CHAPTER 3

Theory in the Practice of Psychotherapy

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There are striking discrepancies between theory and practice in psychotherapy. The therapist's theoretical assumptions about the nature and origin of emotional illness serve as a blueprint that guides his thinking and actions during psychotherapy. This has always been so, even though "theory" and " therapeutic method" have not always been clearly defined. Primitive medicine men who believed that emotional illness was the result of evil spirits had some kind of theoretical notions about the evil spirits that guided their therapeutic method as they attempted to free the person of the spirits. I believe that theory is important now even though it might be difficult to define the specific connections between theory and practice.

I have spent almost three decades on clinical research in psychotherapy. A major part of my effort has gone toward clarifying theory and also toward developing therapeutic approaches consistent with the theory. I did this in the belief it would add to knowledge and provide better structure for research. A secondary gain has been an improvement in the predictability and outcome of therapy as the therapeutic method has come into closer proximity with the theory. Here I shall first present ideas about the lack of clarity between theory and practice in all kinds of psychotherapy; in the second section I will deal specifically with family therapy. In discussing my own Family Systems theory, certain parts will be presented almost as previously published (1,2). Other parts will be modified slightly, and some new concepts will be added.

BACKGROUND TO THEORY IN PSYCHOTHERAPY

Twentieth-century psychotherapy probably has its origin in Freud, who developed a completely new theory about the nature and origin of emotional illness. Before him, mental illness was generally considered the result of some unidentified brain pathology, based on the structured model used by medicine to conceptualize all disease. Freud introduced the new dimension of functional illness which dealt with the function of the mind, rather than brain pathology. His theory was derived largely from patients as they remembered details of early life experiences and as they communicated this detail in the context of an intense emotional relationship with the analyst. In the course of the analysis it was discovered that the patients improved, and that the patient's relationship with the analyst went through definite, predictable stages toward a better life adjustment. Freud and the early analysts made two monumental contributions. One was a new theory about the origin and nature of emotional illness. The other was the first clearly defined theory about the transference relationship and the therapeutic value of a talking relationship. Although counseling and "talking about problems" may have existed before, it was psychoanalysis that gave conceptual structure to the "therapeutic relationship," and that gave birth to the profession of psychotherapy.

Few events in history have influenced man's thinking more than psychoanalysis. This new knowledge about human behavior was gradually incorporated into psychiatry, psychology, sociology, anthropology, and the other professional disciplines that deal with human behavior, and into poetry, novels, plays, and other artistic works. Psychoanalytic concepts came to be regarded as basic truths. Along with the acceptance there were some long term complications in the integration of psychoanalysis with other knowledge. Freud had been trained as a neurologist. He was clear that he was operating with theoretical assumptions, and that his concepts had no logical connection with medicine or the accepted sciences. His concept of "psycho" pathology, patterned after medicine, left us with a conceptual dilemma not yet resolved. He searched for a conceptual connection with medicine, but never found it. Meanwhile, he used inconsistent models to conceptualize his other findings. His broad knowledge of literature and the arts served as other models. A striking example was the oedipal conflict, which came from literature. His models accurately portrayed his clinical observations and represented a microcosm of human nature; nonetheless, his theoretical concepts came from discrepant sources. This made it difficult for his successors to think in concepts synonymous with medicine or the accepted sciences. In essence, he conceptualized a revolutionary new body of knowledge about human functioning that came to exist in its own compartment, without logical connection with medicine or any of the accepted sciences.

The knowledge was popularized by the social sciences and the artistic world, but few of the concepts found their way into the more basic sciences. This further separated psychoanalysis from the sciences.

There have been some clear evolutionary developments in psychoanalytic theory and practice during the twentieth century. Successors to Freud have been more disciples than scientists. They lost contact with the fact that his theory is based on theoretical assumption, and they have tended to regard it as established fact. The more it is considered to be fact, the less it has been possible to question the theoretical base on which it rests. Very early the disciples began to disagree with certain details of the theory (predictable in human relationship systems), and to develop different "theories," concepts, and "schools of thought" based on the differences. They have made such an issue over "differences" that they have lost sight of the fact that they all follow Freud's broad assumptions. The different branches of the tree spend their lives debating the proclaimed "differences," unaware that all spring from the same basic roots. As time passes and the number of branches increase, so do the differences.

The number of differences about the therapeutic relationship are even greater. Freud defined a basic theory about the therapeutic relationship. Beyond that, each practitioner is on his own in developing methods and techniques for applying the theory. There is more flexibility for developing " differences" about therapeutic method and techniques than about theory. Psychoanalysts maintain a strict interpretation of the "transference," which is considered to be different from the popular notion of the therapeutic relationship. There are differences, but the focus on differences obscures the common denominators. Group therapy is a good illustration of the trend. It sprang primarily from theory about the therapeutic relationship, and secondarily from basic psychoanalytic theory about the nature of emotional illness. The growing multitudes of mental health professionals who use all the different theories and therapies still follow two of the basic concepts of psychoanalysis. One is that emotional illness is developed in relationship with others. The second is that the therapeutic relationship is the universal " treatment" for emotional illness.

There are other evolutionary trends that illustrate the separation of theory and practice. It has to do with psychological research. The basic sciences have long been critical of psychoanalysis and psychological theory as nonscientific and based on shifting hypotheses that defy critical scientific study. There is validity to this criticism. The psychoanalysts and psychologists have countered that the field is different, and the same rules do not apply. They have coined the term social "sciences," and much research has gone into proving that they are scientific. There is some support for the proposition that social sciences are scientific. The major change has been in the development of the scientific method designed to study random and

discrepant data *in a scientific* way. *If the* scientific method is pursued long enough, it should eventually produce the data and facts that are acceptable to the basic sciences. This has not occurred. The debate has gone through the century with the psychologists accepting psychoanalytic assumptions as fact and believing that the scientific method makes the field into a science, while workers in the basic sciences are still unconvinced. This is where research in the mental health field is today. The directors of research and experts who control the funds for research are schooled in the scientific method, which tends to perpetuate fixed postures. My own position on this is that, "There is no way to chi square a feeling and make it qualify as a scientific fact." This is based on the belief that human behavior is a part of all nature, so that it is as knowable and predictable and reproducible as other phenomena in nature; but I believe that research should be directed at making theoretical contact with other fields, rather than applying the scientific method to subjective human data. This has been a long-term conflict I have had with research in mental illness. To summarize, I believe that research in emotional illness has helped to contribute to the separation of theory and practice, and to the notion that psychological theory is based on proven fact.

There are trends in the training of mental health professionals that support the separation of theory and practice. Early in the twentieth century the popularity of psychoanalysis was increasing, but overall, psychiatry, and also the public, was still negative about it. By the 1940s and 1950s, psychoanalytic theory had become *the* predominant theory. By that time the psychoanalysts had developed so many superficial "differences" among themselves that the new trainees of the 1940s and 1950s were confronted with a spectrum of different "theories" all based on basic psychoanalytic concepts. They learned psychoanalytic theory as proven fact and the therapeutic relationship as *the* treatment for emotional illness. The trainees from that period are now the senior teachers in the field. The number of superficial "differences" have increased. Starting in the 1950s and increasing into the 1960s, we have heard much antipsychoanalytic talk by people who use basic psychoanalytic concepts in theory and practice. In the present era we have the "eclectic," who tells us that there is no single theory adequate for all situations and he chooses the best parts of all the theories to best fit the clinical situation of the moment.

I believe that all the differences belong within the basic framework of psychoanalysis, and that the eclectic shifting may be more for the needs of therapist than the patient. The average training programs for mental health professionals contain a few didactic lectures on theory appended to the basic training An overwhelming amount of time goes to tutorial training, which emphasizes the therapeutic relationship, learning about one's own emotional problems, and the management of self in relation to the patient. This

produces professionals who are oriented around the therapeutic relationship, who assume they know the nature and origin of emotional illness, who are unable to question the theoretical base on which the field rests, and who assume the therapeutic relationship is the basic treatment for emotional problems. Society, insurance companies, and the licensing bodies have come to accept this theoretical and therapeutic position, and have become more lenient about providing payment for psychotherapeutic services. Counselors, teachers, police, courts, and all the social agencies that deal with human problems have also come to accept the basic assumptions about theory and therapy.

Mental health professionals relate to theory in a spectrum. At one extreme are the few who are serious students of theory. A larger group can state theoretical positions in detail, but they have developed therapeutic approaches discrepant with the theory. A still larger group treats theory as proven fact. These last are similar to the medicine men who *knew* that illness was caused by evil spirits. Professional expertise becomes a matter of finding more ingenious techniques for externalizing the bad spirits. At the other extreme are the therapists who contend there is no such thing as theory, that theoretical efforts are post hoc explanations for the therapist's intuitive actions in the therapeutic relationship, and that the best therapy is possible when the therapist learns to be a "real self ' in relation to the patient.

In presenting these ideas about the separation of theory and therapy in the mental health professions, I have inevitably overstated to clarify the issues. I believe that psychoanalytic theory, which includes the theory of the transference and talking therapy, is still the one major theory to explain the nature and origin of emotional illness, and that the numerous different theories are based more on minor differences than on differences with basic concepts. I believe Freud's use of discrepant theoretical models helped make psychoanalysis into a compartmentalized body of knowledge that prevented successors from finding conceptual bridges with the more accepted sciences. Psychoanalysis attracted followers who were more disciples than scholars and scientists. It has evolved into more of a dogma or religion than a science, with its own "scientific" method to help perpetuate the cycle. I believe it has enough new knowledge to be part of the sciences, but the professionals who practice psychoanalysis have evolved into an emotional ingroup, like a family or a religion. Members of an emotional ingroup devote energy to defining their "differences" with each other and defending dogma that needs no defense. They are so caught up with the ingroup process that they cannot generate new knowledge from within, nor permit the admission of knowledge from without that might threaten the dogma. The result has been a splintering and resplintering, with a new generation of eclectics who attempt to survive the splintering with their eclecticism.

THE THERAPEUTIC RELATIONSHIP IN BROADER PERSPECTIVE

Family research has identified some characteristics of emotional systems that put the therapeutic relationship into broader perspective. An emotional system is usually the family, but it can be a larger work group or a social group. The major characteristic to be examined here is that *the successful introduction of a significant other person into an anxious or disturbed relationship system has the capacity to modify relationships within the system*. There is another characteristic of opposite emotional forces, which is that the higher the level of tension or anxiety within an emotional system, the more the members of the system tend to withdraw from outside relationships and to compartmentalize themselves with each other. There are a number of variables that revolve around the characteristic in focus. The first variables have to do with the *significant other.* Other variables have to do with what is meant by *successful* introduction. Other variables have to do with the *introduction* of the significant other and how long he remains a member of the system. Still other variables have to do with what it means to *modify* a system. I have chosen the term *modify* in order to avoid the use of *change,* which has come to have so many different meanings in psychotherapy.

An individually oriented psychotherapist is a common *significant other.* If he can manage a viable and moderately intense therapeutic relationship with the patient, and the patient remains in viable contact with the family, it can calm and modify relationships within the family. It is as though the therapeutic relationship drains the tension from the family and the family can appear to be different. When the therapist and patient become more intensely involved with each other, the patient withdraws from emotional contact with the family and the family becomes more disturbed. Therapists have intuitive ways of dealing with this situation. Some choose to intensify the relationship into a therapeutic alliance, and to encourage the patient to challenge the family. Others are content with a supportive relationship. There are a number of other outside relationships that can accomplish the same thing. A significant new relationship with a friend, minister, or teacher can be effective if the right conditions are met. The right degree of an outside sexual relationship can calm a family as much as individual psychotherapy. When the affair is kept at the right emotional level, the family system can be calm and blind to evidences of the affair. The moment the outside affair becomes emotionally overinvested, it tends to alienate the involved person from the family and increase tension within the family. At this point the other spouse becomes a suspicious detective, alert to all the evidence previously ignored. This phenomenon, which has to do with the balance of relationships in a family, applies to a broad spectrum of relationships.

A set of variables revolve around the qualities that go into a significant

other relationship. One variable deals with the importance of the family member to the rest of the family. The family would respond quickly to the outside emotional involvement of an important family member who is relating actively to the others. It would respond slowly to a withdrawn and inactive family member unless the outside relationship was fairly intense. The most important variable has to do with the assumed, assigned, or actual importance of the significant other person. At one extreme is the significant other who assumes or is assigned magical or supernatural importance. This includes voodoo experts, leaders of cults, great healers, and charismatic leaders of spiritual movements. The significant other can pretend to represent the diety and to have supernatural power. He pleads for the other to " believe in me, trust me, have confidence in me." The assuming of great importance and the assigning of importance is usually a bilateral operation, but there probably could be situations in which the importance is largely assigned, and significant other goes along with it. These relationships operate on high emotionality and minimal reality. When successful, the change can come rapidly or with instantaneous conversion.

