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THE SCIENCE OF FAMILIES

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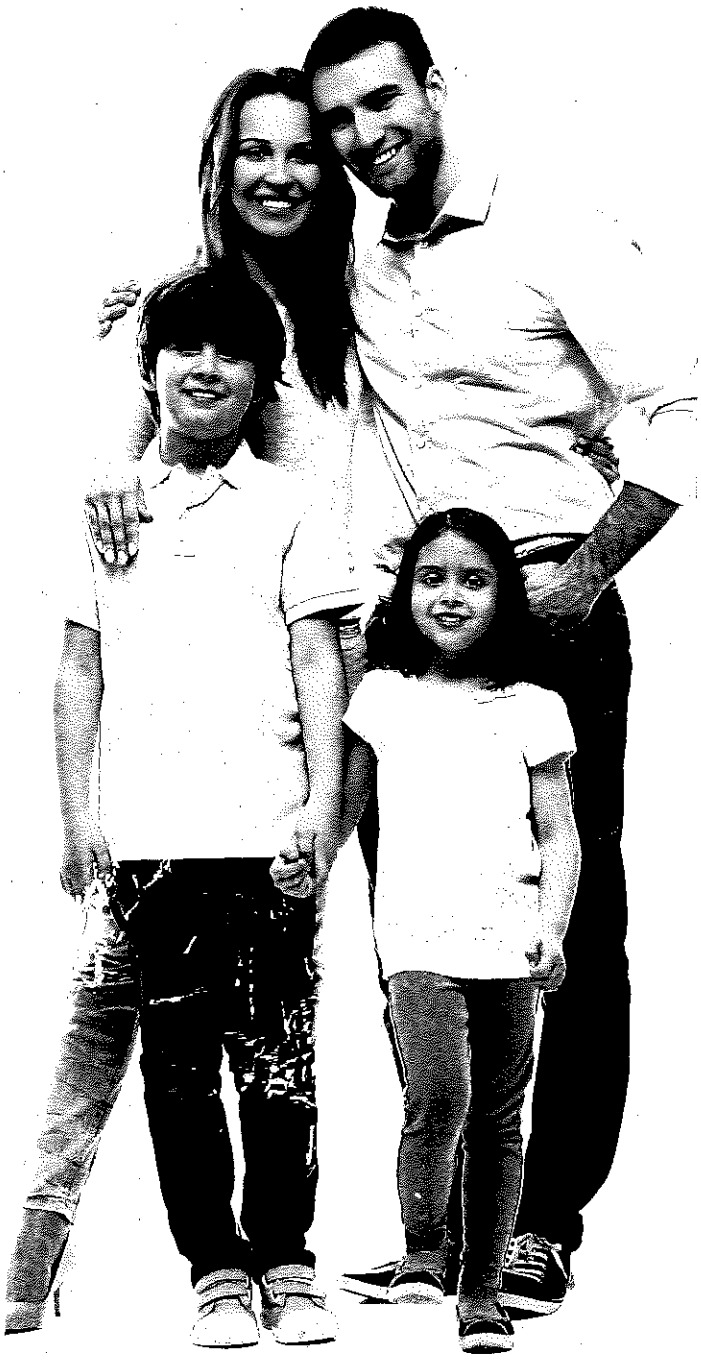

