchange was the beginning of a new approach to the problem of Mr. Smith. Instead of focusing on the individual, the therapist focused on the person within his family. The therapist's statement, "Don't be so sure," challenged the certainty that Mr. Smith alone was the problem or had the problem—a certainty which had been shared by Mr. Smith, his family, and the many mental health professionals he had encountered.

The therapist's framework was structural family therapy, a body of theory and techniques that approaches the individual in his social context. Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of members in that group are altered accordingly. As a result, each individual's experiences change.

The theory of family therapy is predicated on the fact that man is not an isolate. He is an acting and reacting member of social groups. What he experiences as real depends on both internal and external components. The paradoxical duality of the human perception of reality is explained by Ortega y Gasset in a parable: "Peary relates that on his polar trip he traveled one whole day toward the north, making his sleigh dogs run briskly. At night he checked his bearings to determine his latitude and noticed with great surprise that he was much further south than in the morning. He had been toiling all day toward the north on an immense iceberg drawn southwards by an ocean current."[1] Human beings are in the same situation as Commander Peary on the iceberg. Man's experience is determined by his interaction with his environment.

To say that man is influenced by his social context, which he also influences, may seem obvious. Certainly the concept is not new; it was familiar to Homer. But it is a new approach to base mental health techniques on this concept.

The traditional techniques of mental health grew out of a fascination with individual dynamics. This preoccupation dominated the field and led therapists to concentrate on exploring the intrapsychic. Of necessity, the resulting treatment techniques focused exclusively on the individual, apart from his surroundings. An artificial "boundary" was drawn between the individual and his social context.

In theory, this boundary was recognized as artificial, but in practice it was maintained by the process of therapy. As the patient was treated in isolation, the data encountered were inevitably restricted to the way he alone felt and thought about what was happening to him; such individualized material in turn reinforced the approach to the individual apart from his context and provided little possibility for corrective feedback. The very richness of the data available discouraged other approaches. As a result, the individual came to be viewed as the site of pathology.

A therapist oriented to individual therapy still tends to see the individual as the site of pathology and to gather only the data that can be obtained from or about the individual. For instance, an adolescent boy might be referred to therapy because he is shy and daydreams in class. He is a loner, with difficulty relating to his peers. A therapist who operates in individual sessions would explore the boy's thoughts and feelings about his present life and the people in it, the historical development of his conflict with parents and siblings, and the compulsive intrusion of this conflict into extrafamilial, seemingly unrelated situations. He would establish contact with the family and the school, but to understand the boy and the boy's relationship with his family, he would rely mainly on the content of the boy's communication and on transferential phenomena. An internal cognitive-affective rearrangement is regarded as the necessary step to facilitate improvement of the presenting problem.

A therapist working within this framework can be compared to a technician using a magnifying glass. The details of the field are clear, but the field is severely circumscribed. A therapist working within the framework of structural family therapy, however, can be compared to a technician with a zoom lens. He can zoom in for a closeup whenever he wishes to study the intrapsychic field, but he can also observe with a broader focus.

If the same boy were referred to a family therapist, the therapist would explore his interactions within significant life contexts. In family interviews, the therapist would observe the relationship of the boy and his mother, with its mingled closeness and hostility. He might see that when the boy talks in the presence of his parents, he rarely addresses his father, or that when he does talk to his father, he tends to do so through his mother, who translates and explains her son to her husband. He might notice that other siblings seem more spontaneous, interrupt the parents, and talk to the father and mother

alike. Thus, the therapist does not have to depend on the boy's descriptions of his father, mother, and siblings to postulate the introjection of the familial figures. The family members are present, demonstrating behavior in relation to the boy that can be operationally described. The broader focus and the greater flexibility opened to the therapist enhance the possibilities for therapeutic intervention. The therapist is not restricted to the family interaction as internalized by the boy, but can himself experience the way in which the family members support and qualify each other. He then develops a transactional theory to explain the phenomena he is observing. He can also be in touch with the boy's school, since the presenting problem is related to school performance, and the theories and techniques of family therapy lend themselves readily to work with the individual in contexts other than the family.

Thus, the family therapist does not conceive of an "essential" personality, remaining unchanged throughout the vicissitudes of different contexts and circumstances. He sees the boy as a member of different social contexts, acting and reacting within them. His concept of the site of pathology is much broader, and so are the possibilities for intervention.