At the other extreme are the situations in which the evaluation of the significant other is based largely on reality, with little pretense, and with little of the intense relationship phenomenon. The principal ingredient is knowledge or skill. Examples of this might be a genetic counselor, an estate planner, or a successful professor who has the ability to inspire students in his subject, more through knowledge than relationship. In between these two extremes are relationships with healers, ministers, counselors, physicians, therapists of all kinds, and people in the helping professions who either assume or are assigned an importance they do not have. The assuming and assigning of importance is clearest in its extreme forms in which the pretending of importance is sufficiently grotesque for anyone to notice. Actually, the assigning and assuming of importance, or unimportance, is present to some degree in all relationships, and present enough to be detectable in most relationships on careful observation. A clear example is a love relationship in which each has an overvalued image of the other. It is also easy to recognize the change in a person who is in love. Overall, the degree of assigning and assuming overimportance in the therapeutic relationship is on the high side. Psychoanalysis has subtle techniques to encourage the development of a transference, which is then dealt with in the therapy. Other methods do even more of this, and efforts to correct the distortion are even less.

Another set of variables revolve around the way the significant other is introduced into the system. At one extreme, the significant other pleads, exhorts, advertises, evangelizes, and makes promises of the great things if he is invited in. At the other extreme, the significant other enters the system only on unsolicited invitation and with a contract either verbal or written

that comes closer to defining the reality of the situation. The rest fall somewhere between these two extremes. Other variables have to do with the length of time the significant other is involved in the system. The successful involvement depends on whether or not the relationship works. This involves the family member devoting a reasonable amount of thinking-feeling energy to the relationship without becoming too emotionally preoccupied.

An important set of variables revolves around what it means to modify relationships within the family. I avoid using *change* here because of the loose way this word is used within the profession. Some speak of an emotional conversion, a shift in mood, a shift in attitude, or a shift from feeling sad to happy as being "change" or emotional "growth." The word *growth* has been so misused during the past decade, that it has become meaningless. In contrast, other people do not consider change to have taken place without basic, documentable, structural alteration in the underlying situation that gave rise to the symptoms. Between these two lie all the other manifestations of change. It is common for mental health professionals to consider the disappearance of symptoms as evidence of change.

The more the relationship with the significant other person is endowed with high emotionality, messianic qualities, exaggerated promises, and evangelism, the more the change can be sudden and magical, and the less likely it is to be long term. The lower the emotionality and the more the relationship deals in reality, the more likely the change is to come slowly and to be solid and long lasting. There is some degree of emotionality in any relationship, especially in the helping professions where the principal ingredient is services rather than materials, but it is also present around those who deal in materials, such as supersalesmen. The emotionality can exist around the charismatic person who attracts the assignment of importance from others. Emotionality may be hard to evaluate with public figures who attain their positions from superior skill and knowledge, in which emotionality is low, and who then operate on reputation, in which assigned importance is high. The doctor-patient relationship encompasses a wide range of emotionality. At one extreme it can be almost all service and little relationship, and at the other extreme the emotional component is high. The physician who operates with a posture which says, "Have no fear, the doctor is here," is assuming great importance, and also using it to calm anxiety. The physician who says, "If doctors could only be half as important as their patients think they are," is operating with awareness and less assumption of importance. Emotionality is sufficiently high in medicine that the placebo effect is routinely built into responsible research to check the emotional factor.

Psychotherapy is a service that deals in a higher level of emotionality than the average doctor-patient relationship. The level of assumed and assigned importance is on the high side. The well-trained therapist has

techniques to encourage the patient to assign him an overimportance which he interprets to the patient as part of the therapy. He is aware of transference "cures," and of the unhealthy aspects of countertransference when he becomes emotionally overinvolved with the patient. He may have operating rules to govern the right kind of therapeutic relationship: trying to match the patient with the therapist's personality, avoiding working with a patient he does not "like," or recommending a male or female therapist for particular kinds of problems. The psychotherapist does not get into emotionality that is in the spiritual range, but he deals constantly in a high level of emotionality. The well-trained therapist does well with these emotional forces, but the rapidly enlarging field of psychotherapy includes many who do not have this expertise. The training of therapists may involve the selection of trainees who have the right personality for a good "therapeutic relationship." The level of emotionality in the field makes it difficult to evaluate the results of psychotherapy.

I go into this much detail about the therapeutic relationship because concepts about the therapeutic relationship and the notion that psychotherapy is *the* treatment for emotional illness are basic teachings in the training of mental health professionals. The orientation is probably greater for nonmedical people who do not have to learn the medical part of psychiatry. Mental health professionals are so indoctrinated in these basic concepts they have difficulty hearing another way of thinking. That is why my own theory is incomprehensible to those who cannot think through their early basic teaching and practice. Early in my professional career I was a serious student of the therapeutic relationship. In the psychotherapy of schizophrenia much effort went into eliminating the assumed and assigned importance from the therapeutic relationship. The more I was successful at this, the more I could get good results after others had failed. It was usual for others to consider these good results as related to some undefined personality characteristic in me, or to coincidence. A good result could be followed by a comment such as, "Some schizophrenics come out of their regression automatically." Successfully managing the transference in schizophrenia made it easy to automatically manage the milder transference in the neuroses. The change to family research provided a new dimension for dealing with the therapeutic relationship. It became theoretically possible to leave the intensity of the relationship between the original family members, and bypass some of the time-consuming detail. I began to work toward avoiding the transference. When I started to talk about "staying out of the transference," the usual response was, "You don't mean you stay out of the transference; you mean you handle it well." That is, my statement was countered by another even more dogmatic, and pursuit of the issue only resulted in polarized emotional debate.

The prevailing opinion of therapists who operate with the therapeutic

relationship is that I handle the transference well. However, a therapist with knowledge of the facts inherent in systems theory, and especially a knowledge of triangles (discussed below) can deal largely in reality and facts and eliminate much of the emotional process that usually goes into a transference. Indeed, it is possible to routinely reproduce an operational version of the same expertise in a good percentage of professional trainees. This is in contrast to usual training methods in which the result of training depends more on the intuitive and intangible qualities in the trainee than on knowledge. One never reaches the point of not being vulnerable to automatically falling back into the emotionality of transference. I still use mechanisms to reduce the assumed and assigned overimportance that can get into any relationship. When one acquires a reputation in any field, one also acquires an aura of assigned overimportance that goes beyond reality. Among the ways I have dealt with this is by charging average fees, which helps avoid the emotional pitfalls inherent in charging high fees. The therapeutic effort is so different from conventional therapy that I have developed other terms to refer to the therapy process; for instance I speak of "supervising" the effort the family makes on its own behalf, and "coaching" a family member in working with his own family. It is accurate to say there is some emotionality in any relationship, but it is also accurate to say that the emotionality can be reduced to a low level through knowledge about emotional systems.

THE THERAPEUTIC RELATIONSHIP IN FAMILY THERAPY

The separation between theory and therapy in most family therapy is far greater than with individual therapy. The vast majority of family therapists started from a previous orientation in individual or group therapy. Their family therapy descends almost directly from group therapy, which came out of psychoanalytic theory with an emphasis on the theory of the transference. Group therapy led to far more differences in method and technique than individual therapy, and family therapy lends itself to more differences than group therapy. I have referred to this as the "unstructured state of chaos" in family therapy.

Family therapists deal with the therapeutic relationship in a variety of ways. Some great family therapists, who were adept at dealing with transference in individual or group therapy, continue their adeptness in family therapy. They use psychoanalytic theory for thinking about problems in the individual, and transference theory for thinking about relationships. There are those who speak of "getting into and getting out of ' intense relationships with individual family members. They are confident in their skill and ability to operate freely within the family. They operate more on intuition

than any special body of knowledge. Their therapy is difficult for trainees to imitate and reproduce. Most therapists use some version of group therapy in their effort to keep relationships "spread out" and manageable. Another group uses cotherapists, usually of the opposite sex; their rationale is derived from psychoanalytic theory that this provides a male-female model for the family. The cotherapist functions to keep some degree of objectivity when the other therapist becomes emotionally entangled in the family.

Others use a team approach in which an entire mental health team meets with a family or group of families in a problem-focused group therapy method. The team, or "therapeutic group," is composed of members of the various mental health professions. The team-group meetings are commonly used for "training" inexperienced professional people who learn by participation in the team meetings, and who can rather quickly gain the status of " family therapist." Trainees begin by observing, following which they are encouraged to become part of the group by expressing their "feelings" in the therapy meetings. These are people who have never had much training in theory, or in the emotional discipline of learning the intricacies of transference and countertransference. Theory is usually not explicit, but the implicit format conveys that emotional illness is the product of suppressed feeling and poor communication, that treatment is the free expression of feelings and open communication, and that a competent therapist is one who can facilitate the process. Family therapy has also attracted therapists who were never successful at individual therapy, but who find a place in one of the numerous kinds of group therapy methods being used in family therapy. These admitted overstatements convey some idea of the many kinds of family therapy methods and techniques that are in use.

Group therapy has long acted as though it did not have a theory. I believe the reasons for this are that family therapy for the most part is a decendant of group therapy, that family therapy has started variations in method and technique that were not possible in group therapy, and that the separation between theory and practice is greater in family therapy than any of the other therapies. All these circumstances may account for the fact that few family therapists have much awareness of theory.

My approach differs from the mainstream of family therapy. I have learned more about the intricacies of the therapeutic relationship from family research than from psychoanalysis or the psychotherapy of schizophrenia. Most of this was learned from the study of triangles. The automatic emotional responsiveness that operates constantly in all relationships is the same as the therapeutic relationship. As soon as a vulnerable outside person comes into viable emotional contact with the family, he becomes part of it, no matter how much he protests the opposite. The emotional system operates through all five senses, and most often through visual and auditory stimuli. In addition, there is a sixth sense that can include extrasensory

perception. All living things learn to process this data very early and to use it in relation to others. In addition, the human has a sophisticated verbal *language which* is as *often used to deny* the automatic emotional process as to confirm it. I believe the automatic emotional process is far more important in establishing and maintaining relationships than verbal language. The concept of triangles provides a way of reading the automatic emotional responsiveness so as to control one's own automatic emotional participation in the emotional process. This control I have called detriangling. No one ever stays outside, but a knowledge of triangles makes it possible to get outside on one's own initiative while staying emotionally in contact with the family. Most important, family members can learn to observe themselves and their families, and to control themselves while on stage with the family without having to withdraw. A family member who is motivated to learn and control his own responsiveness can influence relationships in the entire family system.

The effort of being outside the family emotional system, or remaining workably objective in an intense emotional field, has many applications. Family relationships are remarkably different when an outsider is introduced into the system. A disturbed family is always looking for a vulnerable outsider. It would be healtheir if they worked it out among themselves, but the emotional process reaches out for others. For a quarter of a century there has been a debate in family research about ways to do objective observations of the family, free from outside influences. Well-known research investigators such as Erving Goffman and Jules Henry have insisted that objective observations be made in the family's native habitat, the home, by a neutral observer. Based on my experience with emotional systems, I am sure any such observers were fused with the family as soon as they entered the home, that the family automatically became different, and that their belief they were being objective was erroneous. Complete objectivity is impossible; but I believe the best version of objectivity is possible with significant others who know triangles. There was a recently publicized movie-television study of a family done by a movie crew who went into the home to film the family as it really was. From my viewpoint, the movie crew automatically became a significant other which helped propel the parents toward divorce. This situation might have found another triangle that would have served the same triangle force.

THEORY IN THE DEVELOPMENT OF FAMILY THERAPY

The family movement in psychiatry was started in the mid-1950s by several different psychiatrists who worked independently for several years

before they began to hear about each other. I have described my version of that in other papers (1, 2, 6). Among those who started with family research on schizophrenia was Lidz and his group at Johns Hopkins and Yale (7), Jackson and his group in Palo Alto (3), and Bowen and his group in Bethesda (4, 8). The psychoanalytic principle of protecting the privacy of the patient-therapist relationship may account for the family movement's remaining underground for some years. There were strict rules against the therapist's contaminating the transference by seeing other members of the same family: the early family work was done privately, probably to avoid critical colleagues who might consider this irresponsible until it was legitimized in the name of research. I began formal research in 1954 after several years of preliminary work. During 1955 and 1956 we each began to hear about the others and to meet. Ackerman had been thinking and working toward family concepts in social service agencies and clinics (9). Bell, who remained separate from the group for some years, had a different beginning. His first paper was written some seven or eight years after he started (10). There were others mentioned in the earlier summaries.

For me, 1955 to 1956 was a period of elation and enthusiasm. Observing entire families living together on a research ward provided a completely new order of clinical data never before recorded in the literature. Only those who were there could appreciate the impact of the new observations on psychiatry. Other family researchers were observing the same things, but were using different conceptual models to describe their findings. Why had these findings, now so commonplace, been obscured in previous observations? I believe two factors to account for this observational blindness. One was a shift in the observing lens from the individual to the family. The other is man's failure to see what is in front of him unless it fits his theoretical frame of reference. Before Darwin, man considered the earth to have been created as it appeared before his eyes. He had stumbled over the bones of prehistoric animals for centuries without seeing them, until Darwin's theory permitted him to begin seeing what had been there all the time.

