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**ETHICAL AND SOCIAL ISSUES IN INDIVIDUAL AND FAMILY BASED
THEORIES: A FRAMEWORK FOR INTEGRATION**

City University of New York

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ETHICAL AND SOCIAL ISSUES IN INDIVIDUAL AND FAMILY BASED
THEORIES: A FRAMEWORK FOR INTEGRATION

by

SARA PALMER

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CHAPTER ONE

INTRODUCTION: RATIONALE FOR AN
ETHICAL EXAMINATION OF THEORY

An examination of the literature of psychoanalysis and family based approaches to psychology reveals a dichotomy on both theoretical and technical levels. While there have been some attempts to integrate these approaches in clinical practice, theoretical integrations have been scarce and inadequate. Several reasons have been proposed to explain the difficulty of integrating these approaches: the temptation to simplify theory, the use of different patient populations for theory building, and the use of different data in theory formation, i.e. "inner" dynamics versus "external" behaviors (Slipp, 1973; Stierlin, 1977). Other explanations of this dichotomy point to the unfortunate tendency of any theoretical construction to become a constricting force on future observations, limiting one's ability to assimilate new ways of thinking (Bowen, 1978).

All of the above hypotheses for the separation of analytic and family approaches appear to have some validity. It is my contention, however, that the inadequacy of integration in this area is due as much to conflicts in the value systems and social-political implications of each of these models as to their differences in applicability, simplicity, or "rightness." Further, there are ethical issues peculiar to each of these approaches to human experience (and their associated therapeutic methods) which

tend to intensify their opposition. The perspectives on psychological understanding offered by these approaches reflect differences in basic philosophical and ethical assumptions, and have varying implications for the relationship of psychology to social and political reality. These differences are rarely addressed in the literature supporting one theory or the other, and are strikingly absent in the existing attempts to bridge these theories. I believe that this has been a major stumbling block in the development of a unified analytic-family theory, and has contributed to a degree of defensiveness on both sides of the argument. These ethical and social issues are highly charged emotionally, and it is this aspect, as well as the intellectual acceptance of a particular set of hypotheses, which has resulted in the inability of analytic theorists to "see" family dynamics (Bowen, 1978) and vice versa. Thus, any theoretical reconciliation of intrapersonal and relational models of psychology must begin with an examination of the values and philosophies implicit in them; when the ethical, philosophical and moral issues underlying these approaches are exposed, then a truly psychological integration may be possible.

My interest in the interface between psychology and social values began with my reading on family therapy; I soon discovered that differences in value orientation were to a great extent responsible for the distinction between family therapists and their individually focused colleagues. While analysts valued autonomy, achievement and individuation, family therapists seemed more concerned with cooperation, interdependence, and mutuality. Where

family therapists stressed the importance of open communication among family members, analysts stressed the importance of privacy and the confidentiality of the patient-therapist relationship. And while analysts professed the importance of insight and understanding, family therapists appeared more concerned with behavior and functioning.

Although some authors have dealt openly and explicitly with value questions, many have ignored or glossed over the issues involved. Family therapists are as guilty of ambiguity in this regard as are the analysts who boast of a "value-free" therapy; and one family therapist acknowledges the need for "younger people starting with the advantages of our insights . . . [to] identify the values implicit in our work" (Bell, 1975, p. 286). It was this challenge that originally piqued my interest and which I am taking up again in the present work.

My interest was rekindled by two articles concerned with the effects of psychotherapy on the family members of the patient (Fox, 1963; Glasser, 1968). Both cited negative effects on family members and suggested family therapy or regular therapist-family contacts as a possible solution. Additionally, these articles raised an important ethical question: Is it ethical to treat any one person to the exclusion of his family members when those members may be adversely affected by the treatment? This poses a challenge to the individual-analytic model that is based not on theory per se, but on the practical and ethical ramifications of its application.

One is confronted with such value questions as whether it is "good" if a patient gets "better" and also gets divorced.

The values of family integrity on the one hand and individual growth on the other, are important in differentiating family from analytic theory and therapy. In their critique of psychoanalysis, Pinckney and Pinckney (1965) question the logic of using analytic therapy for treating marital and relationship problems, and the ethics of treating such problems with a technique that is based on a therapeutic alliance with a single individual. They express the view that, despite its avowed neutrality, individualized analysis implicitly condones unilateral decision making, and thereby tampers with the moral and ethical codes on which family relationships are based. Their thesis underscores the fact that moral judgments and social values are important elements in theory formation and treatment choice.