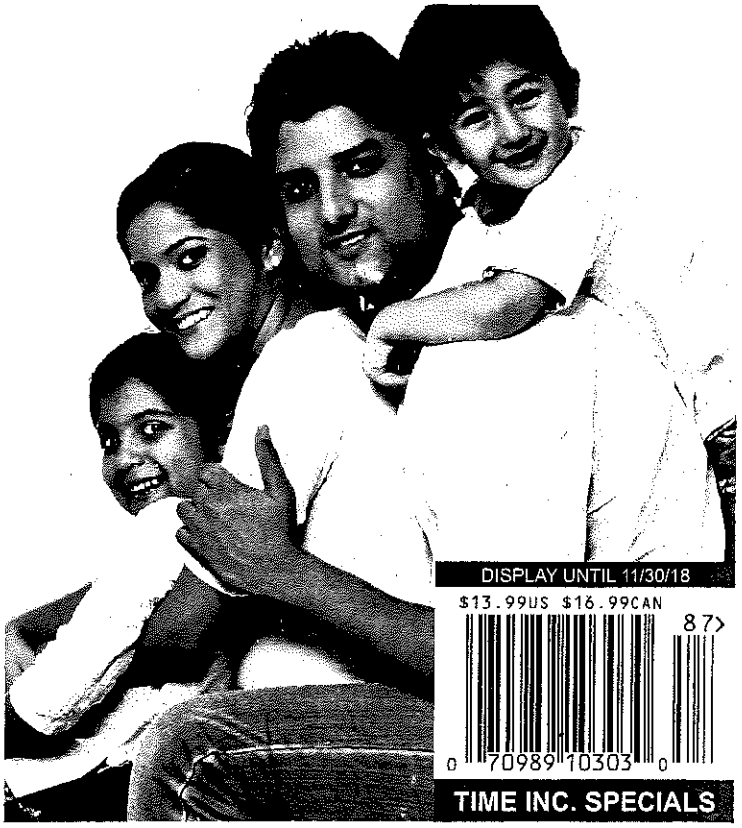

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PUTTING FAMILIES ON THE COUCH

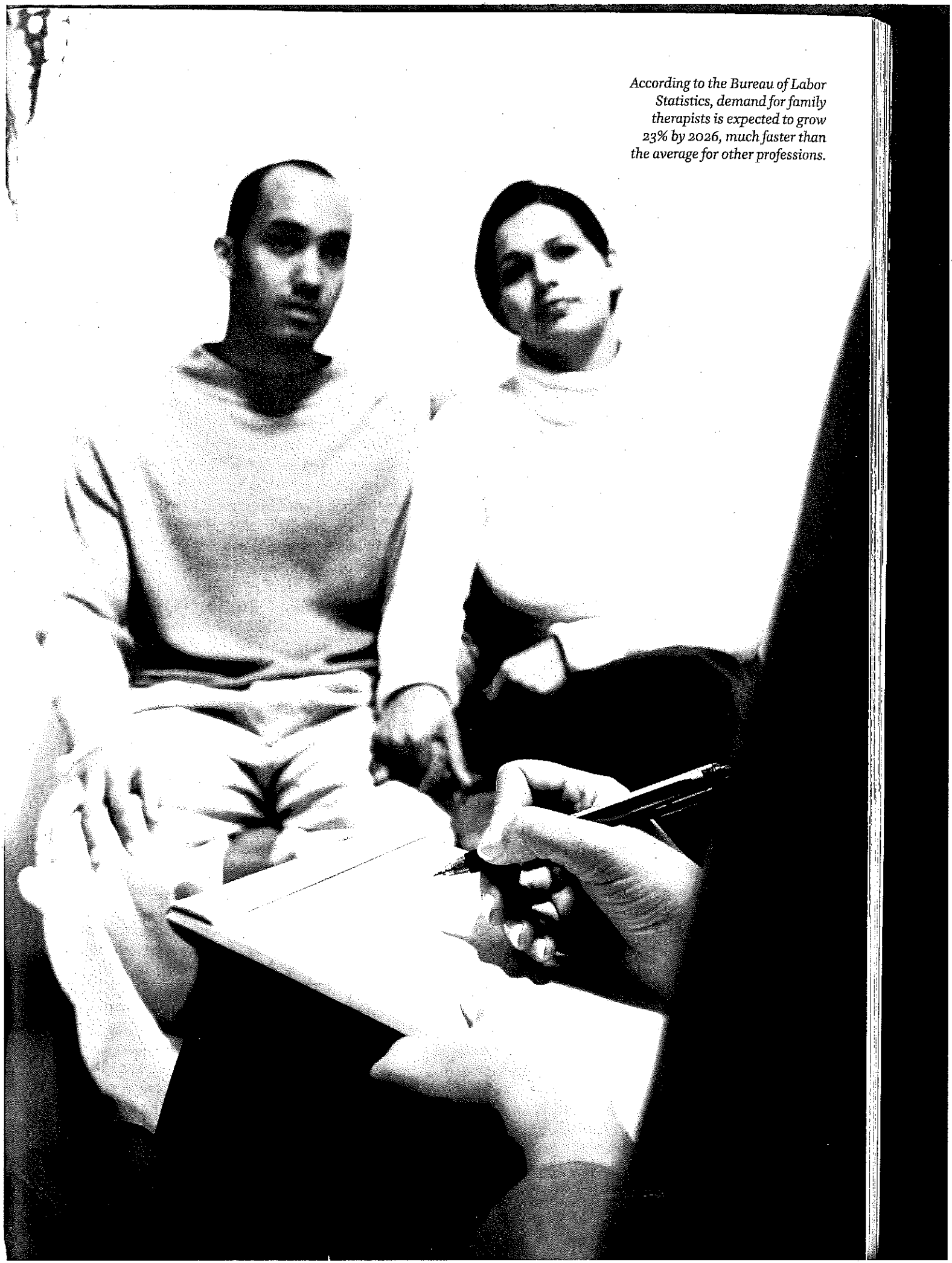
Since the middle of the last century, therapists have embraced the idea that family dynamics can exert a powerful influence over mental—and even physical—health