For years I had pondered the discrepancies in psychoanalytic theory without finding new clues. Now I had a wealth of new clues that could lead to a completely different theory about emotional illness. Jackson was the other of the early workers who shared the theoretical potential. Lidz was more established in his psychoanalytic practice than Jackson and I, and he was more interested in an accurate description of his findings than in theory. Ackerman was also established in psychoanalytic practice and training, and his interest lay in developing therapy and not theory. I had built a method of individual therapy into my research design for studying the families. Within six months there was evidence that some method of therapy for family members together was indicated. I had never heard of family therapy. Against the strong theoretical and clinical admonitions of the time,

I followed the dictates of the research evidence and after much careful planning started my first method of family psychotherapy. Later, I heard that others had also thought of family therapy. Jackson had been approaching on one level and Ackerman was approaching on another. In 1956 I heard that Bell had been doing something called family therapy, but I did not meet him until 1958.

J'he first family sectional a, mationa1 meeting was organized by Spiegel-at the American Q.rthczpsyychiatricmeeting_in,Chicagain March, Ig57. He was Chairman of the Committee on the Family of the Group for the Advancement of Psychiatry and he had just heard about the family work in progress. That was a small and quiet meeting. There were papers on research by Spiegel, Mendell, Lidz, and Bowen. In my paper I referred to the "family psychOtherapy" used in my research since late 1955. I believe that may have been the first time the term was used in a national meeting. However it happened, I would date the family therapy explosion to March, 1957. In May, 1957, there was a family section at the American Psychiatric meeting, also in Chicago. In the two months since the previous meeting, there had been an increasing fervor about family therapy. Ackerman was secretary of the meeting, and Jackson was also present. Family ideas generated there led to Jackson's book, *The Etiology of Schizophrenia,* finally published in 1960 (4). At the national meetings in 1958, the family sessions were dominated by dozens of new therapists eager to report their family therapy of the past year. That was the beginning of the family therapy that was quite different from the family research of previous years. The new people, attracted by the idea of family therapy, had been developing empirical methods and techniques based on the psychoanalytic theory of individual and group psychotherapy. The family research and the theoretical thinking that gave birth to family therapy were lost in the rush.

The rush into family therapy in 1957 and 1958 produced a wild kind of therapy which I called a "healthy, unstructured state of chaos." There were almost as many different methods and techniques as there were new therapists. I considered the trend healthy in the belief the new therapists would discover the discrepancies in conventional theory, and that the conceptual dilemma posed by family therapy would lead to new concepts and ultimately to a new theory. This did not occur. I did not realize the degree of therapeutic zeal that makes psychiatrists oblivious to theory Family therapy became a therapeutic method engrafted onto the basic concepts of psychoanalysis, and especially the theory of the transference. New therapists tended toward therapeutic evangelism, and they trained generations of new therapists who also tended toward simplistic views of the human dilemma and family therapy as a panacea for treatment. Family therapy not only inherited the vagueness and lack of theoretical clarity from conventional psychiatry, but it added new dimensions of its own. The number of

minor differences and schools of thought are greater in family therapy than in individual therapy, and it now has its own group of eclectics who solve the problem through eclecticism.

Jackson and I were the only two from the original family researchers with a significant interest in theory. Jackson's group included Bateson, Haley, and Weakland. They began with a simple communication model of human relationships, but soon expanded the concept to include the total of human interaction in the concept. By the time Jackson died in 1968, he had moved toward a rather sophisticated systems model. I believe my theory had a sounder base to connect it with an instinctual motor; Jackson was operating more on phenomenology, but he was moving toward a distinctly different theory. One can only guess where he would have emerged had he lived.

In the past decade, there has been the slow emergence of a few new theoretical trends. It is not possible to stay on a broad conceptual level and do justice to the work of individuals, and at this point it is not possible to do more than survey the field in broad concepts. The notion of systems theory started gaining popularity in the mid-1960s, but the the use of systems in psychiatry is still in a primitive state. On one level, it is no more than the use of one word to replace another. On another level, it has the same meaning as a transportation system or circulatory system. On a more sophisticated level, it refers to a relationship system, which is a system in human behavior. On a broad level, people believe that "system" is derived from general systems theory, which is a system of thinking about existing knowledge. In my opinion, the attempt to apply general systems theory to psychiatry, as psychiatry is presently conceptualized, is equivalent to the effort to apply the scientific method to psychoanalysis. It has a potential, longterm gain if things work out right. However, the slow emergence of something that goes in a systems direction is one of the new evolutions in the family field. There have been some fascinating innovations in concepts that still retain much basic psychoanalytic theory. Among these is Paul's concept (11) concerning unresolved grief reactions which has a therapeutic method that fits the theoretical concept, and effectively taps the basic emotional process. Boszormenyi-Nagy is one of the theoretical scholars in the field (12). He has a rather complete set of theoretical abstractions that may one day provide a theoretical bridge between psychoanalysis and a different family theory. One of the more unique new orientations is Minuchin's (13). He carefully avoids the complex concepts of theory, but he uses the term *Structural Family Therapy* for a therapeutic method designed to change the family through modification of the feedback system in relationships. His focus is more on therapy than on theory.

FAMILY SYSTEMS THEORY

The evolution of my own theoretical thinking began in the decade before I started family research. There were many questions concerning generally accepted explanations about emotional illness. Efforts to find logical answers resulted in more unanswerable questions. One simple example is the notion that mental illness is the result of maternal deprivation. The idea seemed to fit the clinical case of the moment, but not the large number of normal people who, as far as could be determined, had been exposed to more maternal deprivation than those who were sick. There was also the issue of the schizophrenogenic mother. There were detailed descriptions of schizophrenogenic parents, but little to explain how the same parents could have other children who were not only normal, but who appeared supernormal. There were lesser discrepancies in popular hypotheses that linked emotional symptoms to a single traumatic event in the past. This again appeared logical in specific cases, but did not explain the large number of people who had suffered trauma without developing symptoms. There was a tendency to create special hypotheses for individual cases. The whole body of diagnostic nomenclature was based on symptom description, except for the small percentage of cases in which symptoms could be connected to actual pathology. Psychiatry acted as if it knew the answers, but it had not been able to develop diagnoses consistent with etiology. Psychoanalytic theory tended to define emotional illness as the product of a process between parents and child in a single generation, and there was little to explain how severe problems could be created so rapidly. The basic sciences were critical of psychiatric explanations that eluded scientific study. If the body of knowledge was reasonably factual, why could we not be more scientific about it? There were assumptions that emotional illness was the product of forces of socialization, even though the same basic emotional illness was present in all cultures. Most of the assumptions considered emotional illness as specific to humans, when there was evidence that a similar process was also present in lower forms of life. These and many other questions led me to extensive reading in evolution, biology, and the natural sciences as part of a search for clues that could lead to a broader theoretical frame of reference. My hunch was that emotional illness comes from that part of man that he shares with the lower forms of life.

My initial family research was based on an extension of theoretical formulations about the mother-child symbiosis. The hypothesis considered emotional illness in the child to be a product of a less severe problem in the mother. The hypothesis described the balancing forces that kept the relationship in equilibrium. It was a good example of what is now called a system. Very quickly it became apparent that the mother-child relationship was a dependent fragment of the larger family unit. The research design was

modified for fathers and normal siblings to live on the ward with mothers and the schizophrenic patients. This resulted in a completely new order of observations. Other researchers were observing the same things, but they were using a variety of different models to conceptualize findings, including models from psychoanalysis, psychology, mythology, physics, chemistry, and mathematics. There were some common denominators that clustered around the stuck togetherness, bonds, binds, and interlocking of family members with each other. There were other concepts for the balancing forces, such as complementarity, reciprocity, magnetic fields, and hydraulic and electrical forces. Accurate as each concept might be descriptively, the investigators were using discrepant models.

Early in the research, I made some decisions based on previous thinking about theory. Family research was producing a completely new order of observations. There was a wealth of new theoretical clues. On the premise that psychiatry might eventually become a recognized science, perhaps a generation or two in the future, and being aware of the past conceptual problems of psychoanalysis, I chose to use only concepts that would be consistent with a recognized science. This was done in the hope that investigators of the future would more easily be able to see connections between human behavior and the accepted sciences than we can. I therefore chose to use concepts that would be consistent with biology and the natural sciences. It was easy to think in terms of the familiar concepts of chemistry, physics, and mathematics, but I carefully excluded all concepts that dealt with inanimate things, and studied the literature for concepts synonymous with biology—that is, I used biological concepts to describe human behavior. The concept of symbiosis, originally from psychiatry, would have been discarded except for its use in biology where the word has a specific meaning. The concept of differentiation was chosen because it has specific meanings in the biological sciences. When we speak of the "differentiation of self," we mean a process similar to the differentiation of cells from each other. The same applies to the term *fusion. Instinctual* is used exactly as it is used in biology, rather than in the restricted, special meaning of its use in psychoanalysis. There are a few minor exceptions to this overall plan, which will be mentioned later. In the period when I was reading biology, a close psychoanalyst friend advised me to give up "holistic" thinking before I got "too far out."

Another longterm plan was directed at the research staff, and was based on the notion that the clues for important discoveries are right in front of our eyes, if we can only develop the ability to see what we have never seen before. Research observers can see only what they have been trained to see through their theoretical orientations. The research staff had been trained in psychoanalysis, and they tended to see confirmation or extensions of psychoanalysis. On the premise there was far more to be seen if they could

get beyond their theoretical blindness, I devised a plan to help us all open our eyes to new observations. One longterm exercise required investigators to avoid the use of conventional psychiatric terminology and to replace it with simple descriptive words. It was quite an exercise to use simple language instead of terms such as "schizophrenic-obsessive-compulsive-depressed-hysterical-patient." The overall goal was to help observers clear their heads of pre-existing ideas and see in a new way. Although much of this could be classified as an exercise or a game in semantics, it did contribute to a broader viewpoint. The research team developed a new language. Then came the complications of communication with colleagues, and the necessity of translating our new language back into terminology others could understand. It was awkward to use ten words to describe "a patient," when everyone else knew the correct meaning of "patient." We were criticized for coining new terms when old ones would be better, but during the exercise we had discovered the degree to which well-trained professional people use the same terms differently, while assuming that everyone understands them the same way.

The core of my theory has to do with the degree to which people are able to distinguish between the *feeling* process and the *intellectual* process. Early in the research, we found that the parents of schizophrenic people, who appear on the surface to function well, have difficulty distinguishing between the subjective feeling process and the more objective thinking process. This is most marked in a close personal relationship. This led to investigation of the same phenomenon in all levels of families from the most impaired, to normal, to the highest functioning people we could find. We found that there are differences between the ways feelings and intellect are either fused or differentiated from each other, and this led us to develop the concept of differentiation of self. People with the greatest fusion between feeling and thinking function the poorest. They inherit a high percentage of life's problems. Those with the most ability to distinguish between feeling and thinking, or who have the most differentiation of self, have the most flexibility and adaptability in coping with life stresses, and the most freedom from problems of all kinds. Other people fall between the two extremes, both in the interplay between feeling and thinking and in their life adjustments.

Feeling and *emotion* are used almost synonymously in popular usage and also in the literature. Also, little distinction is made between the subjectivity of truth and the objectivity of fact. The lower the level of differentiation, the more a person is not able to distinguish between the two. The literature does not clearly distinguish between *philosophy, belief opinion, conviction,* and *impression.* Lacking guidelines from the literature, we used dictionary definitions to clarify these for our theoretical purposes.

The theoretical assumption considers emotional illness to be a disorder

of the *emotional system*, an intimate part of man's phylogenetic past which he shares with all lower forms of life, and which is governed by the same laws that govern all living things. The literature refers to emotions as much more than states of contentment, agitation, fear, weeping, and laughing, although it also refers to these states in the lower forms of life—contentment after feeding, sleep, and mating, and states of agitation in fight, flight, and the search for food. For the purposes of this theory, the emotional system is considered to include all the above functions, plus all the automatic functions that govern the autonomic nervous system, and to be synonymous with instinct that governs the life process in all living things. The term *emotional illness* is used to replace former terms, such as mental illness and psychological illness. Emotional illness is considered a deep process involving the basic life process of the organism.

The *intellectual system* is a function of the cerebral cortex which appeared last in man's evolutionary development, and is the main difference between man and the lower forms of life. The cerebral cortex involves the ability to think, reason, and reflect, and enables man to govern his life, in certain areas, according to logic, intellect, and reason. The more experience I have had, the more I am convinced that far more of life is governed by automatic emotional forces than man is willing to acknowledge. The *feeling system* is postulated as a link between the emotional and intellectual systems through which certain emotional states are represented in conscious awareness. Man's brain is part of his protoplasmic totality. Through the function of his brain, he has learned many of the secrets of the universe; he has also learned to create technology to modify his environment, and to gain control over most of the lower forms of life. Man has done less well in using his brain to study his own emotional functioning.