The issue of unilateral decision making raised above touches on another important area of ethical concern: exploitation. Exploitation occurs whenever the needs or freedoms of another person are sacrificed in favor of one's own; it is the other side of loyalty. Loyalty is an essential aspect of both therapeutic and family relationships and it has been proposed that individual analytic therapy which fosters a powerful "positive transference" can create conflicts between a patient's loyalty to his family and to his therapist (Boszormenyi-Nagy & Spark, 1973). Psychopathology considered from a family systems perspective represents an important ingredient in the family loyalty system, so that any

improvement in individual therapy poses a threat to family relationships. The results may be a lack of progress, or an improvement accompanied by increased existential guilt (i.e. guilt in connection with real relationship events, as opposed to neurotic guilt). Within this view, treatment that is totally centered on the individual is considered not only therapeutically inadequate for the patient, but also ethically questionable as regards the family: "[w]ithout consideration of the other's needs, therapeutic exploration will be limited to the context of unilateral use of others, and in all likelihood reinforce exploitation" (Boszormenyi-Nagy & Spark, 1973, p. 174).

From the other side, the family itself has also been accused of exploitation. Some therapists blame parents for the psychological problems of their offspring, and even advocate the removal of very disturbed children from the home for the purposes of treatment away from the influence of presumably pathogenic parents (Bettelheim, 1950). Others point to the family's role as an agent of social control, pulling for conformity and preventing children from discovering their autonomy and separateness. Children can be "glued" to the family and used by the parents to fulfill their own needs (Cooper, 1970); and children are particularly vulnerable to such exploitation because of their basic dependence (Slipp, 1973).

These considerations have at times been viewed as contraindications for family therapy, the logic being that as long as the child remains in the family system, he will be used by it. This

may be especially true for the schizophrenic, who is pathologically dependent on his family and thus more easily exploited. Yet, the reciprocal nature of family relationships means that a child so exploited gains a certain power in relation to his parents, who he can exploit in turn by remaining ill, blaming his parents, and playing on their guilt (Stierlin, 1976). Viewed this way, the family is seen as mutually, rather than unilaterally exploitative, and family therapy may be a logical choice for breaking into the destructive cycle. In either case, the issue of exploitation remains an important ethical concern for both family and individual therapy.

Other areas of social and ethical concern in family therapy and psychoanalysis emerge when their varying relationships to the field of medicine are examined. Psychoanalysis originated as a treatment for painful and debilitating symptoms, but soon became a "substitute for religion, politics, and philosophy" (Fromm, 1970, p. 2); it became a tool for self examination rather than a treatment for disease. Family therapy, thus far, has retained a pragmatic and experimental outlook, focused more on functional improvement than the promotion of insight.

A paradox arose when psychoanalysis broadened its scope to become a philosophy of living rather than a treatment per se. Despite Freud's (1926) support for nonmedical analysts, the analytic establishment, particularly in America, was reluctant to give up its medical status (Roman & Trice, 1974). Whereas the move towards philosophy could have turned analysis towards the

idea of self improvement for healthy persons, the reluctance to dispense with a medical model resulted instead in a widening of the psychoanalytic concept of "neurosis" to include a greater portion of the population (Gorovitz et al., 1976). Thus, what began as a movement away from a treatment model ended up as a redefinition of "abnormality" and an expansion of psychoanalytic "medicine."

In a similar paradoxical fashion, family therapy, which had as a major impetus the search for an effective treatment of a poorly understood "disease" (schizophrenia), quickly became focused on the practical problems of helping a family and its disturbed member(s) to function more effectively; the emphasis switched from the dimension of normality-abnormality to one of function-dysfunction, and hence to an interest in expanding potentials for health rather than curing disease.

The use of a medical model has important social implications. A label of "abnormal" may be implicitly more coercive than one of "immoral" or even "deviant," for it implies that one is sick and in danger, ultimately, of death. This creates anxiety, reinforcing the coercion to become "normal" in order to be safe (Gorovitz et al., 1976).

