Family Psychotherapy and Psychoanalysis: The Implications of Difference

NATHAN W. ACKERMAN, M.D., F.A.P.A.

Family Process Vol. 1., March 1962

In our time we are witness to a spreading contagion of interest in the family approach to mental illness. There is a rising inquiry as to the possibility of understanding and treating psychiatric illness in a family way. Historically speaking, it was psychoanalysis that gave pointed emphasis to the role of family conflict in mental illness. It is of no small interest today, therefore, to observe how members of the psychoanalytic profession respond to the concept of the family as the unit of mental health and the unit of diagnosis and therapy. Here, as elsewhere, in matters pertaining to theory and practice, psychoanalysts are divided. Once again we discover the familiar split in the psychoanalytic family as between the conservatives and the liberals. In the evolution of ideas, here as elsewhere, there is value in both points of view. Toward the principles of family diagnosis and treatment, some analysts are critical and antipathetic from the start. They sense in it a threat to the established position of the psychoanalytic technique. One such analyst said to me: "The psychotherapy of the whole family makes me uneasy. It threatens my sense of mastery in the exclusive one-to-one relationship." Other psychoanalysts, skeptical to be sure, are otherwise open-minded and willing for the concept of the family as the unit of mental health to face the test of time.

Regardless of the dilemma of the psychoanalysts, present evidence suggests that this new dimension is here to stay. The family approach offers a new level of entry, a new quality of participant observation in the struggles of human adaptation. It holds the promise of shedding new light on the processes of illness and health, and offers new ways of assessing and influencing these conditions. It may open up, perhaps for the first time, some effective paths for the prevention of illness and the promotion of health.

In the perspective of the history of mental science, the emergence of the principles of family diagnosis and treatment is an inevitable development. It is the natural product of the coalescence of new conceptual trends in a number of fields: cultural anthropology, group dynamics, communication, the link of psychoanalysis with social science, ego psychology, and child development. The family phenomenon bridges the gap between individual personality and society. On this background, it is hardly a coincidence that some psychoanalytic associations now devote whole meetings to the themes of psychoanalysis and values, and psychoanalysis and family. It seems likely, therefore, that the evolution of family diagnosis and family treatment holds far-reaching implications for the future relations of culture change, behavior theory, and the evolving ideology of psychoanalysis and psychotherapy.

I shall present first a brief, impressionistic view of the techniques of family psychotherapy, and then attempt a comparison with psychoanalytic therapy within the

frame of two contrasting theoretical models of psychotherapeutic process. In advance of this, however, I must mention two basic considerations. Just so long as we lack a unitary theory of human behavior and cannot accurately formulate the relations of emotion, body, and social process, we shall be unready to build a comprehensive theory of psychotherapy. We have no psychotherapeutic method that is total. We have no known treatment technique that can affect with equal potency all components of the illness process. The various psychotherapeutic methods presently available are, each of them, specialized, and exert partial, selective effects on certain components of the illness process, but not on all. It is the social structuring of a particular interview method which determines both the potentials of participant observation and the selective effects of a given therapy. In this sense, the psychoanalytic method provides one kind of participant experience, group psychotherapy another, and family psychotherapy still another. It is the specific point of entry of each of these methods which affects the kind of information obtained, the view of the illness process which is communicated to the therapist, and the quality of influence toward health that he may exert. Family interview and family psychotherapy hold the potential of shedding a different and added light on the illness phenomenon and provide still another level of intervention on the area of pathogenic disturbance.

RELEVANT CONCEPTS

Family psychotherapy and psychoanalytic therapy are different methods. For purposes of clarity, hereafter, the term "psychoanalytic therapy" will be reserved for the technique as originally formulated by Freud and his early disciples. The issue as to the essential differences between family therapy and psychoanalysis would be somewhat obscured if we were here to extend the term, "psychoanalytic therapy," to embrace the numerous neo-Freudian modifications of technique.