Much of the early family research was done with schizophrenia. Since the clinical observations from those studies had not been previously described in the literature, it was first thought that the relationship patterns were typical of schizophrenia. Then it was discovered that the very same patterns were also present in families with neurotic level problems, and even in normal families. Gradually, it became clear that the relationship patterns, so clear in families with schizophrenia, were present in all people to some degree and that the intensity of the patterns being observed was related more to the anxiety of the moment than the severity of the emotional illness being studied. This fact about the early days of family research conveys some notion of the state of psychological theory twenty years ago that is not appreciated by those who were not part of the scene at that time. The family studies in schizophrenia were so important that they stimulated several research studies of normal families in the late 1950s and early 1960s. The influence of the schizophrenia research on family therapy was so important that family therapy was still being considered to be a form of therapy

for schizophrenia as much as ten years after the family movement started. The results of the early studies on normal families might be summarized by saying that the patterns originally thought to be typical of schizophrenia are present in all families some of the time and in some families most of the time.

My work toward a different theory began as soon as the relationship patterns were seen to repeat over and over, and we had achieved some notion about the conditions under which they repeated. The early papers were devoted mostly to clinical description of the patterns. By 1957, the relationship patterns in the nuclear family were sufficiently defined that I was willing to call a major paper, "A Family *Concept* of Schizophrenia." Jackson, who was reasonably accurate in his use of the word *theory,* had coauthored a paper in 1956 called, "Toward a Theory of Schizophrenia" (3). He urged me to use the term *theory* in the 1957 paper, which was finally published in 1960 (4), but I refused on the basis that it was no more than a concept in a much larger field, and I wanted to avoid using *theory* for a partial theory or a concept. The situation in the late 1950s was an absolute delight for me. It satisfied my theoretical curiosity that schizophrenia and the psychoses were part of the same continuum with neurotic problems, and that the differences between schizophrenia and the neuroses were quantitative rather than qualitative. Psychoanalysis and the other theoretical systems viewed psychosis as the product of one emotional process, and the neuroses as the product of another emotional process. Even today a majority of people in psychiatry probably still hold the viewpoint that schizophrenia and the neuroses are qualitatively different. It is usual for mental health professionals to speak of schizophrenia as one thing, and the neuroses as another type of problem; they also still speak of "normal" families. However, I *know* they are all part of the total human dimension, all the way from the lowest possible level of human functioning to the highest. I believe that those who assume a difference between schizophrenia, the neuroses, and the normal are operating from basic psychoanalytic theory without being specifically aware of it, and that they base the difference on therapeutic response rather than on systems theory. I believe psychiatry will some day come to see all these conditions as parts of the same continuum.

The main part of this family systems theory evolved rather rapidly over a period of about six years, between 1957 and 1963. No one part was first. A concept about the nuclear family emotional system and another about the family projection process had both been started in the early descriptive papers. They were both reasonably clear by the time it was possible to compare the patterns in schizophrenia with the total range of human problems. The notion that all human problems exist on a single continuum gave rise by the early 1960s, to the concept of.differentiation of self. The notion

of triaiigles, one of the basic concepts in the total theory, had been started in 1957 when it was called the "interdependent triad." The concept was sufficiently developed to be used in therapy by about 1961. The concept of multigenerational transmission process started as a research hypothesis as early as 1955, but the research that brought it to reasonable clarification had to wait till 1959 to 1960, when there was a larger volume of families for study. The concept oKibling position had been poorly defined since the late 1950s, but it had to Wait until Toman's *Family Constellation* (14) in 1961 provided structure. By 1963, these six interlocking concepts were sufficiently defined that I was willing to put all six together into family systems theory, which satisfied a fairly strict definition of theory. It was not included in *Intensive Family Therapy* by Nagy and Framo (5), which was published in 1965, because they had specifically asked for a chapter on schizophrenia. The six concepts were finally published as a coherent, theoretical system in 1966 (1). After 1966, there were numerous changes in therapy, but the theory as presented in 1966 has remained very much as it is today, with some extensionsAnd refinements. Finally, in 1975, two new concepts were added. The first-,-'he emotional cutoff, was merely a refinement and a new emphasis of former theoretical principles. The last and eighth concept, societal regression, had been rather well defined by 1972, and was finally added as a separate concept in 1975. Also, the name *family systems theory* was formally changed to *the Bowen theory* in 1975.

Any relationship with balancing forces and counterforces in constant operation is a system. The notion of *dynamics* is simply not adequate to describe the idea of a *system*. By 1963, when the six interlocking concepts were defined, I was using the concept of system as a shorthand way to describe the complex balancing of family relationships. This idea was finally presented in some detail in the 1966 paper on theory. By the mid-1960s, the term *systems* was being used more frequently; some therapists picked it up from my writings, and others picked it up from general systems theory, which was first defined in the 1930s. In the past decade, the term has become popularized and overused to the point of being meaningless. Family systems theory has been confused with general systems theory, which has a much broader frame of reference and no specific application to emotional functioning. It is very difficult to apply general systems concepts to emotional functioning except in a broad, general way. My family systems theory is a specific theory about the functional facts of emotional functioning.

It is grossly inaccurate to consider family systems theory as synonymous with general systems, although it is accurate to think of family systems theory as somehow fitting into the broad framework of general systems theory. There are those who believe family systems theory was developed from general systems theory, in spite of my explanations to the contrary. At the time my theory was developed, I knew nothing about general systems

theory. Back in the 1940s, I attended one lecture by Bertalanffy, which I did not understand, and another by Norbert Wiener which was perhaps a little more understandable. Both dealt in systems *of* thinking. The *degree* to which I heard something in those lectures that influenced my later thinking is debatable. In those years, I was strongly influenced by reading and lectures in aspects of evolution, biology, the balance of nature, and the natural sciences. I was trying to view man as a part of nature rather than separate from nature. It is likely that my systems orientation was patterned after the systems in nature, and unlikely that systems of thinking played any part in the theory. However it developed, family systems theory as I have defined it is a specific theory about human relationship functioning that has now become confused with general systems theory and the popular, non-specific use of the word *systems.* I have long opposed the use of proper names in terminology, but in order to denote the specificity that is built into this family systems theory, I am now calling it the Bowen theory.

Emotionality, feelings, and subjectivity are the principal commodities which the theoretician has to conceptualize, which the researcher has to organize into some kind of structure, and which the clinician has to deal with in his practice. It is difficult to find verifiable facts in the world of subjectivity. Conventional psychiatric theory focuses on the why of human behavior. All members of the mental health professions are familiar with why explanations. The search for why reasons has been part of man's cause and effect thinking since he became a thinking being. Once the researcher starts asking why, he is confronted by a complex mass of variables. It was the search for reliable facts about emotional functioning that led toward systems thinking early in the family research. From this effort came a method of separating the functional facts from the subjectivity of emotional systems. Systems thinking focused on what happened, and how, when, and where it happened, insofar as these observations could be based on observable facts. The method carefully avoids why explanations and the discrepant reasoning that follows. Some fairly efficient formulas were developed for converting subjectivity into observable and verifiable research facts. For example, one such formula might be, "That man dreams is a scientific fact, but what he dreams is not necessarily a fact," or, "That man talks is a scientific fact, but what he says is not necessarily factual." The same formula can be applied to almost the whole range of subjective concepts, such as, "That man thinks (or feels) is a scientific fact, but what he thinks (or feels) is not necessarily factual." The formula is a little more difficult to apply in the intense feeling states, such as love and hate, but as long as the researcher stays on the facts of loving and hating and avoids the content of these intense emotions, he is working toward systems thinking

The effort to focus on the functional facts of relationship systems is a difficult and disciplined task. It is easy to lose sight of the fact and become

emotionally involved in the content of the communication. The main reason for making this effort was for research purposes. The main concepts in the Bowen theory were developed from the functional facts of relationship systems. In this disciplined research effort, it was discovered that a method of therapy based on the functional facts was superior to conventional therapy. It is so difficult for most therapists to shift from conventional therapy to this method of family systems therapy that no one ever achieves more than partial success at it. When anxiety is high, even the most disciplined systems thinker will automatically revert to cause and effect thinking and why explanations. However, it is possible for therapists to keep perfecting their ability to think in systems concepts. The more I have been able to shift to thinking systems, the better my therapy has become. The shift to systems thinking requires the therapist to give up many of his old concepts. A recent exchange with a therapist involved in psychoanalytic research illustrates the dilemma in making such a shift. He said he could hear the notion of trying to find facts in subjectivity, but he simply could not give up the therapeutic contributions of dreams and analyzing the unconscious. I replied that I could respect his conviction if he could respect mine about the ultimate advantage of a total systems approach. A major advantage of systems theory and systems therapy is that it offers options not previously available. The young professional has the choice of continuing conventional theory and therapy, or of incorporating a few systems concepts, or of trying to go all the way toward systems thinking. I believe a few systems concepts are better than none.

The Bowen theory contains no ideas that have not been a part of human experience through the centuries. The theory operates on an order of facts so simple and obvious that everyone knew them all the time. The uniqueness of the theory has to do with the facts that are included, and the concepts that are specifically excluded. Said in another way, the theory listens to a distant drumbeat that people have always heard. This distant drumbeat is often obscured by the noisy insistence of the foreground drumbeat, but it is always there, and it tells its own clear story to those who can tune out the noise and keep focused on the distant drumbeat. The Bowen theory specifically excludes certain items from individual theory that are equivalent to the foreground drumbeat. The concepts we learned in individual theory all have their accuracy within one frame of reference, but they tend to nullify the unique effectiveness of the simple story told by a broad systems perspective. The Bowen theory is very simple to those who can hear, and the simple approach to therapy is determined by the theory.

THE BOWEN THEORY

The Bowen theory involves Jw.0 main variables. One is the degree of anxiety, and the other is the degree of integration of self. There are several variables having to do with anxiety or emotional tension. Among these are intensity, duration, and different kinds of anxiety. There are far more variables that have to do with the level of integration of the differentiation of self. This is the principal subject of this theory. All organisms are reasonably adaptable to acute anxiety. The organism has built-in mechanisms to deal with short bursts of anxiety. It is sustained or chronic anxiety that is most useful in determining-the differentiation Otself.TfaniietY siiffiCiently low, almost any organism can appear normal in the sense that it is symptom free. When anxiety increases and remains chronic for a certain period, the organism develops tension, either within itself or in the relationship system, and the tension results in symptoms or dysfunction or sickness. The tension may result in physiological symptoms or physical illness, in emotional dysfunction, in social illness characterized by impulsiveness or withdrawal, or by social misbehavior. There is also the phenomenon of the infectiousness of anxiety, through which anxiety can spread rapidly through the family, or through society. There is a kind of average level of differentiation for the family which has certain minor levels of difference in individuals within the family. I shall leave it to the reader to keep in mind there is always the variable of the degree of chronic anxiety which can result in anyone appearing normal at one level of anxiety, and abnormal at another higher level.

Three of the theory's eight.concepts apply to overall characteristics of the family The other five focus on details within certain areas of the family

) *Differentiation of Self* This concept is a cornerstone of the theory, and *d* my discussion becomes repetitive, I beg the reader's indulgence. The concept defines people according to the degree of *fusion,* or *differentiation,* between emotional and intellectual functioning. This characteristic is so universal it can be used as a way of categorizing all people on a single continuum. At the low extreme are those whose emotions and intellect are so fused that their lives are dominated by the automatic emotional system. Whatever intellect they have is dominated by the emotional system. These are the people who are less flexible, less adaptable, and more emotionally dependent on those about them. They are easily stressed into dysfunction, and it is difficult for them to recover from dysfunction. They inherit a high percentage of all human problems. At the other extreme are those who are more differentiated. It is impossible for there to be more than relative separation between emotional and intellectual functioning, but those whose intellectual functioning can retain relative autonomy in periods of stress are more flexible, more adaptable, and more independent of the emotionality about them. They cope better with life stresses, their life courses are more

orderly and successful, and they are remarkably free of human problems. In between the two extremes is an infinite number of mixes between emotional and intellectual functioning.

The concept eliminates the concept of *normal,* which psychiatry has never successfully defined. It is not possible to define *normal* when the thing to be measured is constantly changing. Operationally, psychiatry has called people normal when they are free of emotional symptoms and behavior is within average range. The concept of differentiation has no direct connection with the presence or absence of symptoms. People with the most fusion have most of the human problems, and those with the most differentiation, the fewest; but there can be people with intense fusion who manage to keep their relationships in balance, who are never subjected to severe stress, who never develop symptoms, and who appear normal. However, their life adjustments are tenuous, and, if they are stressed into dysfunction, the impairment can be chronic or permanent. There are also fairly well-differentiated people who can be stressed into dysfunction, but they recover rapidly.