BY DAVID BJERKLIE

"WHAT'S THE MATTER WITH THE FAMILY?" SOPHOCLES ASKED THIS question, so did Shakespeare, Ibsen and O'Neill. Homer Simpson too. But this particular plainspoken version of the question was in fact posed by the anthropologist Margaret Mead just before the end of World War II.

Mead's timing was no accident. Dramatic changes ushered in by the war were having impacts throughout society, and the American family was seen both as our bulwark against outside threats and as an institution increasingly at risk from within. The country was in the grip of an unsettling mix of hope and worry at a time when, as Deborah Weinstein, a professor of American Studies at Brown University, explains in her book, *The Pathological Family*, "fears of nuclear war and the spread of communism sat alongside strengthened national confidence and economic prosperity." And the family was front and center. "Whether concerned with the state of marriage, the ferment of race relations, or patterns of child rearing," notes Weinstein, "public commentators of the postwar years fretted over the American family."

Among psychologists, sociologists and anthropologists, even among



According to the Bureau of Labor Statistics, demand for family therapists is expected to grow 23% by 2026, much faster than the average for other professions.

politicians in Congress and military strategists at the Department of Defense, concerns mounted that something needed to be done. The goal was not just to understand better the mysteries of the family, but also to address its failings and shore it up. It was in this historical context that the family-therapy movement emerged.

Of course, family therapy didn't come out of nowhere. The modern science of psychology had been gathering momentum since the late 1800s. William James wrote the landmark *The Principles of Psychology* in 1890, and around the same time, Sigmund Freud was pondering the unconscious and pioneering psychoanalysis in Vienna. Social reformers were also getting into the act in the early 1900s as the mental-hygiene movement tackled the Dickensian challenge of saving hearts and minds ravaged by poverty and developing alternatives to the asylums and institutions to which they were often relegated.

With the stakes seemingly higher than ever in the Cold War aftermath of World War II, a small group of researchers, working independently, began to assemble the elements of an entirely new therapeutic approach. What was so unprecedented about their efforts was that they considered the entire family as the patient.

FROM THE PERSPECTIVE of pioneers Nathan Ackerman and Salvador Minuchin, the family-therapy approach was both revolutionary and inevitable. The 20th century was well on its way to being psychologized. We wanted ever better and healthier lives, marriages and families. The *Journal of Clinical Psychology* was founded in 1945, Dr. Benjamin Spock's parenting bible appeared in 1946, and research giants such as Rollo May, Carl Rogers, Erich Fromm, Karen Horney, Erik Erikson, B.F. Skinner and Abraham Maslow were popularizing their own research and theories. Society was primed to be receptive.

But family therapy wasn't a matter of impassive psychiatrists getting bigger couches in book-lined offices. Far from it. Family therapists were in the family's face. Therapists engaged, they intervened, and they prodded, poked and even provoked the problem behaviors that had brought the families to the therapist.

One of the first areas that early family therapists focused on was juvenile delinquency, which was seen as a threat to society and a strong democracy. Researchers suspected that absent fathers and working mothers during the war may have set the stage for its spread. As Ackerman later wrote in the journal *Family Process*, "the disordered behavior of the adolescent needs to be understood not only as an expression of a particular stage of growth, but beyond that, as a symptom of parallel disorder in the patterns of family, society and culture."

Minuchin and colleagues looked at juvenile delinquency among impoverished youth at reformatories in New York. They were particularly interested in minority families who had two or more children identified by the criminal-justice system as delinquent.

The other major area of interest was schizophrenia. Gregory Bateson (who had been married to Mead) was studying esoteric questions concerning paradoxes in communication. When his funding ran out, he decided to focus on the more interesting (and fundable) problem of schizophrenia, which Bateson believed also involved incongruous patterns of communication. At the time, schizophrenia was seen to be largely, if not entirely, a consequence of family dysfunction, in particular, the result of deficient mothering.

