Phases of Systems Treatment With the Individual and the Family

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Therapy can be divided arbitrarily into three parts: the beginning, the middle and the end. Of these, the beginning is the easiest to define. In the initial contact, usually over the phone, membership of the first meeting will be decided. It may be more appropriate to see the parents alone if the problem is a marital issue or if they would feel freer to give a complete history of the family without the presence of the children. If the problem is perceived to be in a child, he may be excluded from that initial visit for the sake of a more complete history, or because he is an older teenager and refuses to come. If the problem is in the child and both parents decline to be involved, then I will refer the family elsewhere. I do not consider it possible to help a child without the active participation of at least one parent. Husband or wife may refuse to come because one sees the entire problem in the other ("who ought to come"), or one sees the entire problem in self ("and I alone should come"), or one does not want the other to know a particular piece of information (such as an affair.) From the moment of initial contact, if one insists on seeing the entire family or a portion of the family (conjoint therapy), many people will be unnecessarily excluded from your practice.

One could make a case that every member of the family should be seen at least once alone, to get his unfettered picture of himself and his family. Economy of time and money precludes that, however. Yet, we do know that every time we change the context by increasing or decreasing the number of people in the room, we bring out a different facet of the person and the family. It is generally useful for the beginning therapist to see as many members of the family initially as is possible. More experienced therapists may be able to move faster. Observational therapists (those who watch a family and then make a move) feel obliged to see the entire family before they try to make a move into the family. Theoretical therapists (they approach every family with some preconceived notions) may decide on a membership varying from one to many. The comfort of the therapist will also be a matter of importance. I generally feel most comfortable and effective with one to five members of the family present. More than that tends to lead to confusion.

The second part of the therapy procedure concerns taking a history. This involves at least a three-generational genogram that includes important dates, illnesses, locations of people, the identification of both living and dead members of the family, time and space considerations such as who communicates with whom, when—and who is cut off from the family. It is interesting to observe who is the family historian and statistician. One will often know more than the other about dates and locations. Besides the value of the history, such an approach lets the family know that the therapist is in control. He will decide (giving some leeway so as not to be stifling) who talks; he will make it clear that interruptions are not encouraged, and in general, will control the direction of the meeting. Once families grasp

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control of the session (especially the families of therapists) it is often difficult to restore control later on.

Some people have the mistaken notion that the hour is to be used "to get all of my feelings off my chest." The amount of information that is gathered may be as brief as five to ten minutes, or as lengthy as the entire length of therapy. Some believe that the gathering of information is the therapy, and others believe that information gets in the way of "the experience" in the room. Everyone will seek pieces of data that help that particular therapist gather a picture of the family. For example, I will often ask what someone died of, since I am a doctor. Sometimes this information will be useful, sometimes not. If I hear that women in two generations back have died of breast cancer, I know that the woman I am speaking to is afraid of that, no matter what she says. The kind of history one takes will depend on the expectation of the patient in regard to the therapist. If the therapist is known to work on the extended family, people will expect him to spend much time there. I have a more crisis-oriented practice, and therefore take a very brief genogram and fill it in as I go along. I try to maintain a calm atmosphere in the room and at home, with an anxiety-free emotional climate and a fairly highly structured, rapid relief of the presenting problem so that "real therapy" can begin. It makes a great impression on people if the initial advice is effective, and it increases the leverage of the therapist. Therapists start with very little leverage. I have often said that we charge people lots of money to give them difficult solutions to problems they did not know they had. To accomplish this calmness, the therapist must have the ability to speak to every individual in the room, and let them know they are heard.