At the fusion end of the spectrum, the intellect is so flooded by emotionality that the total life course is determined by the emotional process and by what "feels right," rather than by beliefs or opinions. The intellect exists as an appendage of the feeling system. It may function reasonably well in mathematics or physics, or in impersonal areas, but on personal subjects its functioning is controlled by the emotions. The emotional system is hypothesized to be part of the instinctual forces that govern automatic functions. The human is adept at explanations to emphasize that he is different from lower forms of life, and at denying his relation with nature. The emotional system operates with predictable, knowable stimuli that govern the instinctual behavior in all forms of life. The more a life is governed by the emotional system, the more it follows the course of all instinctual behavior, in spite of intellectualized explanations to the contrary. At higher levels of differentiation, the function of the emotional and intellectual systems are more clearly distinguishable. There are the same automatic emotional forces that govern instinctual behavior, but intellect is sufficiently autonomous for logical reasoning and decisions based on thinking. When I first began to present this concept, I used the term *undifferentiated family ego mass* to describe the emotional stuck-togetherness in families. Although this phrase was an assemblage of words from conventional theory, and thus did not conform to the plan to use concepts consistent with biology, it fairly accurately described emotional fusion. I used it for a few years because more people were able to hear the concept when it was put into words they understood.

As I began to present the concept of a well-differentiated person as one whose intellect could function separately from the emotional system, it was common for mental health professionals to hear the intellectual system as

equivalent to intellectuality which is used as a defense against emotionality in psychiatric patients. The most common criticism was that a differentiated person appeared to be cold, distant, rigid, and nonfeeling. It is difficult for professional people to grasp the notion of differentiation when they have spent their working lives believing that the free expression of feelings represents a high level of functioning and intellectualization represents an unhealthy defense against it. A poorly differentiated person is trapped within a feeling world. His effort to gain the comfort of emotional closeness can increase the fusion, which can increase his alienation from others. There is a lifelong effort to get the emotional life into livable equilibrium. A segment of these emotionally trapped people use random, inconsistent, intellectual- sounding verbalization to explain away their plight. A more differentiated person can participate freely in the emotional sphere without the fear of becoming too fused with others. He is also free to shift to calm, logical reasoning for decisions that govern his life. The logical intellectual process is quite different from the inconsistent, intellectualized verbalizations of the emotionally fused person.

In earlier papers, I presented this as a Differentiation of Self Scale." I did that to convey the idea that people have all gradations of differentiation of self, and that people at one level have remarkably different life styles from those at other levels. Schematically, I presented a scale from 0 to 100, with 0 representing the lowest possible level of human functioning and 100 representing a hypothetical notion of perfection to which man might evolve if his evolutionary change goes in that direction. I wanted a spectrum broad enough to cover all possible degrees of human functioning. To clarify the fact that people are different from each other in terms of emotional-intellectual functioning, I did profiles of people in the 0 to 25, the 25 to 50, the 50 to 75, and the 75 to 100 ranges. Those profiles are still amazingly accurate ten years later. In that first paper, I also presented the notion of functional levels of differentiation that can shift from moment to moment, or remain fairly constant for most of a life. Some of the major variables that govern the shifting were presented as a way of clarifying the concept and categorizing the apparent complexity of human functioning into a more knowable framework. The schematic framework and the use of the term *scale* resulted in hundreds of letters requesting copies of "the scale." Most who wrote had not grasped the concept nor the variables that govern the functional levels of differentiations. The letters slowed down my effort to develop a more definite scale that could be used clinically. The theoretical concept is most important. It eliminates the barriers between schizophrenia, neurosis, and normal; it also transcends categories such as genius, social class, and cultural-ethnic differences. It applies to all human forms of life. It might even apply to subhuman forms if we only knew enough. Knowledge of the concept permits the easy development of all kinds of research instruments,

but to attempt to use the scale without knowledge of the concept can result in chaos.

Another important part of the differentiation of self has to do with the levels of *solid self* and *pseudo-self* in a person. In periods of emotional intimacy, two pseudo-selfs will fuse into each other, one losing self to the other, who gains self. The solid self does not participate in the fusion phenomenon. The solid self says, "This is who I am, what I believe, what I stand for, and what I will do or will not do," in a given situation. The solid self is made up of clearly defined beliefs, opinions, convictions, and life principles. These are incorporated into self from one's own life experiences, by a process of intellectual reasoning and the careful consideration of the alternatives involved in the choice. In making the choice, one becomes responsible for self and the consequences. Each belief and life principle is consistent with all the others, and self will take action on the principles even in situations of high anxiety and duress.

The pseudo-self is created by emotional pressure, and it can be modified by emotional pressure. Every emotional unit, whether it be the family or the total of society, exerts pressure on group members to conform to the ideals and principles of the group. The pseudo-self is composed of a vast assortment of principles, beliefs, philosophies, and knowledge acquired because it is required or considered right by the group. Since the principles are acquired under pressure, they are random and inconsistent with one another, without the individual's being aware of the discrepancy. Pseudo-self is appended onto the self, in contrast to solid self which is incorporated into self after careful, logical reasoning. The pseudo-self is a "pretend" self. It was acquired to conform to the environment, and it contains discrepant and assorted principles that pretend to be in emotional harmony with a variety of social groups, institutions, businesses, political parties, and religious groups, without self s being aware that the groups are inconsistent with each other. The joining of groups is motivated more by the relationship system than the principle involved. The person may "feel" there is something wrong with some of the groups, but he is not intellectually aware. The solid self is intellectually aware of the inconsistency between the groups and the decision to join or reject membership is an intellectual process based on careful weighing of the advantages and disadvantages.

The pseudo-self is an actor and can be many different selfs. The list of pretends is extensive. He can pretend to be more important or less important, stronger or weaker, or more attractive, or less attractive than is realistic. It is easy for most people to detect gross examples of pretense, but there is enough of the impostor in all of us so that it is difficult to detect lesser degrees of the impostor in others. On the other hand, a good actor can appear so much for real that it can be difficult for the actor or for others without detailed knowledge of how emotional systems function to know the

dividing line between solid self and pseudo-self. This also applies to therapists, mental health professionals, and researchers who may attempt to estimate the level of differentiation in themselves or in others. The level of solid self is stable. The pseudo-self is unstable, and it responds to a variety of social pressures and stimuli. The pseudo-self was acquired at the behest of the relationship system, and it is negotiable in the relationship system.

Based on my experience with this concept, I believe that the level of solid self is lower, and of the pseudo-self is much higher in all of us than most are aware. It is the pseudo-self that is involved in fusion and the many ways of giving, receiving, lending, borrowing, trading, and exchanging of self. In any exchange, one gives up a little self to the other, who gains an equal amount. The best example is a love relationship when each is trying to be the way the other wants self to be, and each in turn makes demands on the other to be different. This is pretending and trading in pseudo-self. In a marriage, two pseudo-selfs fuse into a we-ness in which one becomes the dOminant decision maker or the most active in taking initiative for the we-ness. The dominant one gains self at the expense of the other, who loses it. The adaptive one may volunteer to give up self to the dominant one, who accepts it; or the exchange may be worked out after bargaining. The more that the spouses can alternate these roles, the healthier the marriage. The exchanging of selfs may be on a short or longterm basis. The borrowing and trading of selfs may take place automatically in a work group in which the emotional process ends up with one employee in the one-down or deselfed, position, while the others gain self. This exchanging of pseudo-self is an automatic emotional process that occurs as people manipulate each other in subtle life postures. The exchanges can be brief—for instance, criticism that makes one feel bad for a few days; or it can be a longterm process in which the adaptive spouse becomes so deselfed, he or she is no longer able to make decisions and collapses in selfless dysfunction—psychosis or chronic physical illness. These mechanisms are much less intense in better levels of differentiation or when anxiety is low, but the process of people losing and gaining self in an emotional network is so complex and the degree of shifts so great that it is impossible to estimate functional levels of differentiation except from following a life pattern over long periods.

Profile of Low Levels of Differentiation. This is the group I previously described as 0 to 25, the lowest level of differentiation. The emotional fusion is so intense that the variables extend beyond the undifferentiated family ego mass into the undifferentiated societal ego mass The intricacies of fusion and differentiation are much clearer in people with moderate levels of fusion in whom the various processes are more easily defined. There are some striking overall characteristics of the low levels of differentiation. People at the lowest level live in a feeling-dominated world in which it is impossible to distinguish feeling from fact. They are totally relationship oriented. So

much energy goes into seeking love and approval and keeping the relationship in some kind of harmony, there is no energy for life-directed goals. Failing to achieve approval, they can spend their lives in withdrawal or fighting the relationship system from which they fail to win approval. Intellectual functioning is so submerged that they cannot say, "I think that . . ." or, "I believe. . . ." Instead, they say, "I feel that . . ." when it would be accurate to express an opinion or belief. They consider it truthful and sincere to say, "I feel," and false and insincere to express an opinion from themselves. Important life decisions are made on the basis of what feels right. They spend their lives in a day-to-day struggle to keep the relationship system in balance, or in an effort to achieve some degree of comfort and freedom from anxiety. They are incapable of making longterm goals except in vague general terms, such as, "I want to be successful, or happy, or have a good job, or have security." They grow up as dependent appendages of their parents, following which they seek other equally dependent relationships in which they can borrow enough strength to function. A no-self person who is adept at pleasing his boss may make a better employee than one who has a self. This group is made up of people preoccupied with keeping their dependent relationships in harmony, people who have failed and who go from one symptomatic crisis to another, and people who have given up in the futile effort to adapt. At the lowest level are those who cannot live outside the protective walls of an institution. This group inherits a major portion of the world's serious health, financial, and social problems. Life adjustments are tenuous at best, and when they fall into dysfunction, the illness or "bad luck" can be chronic or permanent. They tend to be satisfied with the result if a therapy effort brings a modicum of comfort.

Profile of Moderate Levels of Differentiation of Self This is the group previously presented as 25 to 50. There is some beginning differentiation between the emotional and intellectual systems, with most of the self expressed as pseudo-self. Lives are still guided by the emotional system, but the life styles are more flexible than the lower levels of differentiation. The flexibility provides a better view of the interplay between emotionality and intellect. When anxiety is low, functioning can resemble good levels of differentiation. When anxiety is high, functioning can resemble that of low levels of differentiation. Lives are relationship oriented, and major life energy goes to loving and being loved, and seeking approval from others. Feelings are more openly expressed than in lower-level people. Life energy is directed more to what others think and to winning friends and approval than to goal-directed activity. Self-esteem is dependent on others. It can soar to heights with a compliment or be crushed by criticism. Success in school is oriented more to learning the system and to pleasing the teacher than to the primary goal of learning. Success in business or in social life depends more on pleasing the boss or the social leader, and more on who

one knows and gaining relationship status than in the inherent value of their work. Their pseudo-selves are assembled from an assortment of discrepant principles, beliefs, philosophies, and ideologies that are used in pretend postures to blend with different relationship systems. Lacking solid self, they habitually use, "I feel that . . ." when expressing their pseudo-self philosophies; they avoid, "I think," or "I believe," positions by using another person or body of knowledge as their authority when making statements. Lacking a solid self-conviction about the world's knowledge, they use pseudo-self statements, such as, "The rule says .. ." or "Science has proved . . ." taking information out of context to make their points. They may have enough free-functioning intellect to have mastered academic knowledge about impersonal things; they use this knowledge in the relationship system. However, intellect about personal matters is lacking, and their personal lives are in chaos.

The pseudo-self may be a conforming disciple who pretends to be in harmony with a particular philosophy or set of principles, or, when frustrated, he can assume the opposite posture as a rebel or revolutionary person. The rebel is lacking a self of his own. His pseudo-self posture is merely the exact opposite of the majority viewpoint. The revolutionary person is against the prevailing system, but he has nothing to offer in its place. The sameness of polarized opposites in emotional situations has led me to define revolution as a convulsion that prevents change. It is relationship-oriented energy that goes back and forth on the same points, the issue on each side being determined by the position of the other; neither is capable of a position not determined by the other.

People in the moderate range of differentiation have the most intense versions of overt feeling. The relationship orientation makes them sensitive to others and to the direct action expression of feelings. They are in a lifelong quest for the ideal relationship with emotional closeness to others and direct, open communication of feelings. In their overt emotional dependence on others, they are sensitized to reading the moods, expressions, and postures of the other, and to responding openly with direct expression of feeling or impulsive action. They are in a lifelong pursuit of the ideal close relationship. When closeness is achieved, it increases the emotional fusion to which they react with distance and alienation, which can then stimulate another closeness cycle. Failing to achieve closeness, they may go to withdrawal and depression, or to pursuit of closeness in another relationship. Symptoms and human problems erupt when the relationship system is unbalanced. People in this group develop a high percentage of human problems, including the full range of physical illness, emotional illness, and social dysfunctions. Their emotional illness includes neurotic-level internalized problems, depression, and behavior and character disorder type problems; they get involved in the increasing use of alcohol and drugs to relieve

the anxiety of the moment. Their social disorders include all levels of impulsive and irresponsible behavior.