That idea turned out to be wrong, says Jay Lebow, a professor and psychologist at Northwestern University's Family Institute: "A fuller picture of schizophrenia has emerged. Clearly people with schizophrenia have something going on in their brain." If this devastating mental disorder isn't caused by family dysfunction, let alone by mother issues, that doesn't mean the patient's home environment is insignificant. "We also know that the family piece is really important," Lebow adds. "By far the best treatments are these combinations of medication and family therapy that includes work on skill building for the schizophrenic person."

Family therapy has gone well beyond its initial focus of delinquency and schizophrenia. Although most treatments for depression have concentrated on the individual, family therapy is making inroads as the number of kids and adults who suffer from depressive disorders grows. Family programs that can be more widely distributed are also being developed, including a video series created by a team under the direction of William Beardslee, a psychiatrist at Boston Children's Hospital and Harvard Medical School.

Beardslee, whose early research investigated how civil rights workers in the South were able to

psychologically endure and persevere, has studied resilience in the children of depressed parents and has developed a video-based intervention called the Family Depression Program. "What we want to do is foster hope, not resignation," says Beardslee. The program educates parents about the impact that depression can have on families and does the same for kids, using videos that recount the experiences of children trying to cope. The key is that it treats the depressed parent, protects children and strengthens the family, not in a piecemeal fashion but in a coordinated way.

It can seem obvious to treat depression in the broader context of family, less obvious to treat an illness like asthma that way. But people are not sick in a vacuum. Researchers have found that asthma is aggravated by family stress and have studied the potential mechanisms. Airway constriction in asthma can be influenced by the interaction of neurological and immunological systems. One study found that what characterized the families in which children died from severe asthma attacks, compared with those who survived, was turmoil, hopelessness and despair. Other studies have looked at how family routines influence coping and treatment adherence in kids with asthma and how turmoil can disrupt those routines.

THE FAMILY-THERAPY APPROACH WAS BOTH REVOLUTIONARY AND INEVITABLE. WE WANTED EVER BETTER LIVES, MARRIAGES AND FAMILIES.

Health and illness have profound effects on families and vice versa. Stress results in the release of pituitary and adrenal hormones that in turn affect immune function. The psychological is physical. That's not to blame victims or suggest that sufficient family bliss can overcome disease. What it does mean is that health-care teams are increasingly coming to realize that effectively treating disease includes understanding how family conflict can exacerbate symptoms and interfere with efforts to alleviate the illness.

THERAPY OF ANY kind involves keen observation. The challenges of observing an entire family, however, brought special demands. In 1954, the National Institute of Mental Health, which was established just five years earlier, funded a study in which schizophrenic children and their families were observed as they lived in a special hospital ward in Bethesda, Md. As Weinstein recounts in her history of family therapy, "families traveled from as far as Minnesota, Michigan and Florida to participate for months or, in some cases, years."

That project ended in 1959, but it was not the only unusual approach. Weinstein explains that other researchers "interested in observing whole families with a schizophrenic member tried to capture the essence of family life by studying families in situ, in their 'natural habitat' of the home." One such investigator was Jules Henry, an anthropologist who had previously studied and lived with indigenous groups in Brazil and Argentina.

In his observation of the families with schizophrenia, Henry would take up residence with the families, sleeping in a spare room, or show up at breakfast and observe until they went to bed. He believed his observations would not only "furnish new insights into psychotic breakdown and other forms of emotional illness, and suggest new ideas for prevention and treatment," but also provide insights into the universal workings of families. Henry was adamant that his presence wasn't disruptive because the patterns of family behavior were so entrenched as to be imperturbable.

This sort of anthropological scrutiny soon gave way to methods that could serve multiple purposes, namely one-way mirrors and film (later video). Therapists could now have a permanent record that captured not just what was actually said, with all of its emotional timbre, but also the accompanying facial expressions and body language. The recordings and one-way mirrors were effective ways to train students, as well as to involve other therapists.

One-way mirrors and video are still used, says Martha Edwards, who directs the Center for the Developing Child and Family at the Ackerman Family Institute, founded in 1960. "We're a teaching institute. It offers us a way to step back and better see all the individual and systemic dynamics that seem to be happening. And sometimes I will say to the parents, 'Let's watch the video together,' so that they

A 6-year-old girl at a psychologist's office in Dourdan, France, is observed during a play-therapy session, designed for kids who can't verbalize feelings and experiences in the same manner as adults.

can step back and get a sense of what other family members are experiencing. 'Look at what happened there. What do you think was going on for your child?' We help them develop a sense of the other person's feelings, intentions, experience. We help make that bridge."