The next step in the beginning of therapy is the diagnosis. Sometimes this is done because of the belief in the medical model, and that psychiatric dysfunction resides in the individual. It may be done for insurance purposes. Some family therapists believe that this is an attempt on the part of the family to place the problem within the individual. Misunderstanding the systems, poorly trained in dealing with the insides of a person, they have almost a paranoid aversion to the problems in the person. In truth, problems reside in a continuum both inside and outside the person. An individual physical problem such as a learning disorder in the brain of a person will have systematic consequences on those who live with him. Family diagnosis is far from even beginning. While it is true that it would serve an important function in the organization of research, we are far removed from that goal. My own view is that it is impossible, now or ever. Families and individuals evolve backwards, stand still and move forward. The child-centered family evolves backward and forward into a depression in one parent (usually mother), marital discord, extended family problems, etc. The diagnosis may shift from day to day. Much of individual diagnosis has the same lack of specificity.

The final step in the initial part of therapy is the therapeutic development of a plan. This involves setting up temporary goals, fees, questions about duration, times for meeting, and who will attend (membership.) The goals are temporary because as the system unfolds, so the goals change. A marital problem may evolve into a problem in one spouse. Membership in general goes from visit to visit. A good therapist will keep his options open and search for and select the grouping that can accomplish the most at that particular time, dealing with that particular portion of the family that is relevant at that time, and not get boxed in by thinking that family therapy means you must see more than one person. I will see one person if there is the hope that this setup will move things toward a change.

It is especially important to make significant and meaningful connection to the member of the family that we call the emotional hub, or therapeutic pursuer. This is the one who wants to come to the therapist and is most often the emotional pursuer in the family. However, a distancer in the family may become the pursuer in therapy when faced with a revolt by his wife. The emotional hub is the person who wants change in the family and will move the family. Unfortunately, psychiatry is still somewhat bogged down in seeing the one who has the symptoms. This is not what we mean by the individual and the family. The therapeutic plan will involve the development of strategy, hours, conditions, control, rules and limitations. This part is ordinarily done directly as issues arise and over some period of time. But limitations are critical and become more critical as the level of anxiety and tension within the family rises. At this point, it is important that the therapist control his anxiety and not plunge into the "cure" of the symptoms too fast. A common example is the therapist who tries to get the parents off the child's back by

jumping (uninvited) into the marriage. This will generally alarm the parents in their most sensitive spot, be heard as blame—and the family will never be seen again.

An important point of the initial phase of therapy is to establish control, be relevant immediately to the problem as presented, set up a plan, let the system unfold without pushing (as it will if done properly), and decrease the level of anxiety in the family. It is true that people tend to seek out help in moments of tension and anxiety when they have exhausted their own remedies. It is equally true that people do their best work in moments of calm. The initial phase of therapy will then occupy anywhere from five visits to many sessions in ordinary circumstances. The end of this phase is marked by a relief of symptoms surrounding the presenting problem. Family therapy is remarkably effective in accomplishing this goal, given any degree of cooperation by the family. The more members of the family that are willing to be cooperative, the better the prognosis. As the family systems unfold, the initial complaints gradually diminish, and in a blurred fashion, one may enter the middle of therapy. With anxiety down, many families and individuals will stop therapy here. This does not indicate that they are resistant, defensive, uncooperative or poorly motivated. It is their position and should be respected. Often they return later when ripe for further work. There is nothing necessarily continuous about therapy.

The middle part of therapy could be conceived as real therapy. The initial phase has to do with adaptation and includes both strategic and structural formulations. The middle phase attempts to introduce change. (The ability to be with those you care most about and expect nothing.) This is the least understood and least investigated part of the therapy. There are many videotapes of the initial contact with a family, and an equal number of consultation tapes. There are very few about the middle phase of therapy. There are reasons for this. While it ordinarily comprises over 90 per cent of therapy, it can be boring. The immediate problems have disappeared to a large extent, and more chronic and more basic problems emerge if the initial phase has been carried out properly. For example, if the initial phase has concentrated only on the presenting problem, it will appear that all is solved when that problem is solved, and it will make little sense to the family or individual to go on. If various themes about the individuals in the family, and various family themes and patterns are woven through the initial part of therapy, there will be a gradual unfolding into the middle phase. People will not regard systematic family therapy as limited to relationships. They will begin to see the emotional continuum between the insides of the individual and the relationships. Between the past, present and future. This should occur without pushing, salesmanship or the arousal of fear. These are natural human systems which will unfold naturally. The family may elect not to pursue them, but salesmanship is an act of disrespect toward the person.