Profile of Moderate to Good Differentiation of Self. This is the group in the 50 to 75 range. These are the people with enough basic differentiation between the emotional and intellectual systems for the two systems to function alongside each other as a cooperative team. The intellectual system is sufficiently developed so that it can hold its own and function autonomously without being dominated by the emotional system when anxiety increases. In people below 50, the emotional system tells the intellectual system what to think and say, and which decisions to make in critical situations. The intellect is a pretend intellect. The emotional system permits the intellect to go off into a corner and think about distant things as long as it does not interfere in joint decisions that affect the total life course. Above 50, the intellectual system is sufficiently developed to begin making a few decisions of its own. It has learned that the emotional system runs an effective life course in most areas of functioning, but in critical situations the automatic emotional decisions create longterm complications for the total organism. The intellect learns that it requires a bit of discipline to overrule the emotional system, but the longterm gain is worth the effort. People above 50 have developed a reasonable level of solid self on most of the essential issues in life. In periods of calm, they have employed logical reasoning to develop beliefs, principles, and convictions that they use to overrule the emotional system in situations of anxiety and panic. Differentiation between the emotions and the intellect exists in subtle gradations. People at the lower part of this group are those who *know* there is a better way; but intellect is poorly formed, and they end up following life courses similar to those below 50.

People in the upper part of this group are those in which there is more solid self. Persons with a functional intellectual system are no longer a prisoner of the emotional-feeling world. They are able to live more freely and to have more satisfying emotional lives within the emotional system. They can participate fully in emotional events knowing that they can extricate themselves with logical reasoning when the need arises. There may be periods of laxness in which they permit the automatic pilot of the emotional system to have full control, but when trouble develops they can take over, calm the anxiety, and avoid a life crisis. People with better levels of differentiation are less relationship directed and more able to follow independent life goals. They are not unaware of the relationship system, but their life courses can be determined more from within themselves than from what others think. They are more clear about the differences between emotion and intellect, and they are better able to state their own convictions and beliefs calmly without attacking the beliefs of others or without having to defend their own. They are better able to accurately evaluate themselves in

relation to others without the pretend postures that result in overvaluing or undervaluing themselves. They marry spouses with equal levels of differentiation. The life-style of a spouse at another level would be sufficiently different to be considered emotionally incompatible. The marriage is a functioning partnership. The spouses can enjoy the full range of emotional intimacy without either being deselfed by the other. They can be autonomous selfs together or alone. The wife is able to function more fully as a female and the husband more fully as a male without either having to debate the advantages or disadvantages of biological and social roles. Spouses who are more differentiated can permit their children to grow and develop their own autonomous selfs without undue anxiety or without trying to fashion their children in their own images. The spouses and the children are each more responsible for themselves, and do not have to blame others for failures or credit anyone else for their successes. People with better levels of differentiation are able to function well with other people, or alone, as the situation may require. Their lives are more orderly, they are able to cope successfully with a broader range of human situations, and they are remarkably free from the full range of human problems.

In previous papers I have described a level of 75 to 100, which is more hypothetical than real, and which conveys an erroneous impression of the human phenomenon to concretistic thinkers who are searching for another instrument to measure human functioning. Rather than pursue the hypothesis about the upper extremes of differentiation, I shall instead make some general comments about differentiation. A common mistake is to equate the better differentiated person with a "rugged individualist." I consider rugged individualism to be exaggerated pretend posture of a person struggling against emotional fusion. The differentiated person is always aware of others and the relationship system around him There are so many forces and counterforces and details in differentiation that one has to get a broad panoramic view of the total human phenomenon in order to be able to see differentiation. Once it is possible to see the phenomenon, there it is, operating in full view, right in front of our eyes. Once it is possible to see the phenomenon, it is then possible to apply the concept to hundreds of different human situations. To try to apply it without knowing it is an exercise in futility.

The therapy based on differentiation is no longer therapy in the usual sense. The therapy is as different from the conventional therapy as the theory is different from conventional theory. The overall goal is to help individual family members to rise up out of the emotional togetherness that binds us all. The instinctual force toward differentiation is built into the organism, just as are the emotional forces that oppose it. The goal is to help the motivated family member to take a microscopic step toward a better level of differentiation, in spite of the togetherness forces that oppose. When

one family member can finally master this, then other family members automatically take similar steps. The togetherness forces are so strong in maintaining the status quo that any small step toward differentiation is met with vigorous disapproval of the group. This is the point at which a therapist or guide can be most helpful. Without help, the differentiating one will fall back into the togetherness to get emotional harmony for the moment. Conventional therapy is designed to resolve, or talk out, conflict. This does accomplish the goal of reducing the conflict of that moment, but it can also rob the individual of his budding effort to achieve a bit more differentiation from the family togetherness. There are many pitfalls in the effort toward differentiation. If the individual attempts it without some conviction of his own, he is blindly following the advice of his therapist and is caught in a self-defeating togetherness with the therapist. I believe that the level of differentiation of a person is largely determined by the time he leaves the parental family and he attempts a life of his own. Thereafter, he tends to replicate the life-style from the parental family in all future relationships. It is not possible ever to make more than minor changes in one's basic level of self; but from clinical experience I can say it is possible to make slow changes, and each small change results in the new world of a different life-style. As I see it now, the critical stage is passed when the individual can begin to know the difference between emotional functioning and intellectual functioning, and when he has developed ways for using the knowledge for solving future problems in a lifelong effort on his own. It is difficult to assess differentiation during calm periods in a life. Clinically, I make estimates from the average functional level of self as it operates through periods of stress and calm. The real test of the stability of differentiation comes when the person is again subjected to chronic severe stress.

It is reasonably accurate to compare the functioning of the emotional and intellectual systems to the structure and function of the brain. I conceive of one brain center that controls emotions and another that controls intellectual functions. The fusion suggests centers that are side by side with some degree of fusion, or grown togetherness. Anatomically, it would be more accurate to think of the two as being connected by nerve tracts. In poorly functioning people, the two centers are intimately fused, with the emotional center having almost total dominance over the intellectual center. In better functioning people, there is more functional separateness between the centers. The more the separateness between the centers, the more the intellectual center is able to block, or screen out, a spectrum of stimuli from the emotional center, and to function autonomously. The screening process, which might be biochemical, operates best when anxiety is low. The emotional center controls the autonomic nervous system and all other automatic functions. The intellectual center is the seat of intellect and reasoning. The emotional center handles the myriads of sensory stimuli

from the digestive, circulatory, respiratory, and all the other organ systems within the body, as well as stimuli from all the sensing organs that perceive the environment and relationships with others. In periods of calm, when the emotional center is receiving fewer stimuli from its sensing network, the intellectual center is more free to function autonomously. When the emotional center is flooded by stimuli, there is little intellectual functioning that is not governed by the emotional center. In some areas, the intellect operates *in the service of the* emotional center.

There are many clinical examples that illustrate emotional dominance over the intellect in determining a life course. The intellectual center is either appended to, or is directed by, the emotional center. In the various psychotic and neurotic states, the intellect is either obliterated or distorted by emotionality. There may be an occasional situation in which there is an island of reasonably intact intellectual activity, such as in the psychotic person with a computer mind. In the various neurotic states the intellect is directed by emotionality. There is the intellectualizing person whose apparent intellect is directed by the emotional process. There are the behavior problems in which automatic impulsive action is directed by emotionality, and the intellect attempts to explain or justify it after the action. This can vary from childish misbehavior to criminal action. The parents and the social system ask why, pretending there is a logical answer. The organism responds with an instant excuse that appears most acceptable to self and others. In the same category falls the mass of emotional center-dominated behavior that is often called self-destructive. This behavior is designed to relieve anxiety of the moment, and the impulse for immediate relief overrules awareness of longterm complications. It is at its worst in alcohol and drug abuse. There are situations in which the intellect aids emotionally-directed behavior—as, for instance, intellectual planning that helps emotionally directed crime. A large group of people choose their philosophies and ideologies because of emotional system pressure. In another group, a section of the intellect functions well on impersonal subjects; they can be brilliant academically, while their emotionally-directed personal lives are chaotic. Even in people who exhibit some degree of separation between emotion and intellect, and in whom the intellect can hold its own with the emotional system in certain areas most of the time, there are periods of chronic stress in which the emotional system is dominant.

Triangles. I began work on this basic concept in 1955. By 1956 the research group was thinking and talking about "triads." As the concept evolved, it came to include much more than the meaning of the conventional term *triad,* and we therefore had a problem communicating with those who assumed they knew the meaning of triad. I chose *triangle* in order to convey that this concept has specific meaning beyond that implied in triad. The theory states that the triangle, a three-person emotional configu-

ration, is the molecule or the basic building block of any emotional system, *whether it is in the* family or any other group. The triangle is the smallest stable relationship system. A two-person system may be stable as long as it is calm, but when anxiety increases, it immediately involves the most vulnerable other person to become a triangle. When tension in the triangle is too great for the threesome, it involves others to become a series of interlocking triangles.

In periods of calm, the triangle is made up of a comfortably close twosome and a less comfortable outsider. The twosome works to preserve the togetherness, lest one become uncomfortable and form a better togetherness elsewhere. The outsider seeks to form a togetherness with one of the twosome, and there are numerous well-known moves to accomplish this. The emotional forces within the triangle are constantly in motion from moment to moment, even in periods of calm. Moderate tension states in the twosome are characteristically felt by one, while the other is oblivious. It is the uncomfortable one who initiates a new equilibrium toward more comfortable togetherness for self.

In periods of stress, the outside position is the most comfortable and most desired position. In stress, each works to get the outside position to escape tension in the twosome. When it is not possible to shift forces in the triangle, one of the involved twosome triangles in a fourth person, leaving the former third person aside for reinvolvement later. The emotional forces duplicate the exact patterns in the new triangle. Over time, the emotional forces continue to move from one active triangle to another, finally remaining mostly in one triangle as long as the total system is fairly calm.

When tensions are very high in families and available family triangles are exhausted, the family system triangles in people from outside the family, such as police and social agencies. A successful externalization of the tension occurs when outside workers are in conflict about the family while the family is calmer. In emotional systems such as an office staff, the tensions between the two highest administrators can be triangled and retriangled until conflict is acted out between two who are low in the administrative hierarchy. Administrators often settle this conflict by firing or removing one of the conflictual twosome, after which the conflict erupts in another twosome.

A triangle in moderate tension characteristically has two comfortable sides and one side in conflict. Since patterns repeat and repeat in a triangle, the people come to have fixed roles in relation to each other. The best example of this is the father-mother-child triangle. Patterns vary, but one of the most common is basic tension between the parents, with the father's gaining the outside position—often being called passive, weak, and distant — leaving the conflict between mother and child. The mother—often called aggressive, dominating, and castrating—wins over the child, who moves

another step toward chronic functional impairment. This pattern is described as the family projection process. Families replay the same triangular game over and over for years, as though the winner were in doubt, but the final result is always the same. Over the years the child accepts the always-lose outcome more easily, even to volunteering for this position. A variation is the pattern in which the father finally attacks the mother, leaving the child in the outside position. This child then learns the techniques of gaining the outside position by playing the parents off against each other.

Each of the structured patterns in triangles is available for predictable moves and predictable outcomes in families and social systems. A knowledge of triangles provides a far more exact way of understanding the father-mother-child triangle than do the traditional oedipal-complex explanations. Triangles provide several times more flexibility in dealing with such problems therapeutically.

Knowledge of triangles helps provide the theoretical perspective between individual therapy and this method of family therapy. An emotionally involved relationship is unavoidable in the average two-person, patient-therapist relationship. Theoretically, family therapy provides a situation in which intense relationships can remain within the family and the therapist can be relatively outside the emotional complex. This is a good theoretical premise that is hard to achieve in practice. Without some special effort, it is easy for the family to wrap itself around the therapist emotionally, install the therapist in an all-important position, hold the therapist responsible for success or failure, and passively wait for the therapist to change the family. I have already discussed ways other therapists have dealt with the therapeutic relationship, as well as my continuing effort to operate from outside the family emotional system. Initially that included making the family members responsible for each other, avoiding the family tendency to assign importance to me, and promising no benefits except from the family's own effort to learn about itself and change itself. Most important was a longterm effort to attain and maintain emotional neutrality with individual family members. There are many subtleties to this. Beyond this effort, it was knowledge of triangles that provided the important breakthrough in the effort to stay outside the emotional complex.

One experience, above all others, was important in learning about triangles. That was a period in which much of my family therapy was with both parents and behavior problem adolescent child. It was possible to see the workings of the triangle between parents and child in microscopic detail. The more I could stay outside the triangle, the more clearly it was possible to see the family emotional system as it operated on well-defined emotional circuits between father, mother, and child. Therapeutically, the family did not change its original patterns. The passive father became less passive, the aggressive mother less aggressive, and the symptomatic child would become

asymptomatic. The average, motivated family would continue for 30 to 40 weekly appointments and terminate with great praise for the "good result." In my opinion, the family had not changed, but I had learned a lot about triangles. It was possible to observe a family and know the next move in the family before it occurred.