The medical model also perpetuates an individualized view of psychopathology. By fixing the "sickness" within the individual patient, the influences of other persons and of society upon the patient are minimized and their responsibility ignored (Bowen, 1978). Such a stance may become oppressive, particularly for

persons who cannot hope to achieve the goals of psychoanalytic therapy without first changing the conditions of their environment--social, economic, or political. An obvious example is the victim of child abuse; "his" psychological "abnormalities" are created by his environment and are unlikely to change if the abuse continues. Less obvious, perhaps, but no less pertinent, is the plight of women and minorities whose potentials for health are restricted by the prejudices of society. It has been argued that the medical model is ineffective and perhaps oppressive for these groups: "'Feminist therapy' involves an inherent contradiction. The feminist objective is . . . that women may have opportunities equal to those of men . . . When a woman is depressed or anxious, the feminist looks for a probable cause in the facts of her underemployment . . . Solutions to these problems are not to be found in individual pathologies, but in changing the behavior of persons in the woman's environment" (Tennov, 1976, p. 191).

This view raises the question of what therapy should be, and what role the psychologist should play in helping patients to change society, questions I address in more detail in the following chapters. Tennov (1976) advises and supports clients in their struggles with changing environmental conditions, and finds behavior therapy liberating because of its focus on environmental causes of individual problems. Halleck (1978) also supports the view that therapy which treats an individual's symptoms without concern for environmental factors, is "taking an incomplete and unscientific approach to treatment" (p. 140). He contends that

therapists are responsible for making patients aware of ways in which social conditions contribute to their psychological difficulties, and of the potentials and limitations of their abilities to alter these conditions.

Family therapy represents an intermediate step between individual treatment and large scale social change. Leading therapists away from the "medical model dilemma" (Bowen, 1978), family work defines psychology in terms of human interaction rather than individual dynamics. Such work can be applied to help families deal with problems that stem from social conditions. By coping with these problems families may in turn begin to change those same conditions. For example, couples may need help adjusting their lives to the changing role of women in our society. By decreasing the discrepancy between their new consciousness and their actual behavior, they help bridge the gap between accepted social rhetoric and current social reality, thereby increasing the actual rights and powers of women (Halleck, 1976).

Although family work has potential to become a truly "social therapy" (Ackerman, 1966), it too, can be socially oppressive. Whether the effects of family treatment extend beyond the individual family depends partly on the therapist's goals and values. A therapist may help a family to cope with some of its internal problems, while effectively distracting them from the reality of their extrafamilial social situation. Similarly, a therapist may use his leverage within the family to impose norms and values of his own which are inappropriate for the family, a danger that

is most apparent when therapist and family are of different ethnic or racial backgrounds. Therapists may, perhaps unintentionally, favor the status quo by setting up psychological goals contrary to what is required for the family's integrity within the society. For example, "the value of individuation so often invoked by therapists is one that . . . may not . . . be useful to certain oppressed family groups in our society who must remain firmly enmeshed if they are to survive" (Halleck, 1978, p. 485).

The social merits of family therapy may also be questioned in terms of its emphasis on maintaining traditional family units. At a time when the traditional family appears to be a sinking ship (evidenced by rising divorce rates, for example), some favor its abandonment and the adoption of new social-familial structures. Family therapy may also be seen as supporting outmoded sex roles and fostering a work ethic. Just as psychoanalysis has at times been faulted for defining political radicalism as an expression of neurotic conflict (Roman & Trice, 1974), family therapy may be criticized for promoting social adaptation through palliative changes within individual families. Both family and individually based theories have implications for social change and social oppression. The ways in which their social potentials are expressed theoretically and therapeutically are detailed in the following chapters.

Several authors have suggested avenues for the integration of individual and family based concepts in psychological treatment and theory (Laing et al., 1966; Feldman, 1979; Halleck, 1978;

Slipp, 1973). Yet few authors have dealt with the dimension of values and ethics in formulating an integrated theory. Stierlin (1976), however, looks at the interrelationship of individual, family and social dynamics, suggesting that disturbances in social values are related to repressive forces on individual and family levels. He sees the family as a microcosm of society and its dysfunctions as both reflections and potential causes of greater social and political problems. The repressive capacity of the individual unconscious is repeated in the family's capacity to hide certain patterns of motivation and defense. The lid on awareness of these intrapsychic and intrafamilial dimensions is "sealed" with acceptance of socially sanctioned "value standards and modes of defining our feelings and interactions" (Stierlin, 1977, p. 42); this in part accounts for our capacity to deny problematic social and political realities.