## MAN IN HIS CONTEXT

Structural family therapy, approaching man in his social context, was developed in the second half of the twentieth century. It is one of many responses to the concept of man as part of his environment that began to gain currency early in the century. Individual psychodynamic thinking drew upon a different concept, that of man as a hero, remaining himself in spite of circumstances. An example of this concept appears in *Paradise Lost*. When Satan is defeated in his revolt against God and cast into hell, he defies his circumstances:

> The mind is its own place, and of itself
> Can make a Heav'n of Hell, a Hell of Heav'n.[2]

This perception of the individual could survive in a world where the resources of man seemed infinite. Modern technology has changed this view. The earth no longer appears as a limitless territory, waiting for its claimant, but as a spaceship whose resources are dwindling. These changes are reflected in man's current perceptions of himself and of his way of being.

As early as 1914, Ortega y Gasset wrote: "I am myself plus my

circumstances, and if I do not save it, I cannot save myself. This sector of circumstantial reality forms the other half of my person; only through it can I integrate myself and be fully myself. The most recent biological science studies the living organism as a unit composed of the body and its particular environment so that the life process consists not only of the adaptation of the body to its environment, but also of the adaptation of the environment to its body. The hand tries to adjust itself to the material object in order to grasp it firmly; but at the same time, each material object conceals a previous affinity with a particular hand."[3] There is a striking similarity between this poetic observation at the beginning of the century and the more modern explanation, couched in cibernetic language, with which Gregory Bateson erased the boundary between inner and outer space to achieve his own metaphor of the mind: "Consider a man felling a tree with an axe. Each stroke of the axe is modified or corrected, according to the shape of the cut face of the tree left by the previous stroke. This self-corrective . . . process is brought about by a total system, tree-eyes-brain-muscles-axe-stroke-tree; and it is this total system that has the characteristics of . . . mind."[4] The old idea of the individual acting upon his environment has here become the concept of the individual interacting with his environment. To paraphrase Ortega, a man is not himself without his circumstances.

Bateson's metaphor of the mind and Ortega's poetic imagery of man and his circumstances are corroborated by experiments, which have demonstrated that context directly influences the internal processes of the mind. For example, the neurologist José Delgado, who experimented with the implantation of electrodes in animals' brains, showed conclusively that while an animal responds to the triggering effect of electrical stimulation, the behavior thus triggered is organized by the animal's context. Writing of his experiments with monkeys, he reported: "It is well known that monkey colonies constitute autocratic societies in which one animal establishes itself as boss of the group, claiming a large portion of the territory, feeding first, and being avoided by the others, who . . . express their submissiveness. . . In several colonies we have observed that radio stimulation . . . in the boss monkey increased his aggressiveness and induced well-directed attacks against other members of the group, whom he chased around and occasionally bit. . . It was evident that his hostility was oriented purposefully . . . because he usually attacked the other male who represented a challenge to his authority, and he always spared the

little female who was his favorite partner."[5] In other words, the internal, electrical triggering of behavior was always modified by the context. The electrical stimulation could produce aggression, but the expression of that aggression was related to the social group.

Delgado's interest in the relationship between electrical stimulation of the brain and the social context of the stimulated animal led him to experiment with changing the animal's social context. The social rank of a female monkey was altered by changing the composition of the group. In the first group she was the lowest of four, in the second group she was ranked third, and in the third group she was ranked second. In all three colonies, the electrical stimulations induced the monkey to run across her cage, climb, lick, vocalize, and attack other animals. In the first group, she tried to attack another monkey only once. In group two she became more aggressive, attacking twenty-four times. In group three, the stimulated monkey attacked other monkeys seventy-nine times. Delgado concluded: "intraspecies aggression has been evoked . . . by electrical stimulation of several cerebral structures, and its expression is dependent on the social setting . . . an artificially evoked aggressive act may be directed against a specific group member or may be entirely suppressed, according to the stimulated subject's social rank."[6]

Delgado also found that if a low-ranking monkey is mildly stimulated in the rage center, he may not show a rage response at all. This finding might be explained as repression. But it is also possible to explain the monkey's lack of response in terms of two different inputs, one of which is more powerful. If the input of the low-ranking monkey's context is more powerful than the stimulation of the brain, rage might not be felt. If the stimulation is increased, the monkey's behavior within its context changes, as it does if the social circumstances are changed.