Psychoanalytic treatment focuses on the internal manifestations of disorder of the individual personality. Family treatment focuses on the behavior disorders of a system of interacting personalities, the family group. But in no sense need they be viewed as competitive or mutually exclusive; they may be complementary. The psychotherapy of the whole family may, in some instances, be the only method of intervention, or it may be the method of choice. In other instances, however, the psychotherapy of the whole family may constitute a required emotional preparation for intervention with individual psychotherapy, or, the two types of therapy may be employed in a parallel way. The relations between the two approaches will become more clear as we succeed in achieving a better understanding of the relations between the inner and outer aspects of human experience, between what goes on inside one mind, and what goes on between minds.

The basis of family treatment is the therapeutic interview with a living unit, the functional family group, all those who live together as family under a single roof and any additional relatives who fulfill a significant family role, even if they reside in a separate place. In this context, the unit of illness and health and the unit of treatment influence is then the family group; not the single patient in isolation, but father, mother, children, and sometimes grandparents as well. In family therapy one views the psychic functioning of the one person in the wider context of reciprocal family role adaptations, and the

psychosocial organization of the family as a whole, both in the here and now, and across three generations. In this special setting, amelioration of emotional illness requires step-by-step correlation of intrapsychic and interpersonal processes. Within this context, it is essential to view the balance of forces at three levels of integration:

1) A condition of overt illness with the emergence of organized symptoms.
2) A condition of vulnerability to mental breakdown.
3) A condition of effective health.

By contrast with this, in classical psychoanalysis, one focuses in a selective way on the intrapsychic distortions of one individual. The expectation is that as one modifies the internal balance of the components of the personality, emotional health in the individual's relations with the family group will be spontaneously restored. Sometimes this expectation is realized; sometimes it fails. Clearly, a shift toward health in family relationships is not the inevitable product of psychoanalytic treatment. In fact, it is by no means rare that following psychoanalytic treatment of one family member, there occurs a paradoxical worsening of family relationships.

In the psychotherapy of the family group, several main principles must be borne in mind. The breakdown of one member of the family, the nature of his disablement and the associated symptoms, may be viewed as a reflection of the emotional warp of the entire family. One can frequently delineate a specific correlation between the emotional pathology of the family group and the breakdown of a particular member. The individual who is first referred for psychiatric help is either the scapegoat for the pathology of the family or is a stand-in for a more critically disturbed member of the family. Often, a core of pathogenic conflict and associated defense patterns is contagiously passed down from one generation to the next. One must therefore be alert to the movement of a pathogenic disorder across three generations. As one observes a family at a given point in time, the elements of pathogenic conflict that originally contributed to the causation of a psychiatric disorder can still be traced in the contemporary conflicts of the family group, even though now they may be expressed in a modified way.

In disturbed families as a rule, there are multiple instances of psychiatric disorder. It is rarely the case that only one member of the family is emotionally disabled. The issue then arises as to the vicissitudes of interaction among the several disturbed members, and their further influence on the family as a whole, as well as their effect on the more vulnerable individuals. It is also clear that as one intervenes on the family, here and now, the focus of the most intense conflict and disturbance may shift from one part of the family to another. In this setting, it is possible to identify characteristic constellations of family conflict and characteristic patterns of family control. We shall return to this later.

Therapeutic family interview

In a typical therapeutic family interview, the family arrives in a state of distress. It is confused; it is in pain. Family as family has failed. The members know something is deeply wrong, but they cannot say what it is nor what to do about it. The therapist moves

immediately into the life space of the family's current struggles. He joins in these struggles. He is taken into the fold as an older relative, perhaps as a grandparent endowed with some special wisdom concerning the problems of family living. He is observer, participant, supporter, activator, challenger, and reintegrator of family processes.

At the outset, the therapist observes the order of entry into the meeting room, and the spontaneous way in which the family members arrange their seats. Who sits next to whom? Who sits away from whom? Do they look at one another? Do they see, hear, and talk? What is the dominant emotion and mood¾fear, hate, indifference, or apathy and resignation.

The therapist observes the characteristic reactions. Do the members lash out at or shrink from one another; are they alienated? He evaluates the quality of reaching out: Who wants what from whom and how? Is the assertion of these urges insatiable, or violent? Or is it over-controlled, denied, disguised? Or do the members now cease to ask and expect satisfaction from one another?