The middle part of therapy specifically involves work on the definition and development of personal relationships. Whereas the initial phase is often concerned with detriangling triangles in the family, this phase works on people going one-on-one. As one works on twosomes or dyads, the insides of the individual inevitably emerge. Work on the insides of self proceeds simultaneously with work on each personal relationship in the family. This inevitably enlarges the genogram to at least four generations. As a husband tries to understand his son and the son his father, the father must try to understand his own father. To do that, he must go back to his own grandparents. The work between phase one and two is not static but goes back and forth from the initial presenting problem to the development and living contact of personal relationships. What a difference in the living experience of talking with an analyst about your mother, in talking about a so-called transference, and actually talking with your mother! This phase elaborates on what is already known, is endlessly repetitive and leads to a deepening of knowledge by experience, a coming together of thought, feeling, emotionality, the physical and creative. In most cases, it lasts years.

Therapists have problems with the middle phases of therapy. Analysts tend to be so patient that they become paralyzed. Family therapists so impatient that they become bored and pushy. The therapist must maintain his patience without a tendency to coast and simply "put in another hour." He must restrain his anger at one or more members of the family or to view them as unmotivated. Remember, change occurs best within the context of an accepting, interested emotional climate. This may be hard to maintain inside the person of the therapist when movement is slow and grudging. The therapist can preserve

his own equilibrium by having a deep interest in each person, in the insides of that person, in the inner system. Because family therapists have tended to focus on "relationship therapy," they have made the faulty assumption that if one changes his movement, his behavior, then his insides will change. How long does it take to stop smoking before one's insides change? It may never happen. The therapist must keep his curiosity alive and take little for granted so that he can question everything and everyone. He must learn to simply talk to people as people, and become interested in everything in their lives. Not just problems, and pathology and dynamics. Interested in pathology, we often forget to spend time on that which works, on the many things about a person that have nothing to do with problems. What does one think and feel, how come this as opposed to that? Painting a picture of self becomes an exercise in knowing and experiencing self as a more complex person. Everything is questioned and nothing taken for granted. One begins to appreciate that you never get to know self or other completely. It is impossible to get under the skin of the other. Like all endeavors, knowing self and other is never complete; the work of more time than any of us have. This keeps the other person interesting and one's own mind open. As one enters this phase of therapy, visits can often become less frequent and less consistent since the movement is less active. The frequency of the visits is suited to the amount of movement.

Members of the family never change simultaneously. As one goes up in function, the other may go down. As one introspects, the other turns to relationships. As a result, therapy in this phase often involves working with one person. It is difficult to work on one's insides in the presence of another member of the family. We encourage this when possible so that others in the family will hear and understand. However, as one person works on his own troubles in developing personal relationships, as he gets more in touch with uncomfortable parts of his insides, he may fear that other members of the family will laugh at him, use information against him, trade on his shame and embarrassment. Sessions with the individual may be safer and more productive at this point.

I recall a lady who came to see me recently. I had seen her and her husband several years ago about a problem in their son. He was introverted, somewhat sulky, doing poorly in school, and was a loner. As we do in all these situations, I identified the father as distant, the mother as overinvolved with the son, and the son attached to mother, distant and empty around Dad. Therapy involved about 12 visits in which there was some improvement in son after mother pulled back and turned over non-interfering responsibility for son to the father. She came in this time and reported that son was doing fine, had many friends, was talkative and had good performance in school. However, now there was a marital problem. Her husband was talking about leaving. History made clear that he talked about leaving but moved toward her—toward her in a critical way. When people are leaving they do not move toward the other person. The marriage was safe and she could begin to see this. I was about to suggest that she not bring her husband to future sessions for the immediate future, when she stated, "Doctor, I do not want my husband here now. I can get in touch with the insides of myself and all the pain and suffering there. I want to work on *me* now." I was very pleased with the job she had done. She was clearly at the spot where she should be working on herself. That is where the gold is at the moment. Her husband had refused to come anyway since he felt he knew himself. I believe that if a family therapist encouraged or insisted that the husband be included at this moment, therapy would be unproductive and stagnant. It could lead to endless arguing, blame of other and excuse of self—a focus on episodes as opposed to an overview, and a return to the child-centered problem as the adaptation wore off. So much of therapy results in the frustrating returns of problems as adaptations break down in the face of stress.