Delgado carries his observations further into a consideration of the influence of the social sphere on man. "We cannot be free from parents, teachers, and society," he wrote, "because they are the extracerebral sources of our minds."[7] Delgado's concept of cerebral and extracerebral mind is directly comparable to Bateson's and Ortega's concepts.[8] A human mind develops as the brain processes and stores the multiple inputs triggered both internally and externally. Information, attitudes, and ways of perceiving are assimilated and stored, thereby becoming part of the person's approach to the current context with which he interacts.

The family is a highly significant factor in this process. It is a natural social group, which governs its members' responses to inputs from within and without. Its organization and structure screen and qualify family members' experience. In many cases, it can be seen as the extracerebral part of the mind.

The influence of the family on its members was demonstrated experimentally by an investigation of childhood psychosomatic illness being conducted by myself, Lester Baker, and our team. The research findings provided experimental grounding for the basic tenet of family therapy, namely, that the child responds to stresses affecting the family. We developed a method of measuring individual physiological responses to family stress. During a structured family interview designed for this purpose, blood samples are drawn from each family member in such a way that obtaining the samples does not interfere with ongoing interactions. The level of plasma-free fatty acids in the samples is later analyzed. Free fatty acid (FFA) is a biochemical indicator of emotional arousal—the concentration rises within five to fifteen minutes of emotional stress. By comparing the FFA levels at different times during the structured interview, the individual's response to family stress can be physiologically documented.

The FFA results of the Collins family are a good example (Figure 1). Both children were diabetics. Dede, 17, had had diabetes for three years; her sister Violet, 12, had been diabetic since infancy. Studies of

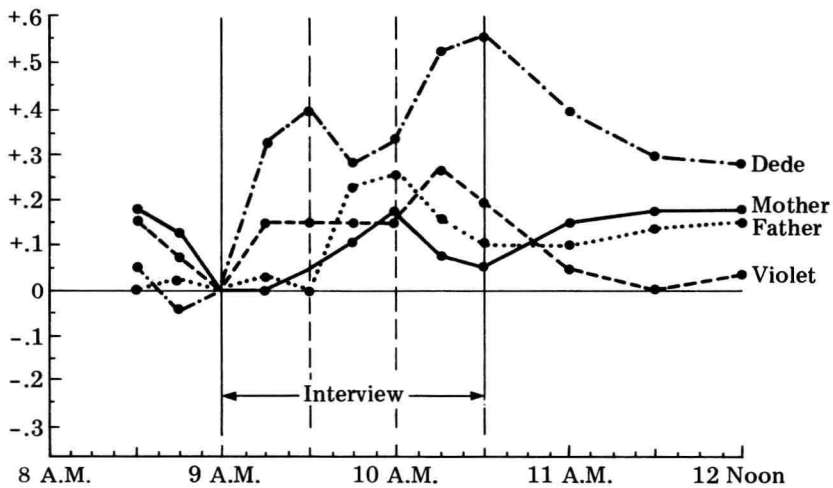



Fig. 1. Change in Free Fatty Acid, the Collins family

the children's "physiological lability" showed that there was no obvious difference in their individual responsivity to stress. Yet these two children, with the same metabolic defect, having much of the same genetic endowment, and living in the same household with the same parents, presented very different clinical problems. Dede was a "superlabile diabetic"; that is, her diabetes was affected by psychosomatic problems. She was subject to bouts of ketoacidosis that did not respond to insulin administered at home. In three years, she had been admitted to the hospital for emergency treatment twenty-three times. Violet had some behavioral problems that her parents complained of, but her diabetes was under good medical control.

During the interview designed to measure the children's response to stress, lasting from 9 to 10 A.M., the parents were subjected to two different stress conditions, while the children watched them through a one-way mirror. Although the children could not take part in the conflict situation, their FFA levels rose as they observed their stressed parents. The cumulative impact of current psychological stress was powerful enough to cause marked physiological changes even in children not directly involved. At 10 o'clock the children were brought into the room with their parents. It then became clear that they played very different roles in this family. Dede was trapped between her parents. Each parent tried to get her support in the fight with the other parent, so that Dede could not respond to one parent's demands without seeming to side against the other. Violet's allegiance was not sought. She could therefore react to her parents' conflict without being caught in the middle.