The first responsibility of the therapist is to arouse the dormant hope of these troubled people. He endeavors to make of the interview a touching experience. He seeks to touch and be touched, in effect, to make it a feeling experience for all. He tries to enhance the quality of interchange among the family members and with himself, to make it more live, more meaningful. Toward this end he makes pointed use of the subverbal aspects of communication: mood, facial expression, posture, gesture and movement. Words may be used to reveal or conceal valid emotion. The therapist neutralizes the common tendency to strip emotion from words. Watchful of each cue, he undercuts mouthings of trivia, in order to get access to the more significant emotional and bodily aspects of communication.

Parts of the family, individuals or alliances of twosomes or threesomes, combine with and separate from elements of the therapist's identity in accordance with need and the means of coping with conflict. The processes of joining with and individuating from the therapist involve elements both of transference and realism.

Currents of mistrust, hostility, defensiveness, and the associated trends toward alienation are noted by the therapist. He observes the configuration of emotional splits within the family, the warring factions and the protective alliances. Who is against whom? Who is allied with whom? He evokes explicit admission of hurts and barriers. He spurs an expanding awareness of fears, avoidances, and the resulting fragmentation in the relationship patterns. He pays particular attention to defensive trends toward displacement of certain conflicts, substitution of one conflict for another, or the prejudicial assault and scapegoating of one part of the family by another. He evaluates the relations between such scapegoating and the unconscious selection of one member of the family as a victim, pushing that member toward a form of breakdown. In a parallel sense, he observes the compensatory healing functions of the family, the way in which one member is unconsciously selected to play the role of healer of family conflict and

thus reduce the destructive effects of scapegoating. As he does this, the conflicts between and within family members come into cleared perspective.
Often the sense of tension and danger mounts in family interview process. The therapist must steer a path between Scylla and Charybdis. He must move between the extremes of rigid avoidance of the dangers of closeness, and the uncontrolled explosion of hostile conflict that tends toward panic and disorganization. Often, members of the family fear a loss of control. Through his own calm presence, the therapist offers the needed assurance against this danger. He marks out the interplay between individual defense against anxiety and family group defense of essential family functions. He engages in a process that I call "tickling the defenses," so as to undermine the pathogenic defense formations and encourage the substitution of healthier kinds of coping. He is alert particularly to the layers of insincerity in family relations, and attacks the hypocritical, righteous, self-justifying forms of defense. As the family conflicts become increasingly defined and more realistic solutions are sought, the intrapsychic symptom-producing conflicts of individual members tend toward external expression, that is, they are projected into the arena of family interaction.

A special challenge is the delineation of the core conflicts of the family and the family defenses. The therapist's aims in dealing with conflict are:

1) To help the family achieve a clearer, more correct perception of family conflict.

2) To energize dormant interpersonal conflict so as to bring them into the live processes of family interaction, where they are more accessible for solution.

3) To lift intrapsychic conflict to the level of interpersonal process, where again it may be coped with more effectively.

4) To neutralize unrational prejudice and scapegoating of one part of the family by another. The aim here is to remove an excessive load of anxiety from the victimized member by counteracting inappropriate displacements of hostility and conflict. Where possible the conflict is put back to its original source in the family group, often the parental pair. In this connection, the therapist often joins forces pro tem with the "family healer."

5) To activate an improved level of complementarity in family role relationships.
Family group defense against conflict, and the related impairment of family functions is distinct from individual defense against anxiety. Family defense may be specific or non-specific in varying degree. The end result of coping with conflict is the outcome of complex interplay between family defense and individual defense. The dominant forms of family defense play a potent part in the selection and in the operational efficiency of individual defenses against anxiety. A tentative group of family defenses is the following:

1) A shared search for a specific and suitable solution to conflict.
2) A shared avoidance or denial of a specific conflict.
3) Compromise formation: rational and irrational. This is exemplified in¾

a) emotional splitting of the family; fragmentation of the group
b) riddance or isolation of conflict
1) quarrels, alienation and reconciliation
2) a shift in the zone and content of conflict by substitution, displacement, protection, etc.
3) scapegoating and compensatory healing
4) Compensation: escape, diversion, drugs, alcohol, vacation and sexual escapades.
5) Shared acting out.
6) Reorganization of complementarity of family roles by means of:
a) reversal of parental and sexual roles, reversal of parent-child
b) "repeopling" of the family: removing or adding persons to the family unit
c) tightening of the family organization: rigidification of authority, sharper division of labor, constriction and compartmentalization of roles
d) loosening of the family organization:
1) dilution of the family bond, distancing, alienation, reduced communication and role segregation
2) thinning of the border between family and community, displacement of need and conflict from inside the family to outside

When these family defenses fail, the essential family functions become disabled, selectively and progressively. The family moves toward breakdown.

The responsibilities of the family therapist are multiple and complex. They require the most flexible, open, undefensive use of self. The therapist must be active, spontaneous, and make free use of his own emotions, though in a selective and suitable manner. His prime function is to foster the family's use of his own emotional participation in the direction of achieving a favorable shift in the homeostasis of family relationships. He loosens and shakes up preexisting pathogenic equilibria and makes way for a healthier realignment of these family relationships. In this role, his influence may be likened to that of a catalyst, a chemical reagent, a re-synthesizer. He seeks constantly to understand the relations between inner and outer, intrapsychic and interpersonal experience. He matches conscious against unconscious, reality against fantasy. He mobilizes those forms of interaction that maximize the opportunity for undoing distorted percepts of self and others, for dissolving confusion, and clarifying the view of the salient conflicts.

The therapist provides, where needed, acceptance, affirmation of worth, understanding, and support. By his own attitudes, he validates genuine expressions of emotion, whether a frustrated need or justified anger. He offers a selective support for the weaker members against the stronger; he gives recognition to thwarted personal needs, crystallizes unreal fears of injury and punishment, opens up new avenues of satisfaction, and provides an expanded interactional matrix for reality testing. He injects into the family something new, the right emotions and the right perceptions in place of the wrong ones. Crucial to the entire effort is the breaking down of anxiety-ridden taboos against the sharing of vital family problems.

The therapist facilitates the efforts of the family to balance sameness and difference, joining and individuation in the ongoing processes of family life. He affirms the positive foundations for shared experience and identification. He awakens respect for differences. In this way, new levels of sharing, support, intimacy, identity, and a greater degree of mutual need satisfaction become possible. The therapist activates the need for a critical examination of family goals and values, especially those which pertain to the basic functions of husband and wife, father and mother, parent and child, child and sibling, parent and grandparent. As the members rearrange their lines of joining and separation, the therapist spurs recognition of the potentials of new growth and creative experience in family living.

Now, let us sum up the nature of this approach to the family as the unit of health. It offers the challenge of evaluating and treating a system of interacting personalities. It requires continuous correlation of the inside of the mind and the outside, the ongoing interconnections of intrapsychic and interpersonal experience. It necessitates a continuous juxtaposing of conscious and unconscious, real and unreal, inner and outer experience, individual and group. It presents the problem of integrating within a single theoretical system all elements of causation, specific and nonspecific, inner and outer, generic and contemporary. The field of observation and the field of influence in family diagnosis and therapy is an expanded one. It involves the internal organization of personality, the dynamics of family role adaptation, and the behavior of the family as a social system. Family therapy deals explicitly both with the forces of illness and health. It intervenes on contemporary conflicts with the assumption that the past sources of pathogenesis are contained in the present conflicts, though now differently organized. It defines the disorders of individual personality within the broader frame of the social psychological distortions of the family system. It assumes that the forces of the individual and the forces of the family are interdependent and interpenetrating, that these relations are relevant to causation, course and outcome of illness and response to therapy.