In the initial phase of therapy, the locus of therapy is very much in the present. In the middle phase, it enlarges from the past into the present, and the present into the past. The past, the exploration into the extended family, is used to understand, so that the present can be different. The present is used as an emotional experiment to get the experience of that understanding—knowledge combined with experience. As this happens, the problems of emotionality emerge from under concrete episodes ("he does not help in the house") and the problems of emotionality emerge from under the superficiality of feelings.

Toward the end of the middle phase of therapy, as personal relationships and what goes into them begin to calm down and work out, there is a greater awareness of self; that I am

my problem; that I must learn to accept and live with myself; that I have trouble getting along with and amusing myself; that it is not bad to be a meatball. This is an acutely painful, uncomfortable and depressing experience. All the old tendencies to run from self return. There are surges of anger, busy activities, substance abuses, feeling sorry for self. In the family system there may be a return of old problems in children or marital discord. Finally there is an anger at self (the only useful form of anger) and a profound realization and experience of how lonely the task of changing oneself will be. There is a keen focus on self and a desire to work on self. This may be done in the presence of the family or alone with the therapist if one is not able to claim these feelings as his own, or family members will not allow him to have these emotions and not try to fix them.

Throughout the middle phases of therapy, it becomes clear that each of us has one or more theories of life. We try to understand our lives according to these theories. There are intellectual theories, abstract and concrete, that explain life by knowledge such as the existence of triangles. There are feeling theories that explain life by our reactions. These feeling theories are the ordinary coin of therapy—paranoia, fears, anger, hysteria, anxiety, controlling obsessions, depression. Because feelings are reactive, all problems in this approach to life have both individual and systematic ramifications. My anger at you will affect you, and your reaction to it will affect my insides, and our relationship. During the middle phase there is a growing awareness that these feeling problems are superficial, that they are the small talk of human relationships; that much of life and my therapy has been wasted talking about, and focusing on that garbage. There are physical theories of life that explain phenomena in terms of objects such as substance abuse, learning disabilities, schizophrenia, manic-depressive disorders, anorexia, and sexual dysfunctions. These theories seek out physical solutions such as tranquilizers. These theories make sense if one thinks in terms of cause and effect (which does exist.) Family therapists have been inclined to deny cause and effect because of the manner in which families use it .to excuse self and blame others. Other theories include the imaginative, in which creativity flourishes from fantasy. This theory becomes more personal. We tend to keep our most personal fantasies away from others because they might seem foolish, embarrassing and shameful. There are crazy theories in which we are downright delusional. Love is an example. In love, people feel they can't live without the other, that the other will make self complete.

Throughout the middle part of the therapy, there is a dawning realization that something is missing; that the problems and the action lies inside self. This realization is a profound emotional experience of emptiness, loneliness, nothingness, confusion, hopelessness, and helplessness bordering on despair. There is a sadness at not belonging, and being uncared for, a sense of shame, failure and paranoia; a sense of emotional death because fantasied expectations of self and other will never be met. At the onset this profound inner experience is uniquely individual. To learn to survive it, to put words on it, to learn from it, is the real gold and work of therapy. When it is claimed as one's own, when it is universalized to others as the human condition; when one does not have to run from it—it allows for the development of genuine love, the fuel of connectedness. Though it is not quite true, one must accept self before he can accept others. Therapies that have their exclusive focus on relationships deal with the human garbage of feelings and miss the profound value of taking an enriching, painful, suffering, rewarding trip into self.