From the knowledge of triangles, I hypothesized the situation would be different by excluding the child and limiting the therapy to the two parents and the therapist. Rather than dealing in generalities about staying out of the family emotional system, I was then armed with specific knowledge about the parents' triangling moves to involve the therapist. Therapeutically, the results were far superior to anything before that time. This has remained the one basic therapeutic method since the early 1960's. On a broad theoretical-therapeutic level, if the therapist can stay in viable emotional contact with the two most significant family members, usually the two parents or two spouses, and he can be relatively outside the emotional activity in this central triangle, the age-old fusion between the family members will slowly begin to resolve, and all other family members will automatically change in relation to the two parents in the home setting. This is basic theory and basic method. The process can proceed regardless of content or subject matter discussed. The critical issue is the emotional reactiveness between the spouses, and the ability of the therapist to keep self relatively detriangled from the emotionality. The process can proceed with any third person who can keep self detriangled, but it would be difficult to find such an outside relationship. The method is as successful as other methods in short-term crisis situations. In the early years, I was active in engaging the family emotionally in consultations and short-term crisis situations. A calm, low-keyed, detriangling approach is more effective with a single appointment or with many.

Nuclear Family Emotional System. This concept describes the patterns of emotional functioning in a family in a single generation. Certain basic patterns between the father, mother, and children are replicas of the past generations and will be repeated in the generations to follow. There are several rather clear variables that determine the way the family functions in the present generation, which can be measured and validated by direct observation. From a careful history, in connection with knowledge of the details in the present generation, it is possible to do a rather remarkable reconstruction of the way the process operated in past generations. From knowledge about the transmission of family patterns over multiple generations, it is possible to project the same process into future generations, and, within limits, do some reasonably accurate predictions about future generations. No one person lives long enough to check the accuracy of predictions into the future, but there is enough detailed knowledge about some families in history to do a reasonable check on the predictive process. Based on

experience in family research, the predictions of *ten to twenty years ago* have been rather accurate.

The beginning of a nuclear family, in the average situation, is a marriage. There are exceptions to this, just as there have always been exceptions, which is all part of the total theory. The basic process in exceptional situations is similar to the more chaotic pattern in poorly differentiated people. The two spouses begin a marriage with life-style patterns and levels of differentiation developed in their families of origin. Mating, marriage, and reproduction are governed to a significant degree by emotional-instinctual forces. The way the spouses handle them in dating and courtship and in timing and planning the marriage provides one of the best views of the level of differentiation of the spouses. The lower the level of differentiation, the greater the potential problems for the future. People pick spouses who have the same levels of differentiation. Most spouses can have the closest and most open relationships in their adult lives during courtship. The fusion of the two pseudo-selfs into a common self occurs at the time they commit themselves to each other permanently, whether it be the time of engagement, the wedding itself, or the time they establish their first home together. It is common for living together relationships to be harmonious, and for fusion symptoms to develop when they finally get married. It is as if the fusion does not develop as long as they still have an option to terminate the relationship.

The lower the level of differentiation, the more intense the emotional fusion of marriage. One spouse becomes more the dominant decision maker for the common self, while the other adapts to the situation. This is one of the best examples in the borrowing and trading of self in a close relationship. One may assume the dominant role and force the other to be adaptive, or one may assume the adaptive role and force the other to be dominant. Both may try for the dominant role, which results in conflict; or both may try for the adaptive role, which results in decision paralysis. The dominant one gains self at the expense of the more adaptive one, who loses self. More differentiated spouses have lesser degrees of fusion, and fewer of the complications. The dominant and adaptive positions are *not* directly related to the sex of the spouse. They are determined by the position that each had in their families of origin. From my experience, there are as many dominant females as males, and as many adaptive males as females. These characteristics played a major role in their original choice of each other as partners. The fusion results in anxiety for one or both of the spouses. There is a spectrum of ways spouses deal with fusion symptoms. The most universal mechanism is emotional distance from each other. It is present in all marriages to some degree, and in a high percentage of marriages to a major degree.

Other than the emotional distance, there are three major areas in which

the amount of undifferentiation in the marriage comes to be manifested in symptoms. The three areas are marital conflict; sickness or dysfunction in one spouse; and projection of the problems to children. It is as if there is a quantitative amount of undifferentiation to be absorbed in the nuclear family, which may be focused largely in one area or distributed in varying amounts to all three areas. The various patterns for handling the undifferentiation comes from patterns in their families of origin, and the variables involved in the mix in the common self. Following are general characteristics of each of the three areas.

Marital Conflict. The basic pattern in conflictual marriages is one in which neither gives in to the other or in which neither is capable of an adaptive role. These marriages are intense in the amount of emotional energy each invests in the other. The energy may be thinking or action energy, either positive or negative, but the self of each is focused mostly on the other. The relationship cycles through periods of intense closeness, conflict that provides a period of emotional distance, and making up, which starts another cycle of intense closeness. Conflictual spouses probably have the most overtly intense of all relationships. The intensity of the anger and negative feeling in the conflict is as intense as the positive feeling. They are thinking of each other even when they are distant. Marital conflict does not in itself harm children. There are marriages in which most of the undifferentiation goes into marital conflict. The spouses are so invested in each other that the children are largely outside the emotional process. When marital conflict and projection of the problem to children are both present, it is the projection process that is hurtful to children. The quantitative amount of marital conflict that is present reduces the amount of undifferentiation that is focused elsewhere.

Dysfunction in One Spouse. This is the result when a significant amount of undifferentiation is absorbed in the adaptive posture of one spouse. The pseudo-self of the adaptive one merges into the pseudo-self of the dominant one, who assumes more and more responsibility for the twosome. The degree of adaptiveness in one spouse is determined from the longterm functioning posture of each to the other, rather than from verbal reports. Each does some adapting to the other, and it is usual for each to believe that he or she gives in more than the other. The one who functions for long periods in the adaptive position gradually loses the ability to function and make decisions for self. At that point, it requires no more than a moderate increase in stress to trigger the adaptive one into dysfunction, which can be physical illness, emotional illness, or social illness, such as drinking, acting out, and irresponsible behavior. These illnesses tend to become chronic, and they are hard to reverse.

The pattern of the overfunctioning spouse in relation to the underfunctioning spouse exists in all degrees of intensity. It can exist as an episodic

phenomenon in families who use a mixture of all three mechanisms. When used as the principal means of controlling undifferentiation, the illnesses can be chronic and most difficult to reverse. The sick or invalided one is too impaired to begin to regain function with an overfunctioning spouse on whom he or she is dependent. This mechanism is amazingly effective in absorbing the undifferentiation. The only disadvantage is the dysfunction in one, which is compensated for by the other spouse. The children can be almost unaffected by having one dysfunctional parent as long as there is someone else to function instead. The main problem in the children is inheriting a life pattern as caretaker of the sick parent, which will project into the future. These marriages are enduring. Chronic illness and invalidism, whether physical or emotional, can be the only manisfestation of the intensity of the undifferentiation. The underfunctioning one is grateful for the care and attention, and the overfunctioning one does not complain. Divorce is almost impossible in these marriages unless the dysfunction is also mixed with marital conflict. There have been families in which the overfunctioning one has died unexpectedly and the disabled one has miraculously regained functioning. If there is a subsequent marriage, it follows the pattern of the previous one.

Impairment of One or More Children. This is the pattern in which parents operate as a we-ness to project the undifferentiation to one or more children. This mechanism is so important in the total human problem it has been described as a separate concept, the family projection process.

There are two main variables that govern the intensity of this process in the nuclear family. The first is the degree of the emotional isolation, or cutoff, from the extended family, or from others important in the relationship system. I will discuss this below. The second important variable has to do with the level of anxiety. Any of the symptoms in the nuclear family, whether they be marital conflict, dysfunction in a spouse, or symptoms in a child, are less intense when anxiety is low and more intense when anxiety is high. Some of the most important family therapy efforts are directed at decreasing anxiety and opening the relationship cutoff.

Family Projection Process. The process through which parental undifferentiation impairs one or more children operates within the father-mother-child triangle. It revolves around the mother, who is the key figure in reproduction and who is usually the principal caretaker for the infant. It results in primary emotional impairment of the child; or, it can superimpose itself on some defect or on some chronic physical illness or disability. It exists in all gradations of intensity, from those in which impairment is minimal to those in which the child is seriously impaired for life. The process is so universal it is present to some degree in all families

A composite of families with moderately severe versions of the projection process will provide the best view of the way the process works. It is

as if there is a definite amount of undifferentiation to be absorbed by marital conflict, sickness in a spouse, and projection to the children. The amount absorbed in conflict or sickness in a spouse reduces the amount that will be directed to the children. There are a few families in which most of the undifferentiation goes into marital conflict, essentially none to sickness in a spouse, and relatively small amounts to the children. The most striking examples of this have been in families with autistic, or severely impaired, children in which there is little marital conflict, both spouses are healthy, and the full weight on the undifferentiation is directed to a single, maximally impaired child. I have never seen a family in which there was not some projection to a child. Most families use a combination of all three mechanisms. The more the problem shifts from one area to another, the less chance the process will be crippling in any single area.

There are definite patterns in the way the undifferentiation is distributed to children. It focuses first on one child. If the amount is too great for that child, the process will select others for lesser degrees of involvement. There are families in which the amount of undifferentiation is so great it can seriously impair most of the children, and leave one or two relatively out of the emotional process. There is so much disorder and chaos in these families, it is difficult to see the orderly steps in the process. I have never seen a family in which children were equally involved in the family emotional process. There may be some exceptions to the process described here, but the overall patterns are clear, and the theory accounts for the exceptions. There are suggestions about the way children become the objects of the projection process. On a simplistic level, it is related to the degree of emotional turn on or turn off (both equal in emotional systems terms) the mother feels for the child. This is an automatic emotional process that is not changed by acting the opposite. On a more specific level, it is related to the level of undifferentiation in the parents, the amount of anxiety at the time of conception and birth, and the orientation of the parents toward marriage and children.

The early thoughts about marriage and children are more prominent in the female than the male. They begin to take an orderly form before adolescence. A female who thinks primarily of the husband she will marry tends to have marriages in which she focuses most of her emotional energy on the husband, and he focuses on her, and symptoms tend to focus more in marital conflict and sickness in a spouse. Those females whose early thoughts and fantasies go more to the children they will have than the man they will marry, tend to become the mothers of impaired children. The process can be so intense in some women that the husband is incidental to the process. Spouses from lower levels of differentiation are less specific about marriage and children. The children selected for the family projection process are those conceived and born during stress in the mother's life; the

first child, the oldest son or oldest daughter, an only child of either sex, one who is emotionally special to the mother, or one the mother believes to be special to the father. Among common special children are only children, an oldest child, a single child of one sex among several of the opposite sex, or a child with some defect. Also important are the special children who were fretful, colicky, rigid, and nonresponsive to the mother from the beginning. The amount of initial special emotional investment in such children is great. A good percentage of mothers have a basic preference for boys or girls, depending upon their orientation in the family of origin. It is impossible for mothers to have equal emotional investment in any two children, no matter how much they try to protest equality for all.

On a more detailed level, the projection process revolves around maternal instinct, and the way anxiety permits it to function during reproduction and the infancy of the child. The father usually plays a support role to the projection process. He is sensitive to the mother's anxiety, and he tends to support her view and help her implement her anxious efforts at mothering. The process begins with anxiety in the mother. The child responds anxiously to mother, which she misperceives as a problem in the child. The anxious parental effort goes into sympathetic, solicitous, overprotective energy, which is directed more by the mother's anxiety than the reality needs of the child. It establishes a pattern of infantilizing the child, who gradually becomes more impaired and more demanding. Once the process has started, it can be motivated either by anxiety in the mother, or anxiety in the child. In the average situation, there may be symptomatic episodes at stressful periods during childhood, which gradually increase to major symptoms during or after adolescence; intense emotional fusion between mother and child may exist in which the mother-child relationship remains in positive, symptom-free equilibrium until the adolescent period, when the child attempts to function on his own. At that point, the child's relationship with the mother, or with both parents, can become negative and the child develop severe symptoms. The more intense forms of the mother-child fusion may remain relatively asymptomatic until young adulthood and the child can collapse in psychosis when he attempts to function away from the parents.

The basic pattern of the family projection is the same, except for minor variations in form and intensity, whether the eventual impairment in the child be one that leads to serious lifelong dysfunction, or one that never develops serious symptoms and is never diagnosed. The greatest number of people impaired by the projection process are those who do less well with life and who have lower levels of differentiation than their siblings, and who may go for a few generations before producing a child who becomes seriously impaired symptomatically. This theory considers schizophrenia to be the product of several generations of increasing symptomatic impairment,

with lower and lower levels of differentiation, until there is a generation that produces schizophrenia. In clinical work, we have come to use the term *the triangled child* to refer to the one who was the main focus of the family projection process. Almost every family has one child who was more triangled than the others, and whose life adjustment is less good than the others. In doing multigenerational family histories, it is relatively easy to estimate the family projection process and identify the triangled child by securing historical data about the life adjustments of each sibling.

Emotional Cutoff. This concept was added to the theory in 1975 after having been a poorly defined extension of other concepts for several years. It was accorded the status of a separate concept to include details not stated elsewhere, and to have a separate concept for emotional process between the generations. The life pattern of cutoffs is determined by the way people handle their unresolved emotional attachments to their parents. All people have some degree of unresolved emotional attachment to their parents. The lower the level of differentiation, the more intense the unresolved attachment. The concept deals with the way people separate themselves from the past in order to start their lives in the present generation. Much thought went into the selection of a term to best describe this process of separation, isolation, withdrawal, running away, or denying the importance of the parental family. However much *cutoff* may sound like informal slang, I could find no other term as accurate for describing the process. The therapeutic effort is to convert the cutoff into an orderly differentiation of a self from the extended family.