By contrast, psychoanalysis deals with the one isolated personality. It intervenes on pathogenic foci within the person, expecting that as the intrapsychic distortions are removed, the potentials for healthy readaptation will be spontaneously realized. As earlier indicated, however, this does not always occur. Psychoanalysis moves mainly from inside-outward, whereas family therapy approaches the relevant processes partly from outside-inward. In its orientation, psychoanalysis is biologistic, mechanistic, genetic. It tends somewhat to isolate the patient from family, and family from analyst. It focuses in a specialized way on older, entrenched forms of conflict with organized symptom formation. To some degree, it emphasizes the schism between fantasy and reality, pleasure and pain, individual and group, thus separating inner and outer experience. In order to minimize acting-out, it aspires to a halting of time and life, while the internal imbalance of the components of the personality are therapeutically realigned. It deals less with emotional health in a positive sense; it does not give us a picture of learning and creative expansive development. It does not give us a healthy image of family relations. To some extent, it obscures the core problem of homeostasis in family relationships.

This is not to raise the question of the one method of treatment being superior to the other. It is rather that they are differently oriented; each does something else. Of the two methods, psychoanalysis is more specialized; it achieves a unique access to disturbances which have their source in the unconscious mental life. By contrast, family therapy approaches conflict experience in a broader matrix of human relations and at multiple interpenetrating levels.

It is easy to exemplify the contrast in orientation of the two methods. Freud judged relatives and family mainly in terms of their nuisance value. In his view, they posed for psychoanalysis the threat of invasion and contamination. He said: "The interference of relatives in psychoanalytic therapy is a very great danger, a danger one does not know how to meet.... One cannot influence them to hold aloof from the whole affair."

Perhaps nowhere in the whole sphere of evolution of psychoanalytic thought is the question of the relations of the individual to his family group more crisply posed than in the field of child analysis.

Anna Freud pointedly indicated that the child's ego takes its cue from the social interaction processes of the family, but there she stopped, since she was not in a position to investigate these relationships. Interestingly enough, it was Anna Freud who first offered the candid assertion that both child analysis and the analysis of students of psychoanalysis violate the rules of analytic technique. Both in the relations of the child patient with his analyst, and in the relations of an analysand with his training analyst, there are face-to-face relations. The patient and analyst know one another as real persons. Direct gratification of need, support, control, even explicit guidance and advice, are a part of the analytic experience. To my mind, Anna Freud's significant disclosure that both child analysis and student analysis violate the classical rules of analytic technique raises some crucial questions concerning the theory of psychotherapy, as this affects the relations of real and unreal, individual and group.

At the extreme of the procedures of child analysis, Melanie Klein went so far as to prohibit the mother of a patient from sitting in the waiting room during the child's analytic session, lest this disturb the unfolding of the child's transference fantasies. The psychoanalytic philosophy concerning child-mother relationships epitomizes in a way the whole problem of the relations of the individual with his family group. In the more conservative forms of child analysis, when the mother is categorically excluded from the private sphere of the child's analytic experience, we have a representation of the tendency of psychoanalysis to isolate the one patient from mother and family. On one occasion, when I asked a well-known child analyst if she ever undertook the analysis of mothers of her child patients, her instantaneous exclamation was, "Oh, heavens no!"

In retrospect, one cannot help but wonder how far this historically-patterned isolation of the analytic patient from family is related to the limitations of therapeutic potency of psychoanalytic treatment. Concerning the therapeutic value of psychoanalysis, there is some persistent and lingering doubt. Weingarten's statistical survey of therapeutic results with psychoanalysis is not encouraging. Karl Menninger echoed a similar skepticism. He

said: "True, Freud warned us against the emphasis on the therapeutic effect it does have, but in my opinion, were this its chief value, psychoanalysis would be doomed." Menninger emphasized not so much the therapeutic potency of psychoanalysis as its educational and research value.
Perhaps the problems of difference between family psychotherapy and psychoanalysis may be illuminated if we compare two theoretical models of psychotherapy:

1) The psychotherapeutic process conceptualized as a one-person phenomenon, non-social, though influenced by an external agent, the psychoanalyst.
2) The psychotherapeutic process viewed as a two-or-more-person, true social phenomenon.

In the first model, with a non-social matrix of psychotherapy, the analyst is not a real person; he is anonymous; he hides his face; he is a mirror reflecting only what is shown to him; he gives no direct emotional satisfaction; he withholds the usual social cues; the social representations of reality are excluded.