Family therapy travels this unique course from the family to the personal relationship—to the individual—and finally to the individual and the family, and the family and the individual. This has created problems. How can one create a picture of the insides of a person from a systematic, family, network perspective? We can use the analytic-dynamic model, and many do. This model is rich in detail, long in experience, lacking in movement and stuck on insight. It already has its own science and method; it moves from the individual to the definition of the system, whereas we are trying to move from the definition of the system to the definition of the individual. As opposed to insight and endless explanations, we try to get people to think about emotions, so they can move in different directions and experience their insides as they do so. To varying degrees the dynamic model concentrates (and much of his knowledge comes from) on the transference-countertransference phenomena. The family therapist uses his self reactions, his sense of people, but tries to keep the emotional and feeling action basically within the family unit. The family therapist identifies himself to the family, lets

them know him, to decrease the projections, to minimize the so-called transference. The analytic model has a language of its own and these words have meaning deeply embedded in our culture. Some of these words—such as resistance, defense, unmotivated, are offensive to family therapists because they are disrespectful to the individual and the family. I have tried to create a picture of the insides of the individual by the use of a language of time, space and movement—such words as triangles, fusion, movement toward and away from, closeness, distance, pursuer and distancer. The infinite ramifications of time, movement toward objects and people, rhythm which is spike and wave, flat or balanced; rhythm which is rapid or slow, the four dimensional self, etc. As people move in different directions, I try to get them to paint a picture of their insides as an experience that comes from within themselves and is not an intellectual explanation. There is a particular focus on emptiness, hopelessness and love.

The final phase of therapy is usually not therapy at all. Very few people pursue it as a part of therapy because it is not ordinarily presented that way. It has to do with the spiritual-moral aspects of a person. It has to do with the unseen, intangible yet essential and activating principles of a person. Therapists avoid this aspect for fear of appearing judgmental (yet we all are anyway)—because we are trained to be listeners and to be accepting; because we deal only in pathology and problems. The spiritual and moral, the field of good and bad, is seen as the arena of the minister or theologian. If good and bad and evil do exist and are part of the person, we can't ignore this or we will miss an important part of the person and the family Physical violence in the family is at least in part a bad act within the family. Therapy cannot proceed in the presence of such fear and violence. It should be labeled as bad and prohibited, not explained away.

Much of the third phase of therapy is worked on after people leave therapy, or on their own over time from their own life experience. It has to do with the development of values, of principles of living, of a philosophy of life. And it has to do with the personal struggle to live up to them. There is a keen focus on self and a realization that one does not have enough time to try to define others. There is an appreciation of the struggle to define the "I" and a respect for the "I" of the other, even if it is different. One is on the path toward a life-long process of differentiation of self from other. You never get there, but the fun is in the getting, in the process.

In the middle phase of therapy one gets the beginnings of an integrated thinking, feeling, emotional, physical, imaginative and crazy theory of life. In the third phase, one develops attitudinal change. There is a position of self, a state of mind, an orientation toward life. Life and self are seen through a different set of glasses. The new set of glasses are largely developed by self. There is less will power required and more of a natural flow. One knows less, but knows it more clearly. Few things matter, and there is a search for what does matter—the meaning and purpose of life. The answer remains unclear but the search is worth it. There is a coming to terms with the incompleteness of self and a search for a religious conviction, religion in its widest sense. There is an acceptance of self and others and glimpses of the experience of peace of mind. In this somewhat blurred and always confused set of mind, one proceeds in an inconsistent, stop, go, and relapsing process toward differentiation. The process often recycles when placed under unusual stress. In the third phase of therapy-nontherapy, the future is introduced into the time equation, learning from the past so that change can be made in the present—so that the future can be different. The process moves from the concrete-thinking-feeling aspects of the initial phase—to the emotional aspects of the second phase—to the character-building parts of the third phase.

It might be said that analytic-dynamic psychology lost the present and the family in the search for the individual. It might be said that family therapy lost the individual and the past in the search for relationships. What we need now is a view of the individual that is consistent with and in a continuum with the view of the family. The view is far from complete and probably never will be.