It is not a passive process. Ackerman, who died in 1971, believed that the family therapist "must be active, spontaneous and make free use of his own emotions. . . . He loosens and shakes up preexisting pathogenic equilibria," and in this role, "his influence may be likened to that of a catalyst, a chemical reagent, a re-synthesizer."

Minuchin, who died in 2017 and also founded an institute, the Minuchin Center for the Family, not only wrote his own script but acted it with theatrical panache. Minuchin believed that conflict and crisis created therapeutic opportunities. Families needed to be challenged into change, and sometimes that set off chain reactions. But that was a good thing. A profile of the therapist in action written 40 years ago by *The New Yorker*'s Janet Malcolm observed that "watching a Minuchin session, or a tape of it, is like being at a tightly constructed, well-directed, magnificently acted play. Without appearing to be doing anything out of the ordinary, Minuchin has an extraordinary effect on the people who come into his therapeutic presence."

IF FAMILIES MATTER, so do the broader contexts and circumstances in which they live. Early therapists sought to take into account cultural, racial and socioeconomic factors in understanding patterns of human behavior (they even asked what sort of family

environment could fuel fascism, prejudice and anti-Semitism). But family therapy was not—and never has been—a monolithic movement with a single perspective. There were—and are—disagreements over the links between poverty and delinquency, debates over the impact of domineering mothers, absent fathers and the standards used to decide which families should be considered pathological.

Too much of the field has rested for too long on research that involved primarily white, middle-class families, acknowledges Edwards. "We've started the process of really looking at race in particular, and it's been both incredibly illuminating but also very painful, very difficult."

Edwards points out, for example, "that parents of color are acutely aware of the dangers their children face—dangers to which white parents are often oblivious. Families of color are subjected to a level of aggression many more times than white families. Because of these dangers in the environment, it is not unusual for parents of color to use more restrictive and punitive parenting practices with their children to ensure their safety." It is a stark reminder that there can be vast differences in parenting realities, goals and practices.

"**THERE IS NO** finding as well-replicated in psychological research as the importance of the family in the lives of the individuals within the family," says Lebow. That means "family therapy has this tremendous advantage. It can use the natural system that people are in to further treatment goals."

But in any science, understanding causality is important. How do various factors interact to produce particular results? Today, family therapists and researchers better understand that causality is rarely linear or direct and that all parts of the family system mutually affect one another, but in feedback loops that can be hard to see clearly. And there are real challenges to the perspective that everything affects everything, especially when applied to issues of addiction, domestic violence and child abuse. While family therapists strive to see the interconnected whole and avoid casting individuals as either villains or victims, they also understand that not all feedback loops are equal and the interconnectedness of cause and effect doesn't abrogate responsibility.

Given this complexity, how do family therapists measure success? For Minuchin and his colleagues in the early years of their work with urban youth, it was not an improvement in economic status or a decline in delinquent behavior, but rather the creation of new opportunities for communication among families. That's valid, but the need to accumulate empirical evidence has certainly increased over time. As Lebow explains, there are well-established results in treating major mental illness, eating disorders and a range of adolescent behavioral problems.

So why isn't family therapy used everywhere and all the time?

First of all, says Jorge Colapinto, a longtime colleague of Minuchin's, "there are many family therapies. And in fact, there are more differences between schools of family therapy than between family and individual therapy."

There are also many different venues for family therapy. "It's a demanding form of treatment in several ways," says Lebow. "As a result, a lot of family therapy is institutionalized as part of specific programs. If you're a kid or a family with a certain problem and you're in a certain kind of program, you get family therapy." That includes programs mandated by family court and foster-care systems.

The use of family therapy continues to grow worldwide, yet obstacles remain. There is the perspective that with better medications, the need for therapy recedes, despite the fact, notes Lebow, that "the evidence is overwhelming that combined treatments for more severe difficulties are much better than medication alone." Especially in the U.S., says Colapinto, an ethos of individualism and self-sufficiency also gets in the way of treating anything as an interrelated whole.

As Colapinto explains, there was a time when mental-health professionals "felt they needed to rescue individuals from bad families. We now have the point of view that while family interactions may be the problem, they are also the key to the solution. Our goal is to focus more on the strengths latent in the family and help them mobilize those strengths. Putting the resources of the family to work for the solution of their own problems."

Ironically enough, another challenge to making fuller use of family therapy, says Colapinto, is that we are so accustomed to carrying our families around in our heads: "With our virtual family in mind, we avoid the changing and disturbing presence of the actual family." □