The effects of these two roles can be seen in the FFA results. Both children showed significant increments during the interview, between 9 and 10, and even higher increments between 10 and 10:30, when they were with their parents. After the end of the interview at 10:30, however, Violet's FFA returned to baseline promptly. Dede's remained elevated for the next hour and a half.

In both spouses, the FFA levels increased from 9:30 to 10, indicating stress in the interspouse transactions. But their FFA decreased after the children had come in to the room and the spouses had assumed parental functions. In this family, interspouse conflict was reduced or detoured when the spouses assumed parental functions. The children functioned as conflict-detouring mechanisms. The price they paid is shown by both the increase in their FFA levels

and Dede's inability to return to baseline. The interdependence between the individual and his family—the flow between "inside" and "outside"—is poignantly demonstrated in the experimental situation, in which behavioral events among family members can be measured in the bloodstream of other family members.

## THE SITE OF PATHOLOGY

When the mind is viewed as extracerebral as well as intracerebral, to locate pathology within the mind of the individual does not indicate whether it is inside or outside the person. Pathology may be inside the patient, in his social context, or in the feedback between them. The artificial boundary becomes blurred, and therefore the approach to pathology must change. Therapy designed from this point of view rests on three axioms. Each has an emphasis quite different from the related axiom of individual theory. First, an individual's psychic life is not entirely an internal process. The individual influences his context and is influenced by it in constantly recurring sequences of interaction. The individual who lives within a family is a member of a social system to which he must adapt. His actions are governed by the characteristics of the system, and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system, to which he adapts; and he may contribute significantly to stressing other members of the system. The individual can be approached as a subsystem, or part, of the system, but the whole must be taken into account. The second axiom underlying this kind of therapy is that changes in a family structure contribute to changes in the behavior and the inner psychic processes of the members of that system. The third axiom is that when a therapist works with a patient or a patient family, his behavior becomes part of the context. Therapist and family join to form a new, therapeutic system, and that system then governs the behavior of its members.

These three assumptions—that context affects inner processes, that changes in context produce changes in the individual, and that the therapist's behavior is significant in change—have always been part of the common sense basis of therapy. They have occupied the background in the literature of psychotherapy, while internal processes have come to the fore. However, they have not become central to psychotherapeutic practice, where an artificial dichotomy between the individual and his social context still exists.

An example can be drawn from concepts of paranoid thinking,

because in this area an understanding of the patient's context is vital. Yet in intrapsychic terms, paranoia is approached as a formal thinking disorder, in which the perception of events is determined by internal processes. As Aaron Beck wrote: "among normals, the sequence perception-cognition-emotion is dictated largely by the demand character of the stimulus situation. . . [However] the paranoid patient may selectively abstract those aspects of his experience that are consistent with his preconceived idea of persecution, etc. He may make arbitrary judgments which have no factual basis. These are usually manifested by reading hidden significances and meanings into events. He also tends to overgeneralize isolated instances of intrusion, discrimination, etc."[9] In these terms, paranoia is an internal phenomenon only tangentially related to reality.

Contrast this with a context-related view of paranoia. In a study of mental patients with paranoid symptoms, Erving Goffman pointed out that in early stages of the illness, the social context enters a complementarity with the patient which supports his illness.[10] Significant social groups, such as job peers, try to contain the patient, because his symptoms have a disruptive effect. They avoid him when possible and exclude him from decisions. They employ a humoring, pacifying, noncommittal style of interaction, which dampens the patient's participation as much as possible. They may even spy on him or form a collusive net so as to inveigle him into receiving psychiatric attention. Their well-meant tact and secrecy deprive the patient of a corrective feedback, with the ultimate consequence of constructing around the paranoid a real paranoid community.

Paranoid thinking and behavior can also be created experimentally in normal, highly educated professionals by group experiences, such as those devised at the Leadership Institutes of the Tavistock Clinic. In the "large-group exercise," thirty to fifty participants are seated in three to five concentric circles. The faculty are scattered through the circles, wearing business clothes, poker-faced, and silent. The group is given an ambiguous task: to study its own behavior.

Within the structure of this leaderless exercise, participants make statements that are not directed to anyone in particular, and because of the seating arrangements, half the participants have their backs turned and cannot see who is speaking. Dialog does not develop; a statement may be followed by a different statement in a different area. Thus, communications are not validated by consenting or dissenting feedback. Again and again, one sees the rapid appearance of