The degree of unresolved emotional attachment to the parents is equivalent to the degree of undifferentiation that must somehow be handled in the person's own life and in future generations. The unresolved attachment is handled by the intrapsychic process of denial and isolation of self while living close to the parents; or by physically running away; or by a combination of emotional isolation and physical distance. The more intense the cutoff with the past, the more likely the individual to have an exaggerated version of his parental family problem in his own marriage, and the more likely his own children to do a more intense cutoff with him in the next generation. There are many variations in the intensity of this basic process and in the way the cutoff is handled.

The person who runs away from his family of origin is as emotionally dependent as the one who never leaves home. They both need emotional closeness, but they are allergic to it. The one who remains on the scene and handles the attachment by intrapsychic mechanisms tends to have some degree of supportive contact with the parents, to have a less intense overall process, and to develop more internalized symptoms under stress, such as physical illness and depression. An exaggerated version of this is the severely impaired person who can collapse into psychosis, isolating himself

intrapsychically while living with the parents. The one who runs away geographically is more inclined to impulsive behavior. He *tends* to *see* the problem as being in the parents and running away as a method of *gaining* independence from the parents. The more intense the cutoff, the more he is vulnerable to duplicating the pattern with the parents with the first available other person. He can get into an impulsive marriage. When problems develop in the marriage, he tends also to run away from that. He can continue through multiple marriages, and finally resort to more temporary living together relationships. Exaggerated versions of this occur in relationship nomads, vagabonds, and hermits who either have superficial relationships or give up and live alone.

In recent years, as the age-old cutoff process became more pronounced as a result of societal anxiety, the emotional cutoff has been called the generation gap. The higher the level of anxiety, the greater the degree of generation gap in poorly differentiated people. There has been an increase in the percentage of those who run away, and who become involved in living together arrangements and communal living situations. These substitute families are very unstable. They are made up of people who ran away from their own families; when tension builds up in the substitute family, they cutoff from that and move on to another. Under the best conditions, the substitute family and outside relationships are poor substitutes for original families.

There are all gradations of the emotional cutoff. An average family situation in our society today is one in which people maintain a distant and formal relationship with the families of origin, returning home for duty visits at infrequent intervals. The more a nuclear family maintains some kind of viable emotional contact with the past generations, the more orderly and asymptomatic the life process in both generations. Compare two families with identical levels of differentiation. One family remains in contact with the parental family and remains relatively free of symptoms for life, and the level of differentiation does not change much in the next generation. The other family cuts off with the past, develops symptoms and dysfunction, and a lower level of differentiation in the succeeding generation. The symptomatic nuclear family that is emotionally cut off from the family of origin can get into cyclical, longterm family therapy without improvement. If one or both parents can re-establish emotional contact with their families of origin, the anxiety level subsides, the symptoms become softer and more manageable, and family therapy can become productive. Merely telling a family to go back to the family of origin is of little help. Some people are very anxious about returning to their families. Without systems coaching, they can make the problem worse. Others can return, continue the same emotional isolation they used when they were in the family, and accomplish nothing. Techniques for helping families to re-establish contact have been

sufficiently developed so that it is now a family therapy method in its own right. This differentiation of a self in one's own family has been presented in another paper (15). It is based on the experience that a spouse who can do a reasonable job at differentiating self in his parental family will have accomplished more than if he was involved in regular family therapy with self and his spouse.

Multigenerational Transmission Process. The family projection process continues through multiple generations. In any nuclear family, there is one child who is the primary object of the family projection process. This child emerges with a lower level of differentiation than the parents and does less well in life. Other children, who are minimally involved with the parents, emerge with about the same levels of differentiation as the parents. Those who grow up relatively outside the family emotional process develop better levels of differentiation than the parents. If we follow the most impaired child through successive generations, we will see one line of descent producing individuals with lower and lower levels of differentiation. The process may go rapidly a few generations, remain static for a generation or so, and then speed up again. Once I said it required at least three generations to produce a child so impaired he would collapse into schizophrenia. That was based on the notion of a starting point with fairly good surface functioning and a process that proceeded at maximum speed through the generations. However, since I now know the process can slow down or stay static a generation or two, I would now say that it would require perhaps eight to ten generations to produce the level of impairment that goes with schizophrenia. This is the process that produces the poorly functioning people who make up most of the lower social classes. If a family encounters severe stress in perhaps the fifth or sixth generation of a ten-generation process, it may produce a social failure who is less impaired than the schizophrenic person. The degree of impairment in schizophrenia comes from those poorly differentiated people who are able to keep the relationship system in relatively symptom-free equilibrium for several more generations.

If we followed the line through the children who emerge with about the same levels of differentiation, we see a remarkable consistency of family functioning through the generations. History speaks of family traditions, family ideals, and so on. If we follow the multigenerational lineage of those who emerge with higher levels of differentiation, we will see a line of highly functioning and very successful people. A family at a highest level of differentiation can have one child who starts down the scale. A family at the lowest level can have a child who starts up the scale. Many years ago I described schizophrenia from a phenomenological standpoint as a natural process that helps to keep the race strong. The weakness from the family is fixed in one person who is less likely to marry and reproduce and more

Sibling Position. This concept is an adaptation of Toman's work on the personality profiles of each sibling position. His first book in 1961 (14) was remarkably close to the direction of some of my research. He had worked from an individual frame of reference and only with normal families, but he had ordered his data in a way no one else had done, and it was easy to incorporate them into the differentiation of self and the family projection process. His basic thesis is that important personality characteristics fit with the sibling position in which a person grew up. His ten basic sibling profiles automatically permit one to know the profile of any sibling position, and, *all things being equal,* to have a whole body of presumptive knowledge about anyone. His ideas provided a new dimension toward understanding how a particular child is chosen as the object of the family projection process. The degree to which a personality profile fits with normal provides a way to understand the level of differentiation and the direction of the projection process from generation to generation. For instance, if an oldest turns out to be more like a youngest, that is strong evidence that he was the most triangled child. If an oldest is an autocrat, that is strong evidence of a moderate level of impaired functioning. An oldest who functions calmly and responsibly is good evidence of a better level of differentiation. The use of Toman's profiles, together with differentiation and projection, make it possible to assemble reliable presumptive personality profiles on people in past generations on whom verifiable facts are missing. Knowing the degree to which people fit the profiles provides predictive data about how spouses will handle the mix in a marriage, and how they will handle their effort in family therapy. Based on my research and therapy, I believe that no single piece of data is more important than knowing the sibling position of people in the present and past generations.

Societal Regression. This eighth and last of the concepts in the Bowen theory was first defined in 1972, and formally added to the theory in 1975. I have always been interested in understanding societal problems, but the tendency of psychiatrists and social scientists to make sweeping generalizations from a minimal number of specific facts resulted in my interest's remaining peripheral except for personal reading. Family research added a new order of facts about human functioning, but I avoided the seductive urge to generalize from them. In the 1960s, there was growing evidence that the emotional problem in society was similar to the emotional problem in the family. The triangle exists in all relationships, and that was a small clue. In 1972 the Environmental Protection Agency invited me to do a paper on human reaction to environmental problems. I anticipated doing a paper on assorted facts acquired from years of experience with people relating to larger societal issues. That paper led to a year of research, and a return to old files for confirmation of data. Finally I identified a link between the family and society that was sufficiently trustworthy for me to extend the

basic theory about the family into the larger societal arena. The link had to do, first, with the delinquent teenaged youngster, who is a responsibility for both the parents and society, and secondly, with changes in the way the parents and the agents of society deal with the same problem.

It has not yet been possible to write this up in detail, but *the overall* structure of the concept was presented in outline form in 1974 (16). The concept states that when a family is subjected to chronic, sustained anxiety, the family begins to lose contact with its intellectually determined principles, and to resort more and more to emotionally determined decisions to allay the anxiety of the moment. The results of the process are symptoms and eventually regression to a lower level of functioning. The societal concept postulates that the same process is evolving in society; that we are in a period of increasing chronic societal anxiety; that society responds to this with emotionally determined decisions to allay the anxiety of the moment; that this results in symptoms of dysfunction; that the efforts to relieve the symptoms result in more emotional band aid legislation, which increases the problem; and that the cycle keeps repeating, just as the family goes through similar cycles to the states we call emotional illness. In the early years of my interest in societal problems, I thought that all societies go through good periods and bad, that they always go through a rise and fall, and that the cyclical phenomenon of the 1950s was part of another cycle. As societal unrest appeared to move toward intensification of the problems through the 1960s, I began to look for ways to explain the chronic anxiety. I was looking for concepts consistent with man as an instinctual being, rather than man as a social being. My current postulation considers the chronic anxiety as the product of the population explosion, decreasing supplies of food and raw materials necessary to maintain man's way of life on earth, and the pollution of the environment which is slowly threatening the balance of life necessary for human survival.

This concept proceeds in logical steps from the family to larger and larger social groups, to the total of society. It is too complex for detailed presentation here. I outline it here to indicate that the theoretical concepts of the Bowen theory do permit logical extension into a beginning theory about society as an emotional system.

SUMMARY

Most members of the mental health professions have little interest in, or awareness of, theory about the nature of emotional illness. I have developed a family systems theory of emotional functioning. For some ten years I have been trying to present the theory as clearly as it is possible for me.

to define it. Only a small percentage of people are really able to hear it. In the early years, I considered most of the problem to be my difficulty in communicating the ideas in ways others could hear. As the years have passed, *I have come* to consider that the major difficulty is the inability of People to detach themselves sufficiently from conventional theory to be able to hear systems concepts. In each presentation, I learn a little more about which points people fail to hear. I have devoted almost half of this presentation to some broad background issues which I hoped would set the stage for people to hear more than they had heard before, and to clarify some of the issues between my family systems theory and general systems theory. I have never been happy about my efforts to present my own theory. I can be perfectly clear in my own mind, but there is always the problem of restating it so others can hear. If it gets too brief, people hear the theory as too static and too simplistic. If I try to fill out the concepts with more detail, it tends to get wordy and repetitive. Ultimately, I hope to present it so that each theoretical concept is illustrated with a clinical example, but that is a long and complex book. I believe that some systems theory will provide a bright new promise for comprehending emotional illness. Whether the ultimate systems theory is this one or another remains to be seen. After some twenty years of experience with this theory, I have great confidence in it. It does mean that the therapist must keep the whole spectrum of variables in his head at once; but, after some experience, knowing the variables well enough to know when one is out of balance becomes automatic.

REFERENCES

1. M. Bowen. "The Use of Family Theory in Clinical Practice," *Comprehensive Psychiatry*, 7(1966), 345-74.
2. _____ "Family Therapy and Family Group Therapy," in H. Kaplan and B. Sadock (eds.). *Comprehensive Group Psychotherapy*. New York: Williams and Wilkins, 1971.
3. G. Bateson, D.D. Jackson, J. Haley, and J.H. Weakland. "Toward a Theory of Schizophrenia," *Behavioral Science*, 1 (1956), 251.
4. M. Bowen. "A Family Concept of Schizophrenia," in D. Jackson (ed.). *The Etiology of Schizophrenia.* New York: Basic Books, 1960, 346.
5 _____ "Family Psychotherapy with Schizophrenia in the Hospital and Private Practice," in I. Boszormenyi-Nagy and J. Framo (eds.). *Intensive Family Therapy*. New York: Harper and Row, 1965, 213.
6. _____ "Family Therapy After Twenty Years," in J. Dyrud and D. Freedman. *American Handbook of Psychiatry*, Vol. V. New York: Basic Books, 1975.
7. T. Lidz, S. Fleck, and A. Cornelison. *Schizophrenia and the Family*. New York: [illegible]

8. M. Bowen. "Family Psychotherapy," *American Journal of Orthopsychiatry*, 30 (1961), 40.
9. N. W. Ackerman *The Psychodynamics of Family Life*. New York: Basic Books, 1958.
10. J. E. Bell. "Family Group Therapy," *Public Health Monograph 64*, United States Department of Health, Education, and Welfare, Washington, D. C., 1961.
11. N. Paul and B. Paul. *A Marital Puzzle*. New York: W. W. Norton, 1975.
12. I. Boszormenyi-Nagy and G. Spark. *Invisible Loyalties*. New York: Harper and Row, 1973.
13. S. Minuchin. *Families and Family Therapy*. Cambridge, Mass.: Harvard University Press, 1974.
14. W. Toman. *Family Constellation*. New York: Springer, 1961.
15. M. Bowen. "Toward the Differentiation of Self in One's Family of Origin," in F. Andres and J. Lorio (eds.). *Georgetown Family Symposium Papers*, I. Georgetown University Press, 1974, 77.
16. _____ *"Societal Regression as Viewed Through Family Systems Theory*. Paper read at the Nathan W. Ackerman Memorial Conference, Venezuela, February, 1974.