In the classical model of psychoanalytic process, conflict with the analyst is reinterpreted in terms of conflict with older parts of the self. It is referred back to childhood conflicts with family. Transference is dominant over the existing realities. The analyst personifies objective reality, but the testing of such reality is postponed, both as epitomized in the real person of the analyst and in the objective world of human relations. Insofar as the analyst has no face, no identity, shows no emotions, this cannot be a true social experience.

Classical analytic technique favors the reliving of the symbiotic, autistic, magic core of the psyche¾the egocentric, entrenched conflicts which contain the distorted percepts of the original, joined infant-parent relation and corresponding fragments of body image. The patient projects irrational conflict-ridden emotions, fantasies, and magic expectations; that is, primary process comes into a position of dominance. The analyst injects the modifying, organizing, and disciplining effects of secondary process. The patient subordinates his ego and external reality. He expands his unconscious, while the analyst contributes insight, reason, reality, and conscious control. Between the two persons, we have the functions of one mind.

The moment we shift to the second conceptual model, a two or more person interaction model, we have a true social experience; an interaction between two or more minds, as compared with patient and analyst recreating the symbiosis of one mind in the infant-parent union. In the second model, we have an expanded foundation for the dynamics of personality, a biopsychosocial model. In this therapeutic setting, we must match:

1) Intrapsychic and interpersonal events.
2) Unconscious and conscious organization of experience.
3) Unreal and real; transference and reality.
4) Past and present.
5) Individual and group.

Transference in this setting may be conceived as a failure of social learning. Transference, resistance, working through, interpretation, reality testing, all become interrelated parts of a unified process. Patient and therapist influence one another in a circular fashion.

In Freud's psychoanalytic frame, symptom, defense, transference, change, and cure have one kind of meaning. In family psychotherapy, with face to face relations and true social interchange, symptom, defense, change, growth and cure hold a broader significance. Conflict, symptom, defense in this setting are more than a walled-off intrapsychic distortion, a phobia, a hysterical conversion or an obsession. In family therapeutic process, they acquire the broader definition of certain recurring, predictable, interactional patterns inappropriate to the prevailing realities of the group. While intended to assure stasis for the individual, they actually impair homeostasis. They produce progressive distortion in the balance of family role relationships. In family psychotherapeutic process, a symptom becomes a unit of interpersonal behavior reflected in a constellation of shared conflict, anxiety and defense which is unrational, inappropriate, automatized, rigid, repetitive, and has the effect of constricting and distorting the range of new growth. The resulting impairments in family role adaptation move in one of two alternative directions: either toward rigidification, narrowing and stereo-typing of roles, or toward an excessively rapid, fluid and unstable shift of multiple roles, which entails a threat of loss of self. Healthy family role adaptation reflects a quality of behavior intermediate between these extremes. It involves an optimal balance between the need to cling to elements of the old way and the ability to try a new way. The degree of success in coping with conflict molds this balance. An excess of anxiety impels a sticky clinging to the old way, narrows the receptivity to new experience, and reduces ability to discover new and better levels of family role adaptation. A lessened anxiety shifts the balance in the opposite direction.

In family therapeutic process, the realities of the group situation are an ever-present force. The therapist functions as a real person, as well as the target of projection. Though the realities of the group are fluid and changing over the course of time, the emotional impact on the family members is an immediate one. The family therapeutic experience offers a selective gratification of emotional needs. It favors motor release of emotion. It provides a matrix for the resolution of conflict at the level of action and reaction, in a continuous impact between the image of self and other. Conflict is lived out in interpersonal relations; it is externalized, experienced in action. Thus, therapy provides satisfaction of valid emotional needs, avenues for the solution of conflict, support of self-esteem, buttressing of healthy defenses against anxiety and an expanding interpersonal matrix for growth. In such a setting, the therapist injects something of himself that is new for the family members, the right emotions and perceptions to neutralize the wrong ones. True change toward health comes with a progressive testing of new ways of thinking, feeling and doing. Gradually, a new synthesis of percept, affect, bodily expression and social action may be achieved.