These considerations imply that a truly liberating and successful therapy must challenge the value standards and morals of society, and break the seal on awareness of social-political realities as well as intrapsychic and familial ones. Acknowledgment of the validity of both intrapersonal and interpersonal factors in behavior and experience is a prerequisite to this therapeutic goal, and attempts to integrate family and analytic ideas are a step in this direction. But integration on a technical level alone does not necessarily lead to the challenging or changing of social conditions; this outcome is primarily dependent on the philosophical and theoretical basis of the therapy and the values and

ethical standards filtered through the therapist to the patients. I believe that family and analytic theories cannot be welded into a socially meaningful gestalt without some clarification and unification of the ethics and values they imply. The lack of value clarification in efforts to combine family and analytic concepts has resulted in treatment that cannot promote a value position without ambiguity and reservation, and theoretical integrations that are murky with respect to ethical and social issues. A failure to fully explore these issues is a major deficiency in the existing attempts to reconcile analytic and family approaches.

The purpose of the present study is to examine analytic and family theories from this ethical-social vantage point and to use this examination towards the goal of rudimentary convergence. In addition to discussing differences and similarities in values, the study identifies several similarities in the conceptual basis of analysis and family theory and develops a psychological framework that incorporates some aspects of each approach. Therapeutic methods are suggested for dealing with human problems on both individual and relational levels, and the social implications of this approach are discussed.

The study considers the social significance of viewing psychological experience as a predominantly intrapsychic or predominantly interpersonal phenomenon, and addresses the question of how a partial reconciliation of these perspectives can contribute to a psychology that is more consistent with the demands of current social reality. Finally, the study outlines a value system based

on humanistic and ecological concepts, as a framework for the development of psychological concepts and techniques that facilitate the health of society on multiple levels.

CHAPTER TWO

PSYCHOANALYSIS AND FAMILY SYSTEMS THEORY:

BASIC ASSUMPTIONS, CONCEPTS AND VALUES

The task of this chapter is to identify those elements of psychoanalysis and family systems theory which contain implicit and explicit value judgments and ethical standards. Psychologists committed to what is perceived as a purely scientific viewpoint, may fail to see the manner in which morals, values and ethics shape their theoretical constructs and limit their therapeutic efforts. This chapter will attempt to bring to light some of these values, and to point out some social and political implications of analytic and family centered theory.

Basic Assumptions

"Psychoanalysis makes a basic assumption, the discussion of which falls within the sphere of philosophical thought . . . We know two things concerning . . . our psyche or mental life: Firstly, its bodily organ and scene of action, the brain . . . and secondly, our acts of consciousness . . . Everything that lies between these two terminal points is unknown to us, and so far as we are aware, there is no direct relation between them" (Freud, 1940, p. 13).

The relation of which we are not aware, according to Freud (1940) is the unconscious, the greatest portion of our mental life. The assumption of the unconscious formed the basis for analysis: the elucidation of unconscious processes and their relation to conscious experience and behavior. That actions and feelings could be controlled largely by mental forces of which one is unaware was a disturbing notion to Freud's Victorian contemporaries. Yet the

concept of unconscious processes has become so entrenched in 20th century thought that we tend to see it as a given, rather than a postulate. It is important to recall that despite its significance in modern psychological thinking, the unconscious is nevertheless a hypothesis and not a fact.

Freud arrived (1940) at the theory of psychoanalysis by "studying the individual development of human beings" (p. 14). Psychoanalytic theory is based on data gathered from individuals; it assumes that the individual is the most relevant unit on which to build a theory of human experience, and generates an understanding of the latter within the boundaries of an individual perspective. These boundaries allow for depth and clarity in analysis of psychic life, but sacrifice a broader view of human interactions. Human psychology is so varied and boundless that it is impossible to attend to all its aspects simultaneously, and psychologists are faced with the task of limiting themselves to a set of observations which can explain only a part of our experience and behavior. The choice of observations to which one attends, however, is not a random process, but one involving factors of interest, temperament and values. Freud and the analytic theorists who followed him, chose the individual as their unit of study not because of an intrinsic superiority of individuals over groups, but because the individual perspective and the importance of the individual as a social unit were widely valued in society. While the individual is a logical focus for psychological study, it is not the only logical one; theorists whose values and interest center on familial

or group concerns have used social groups as a focus of psychological analysis with different, but equally valid results.

Psychoanalytic theory looks at personality dynamics in terms of developmental stages, with particular emphasis on psychosexual conflicts and their resolutions as developmental tasks. Although some attention has been paid in psychoanalysis to cognitive, moral and social development, psychosexuality is seen as the major axis around which psychological development occurs. Proceeding through the oral, anal, phallic, and genital stages, along with resolution of the oedipus complex are assumed to lay the foundations for development of a healthy adult personality, and deviations from this sequence are thought to be predictive of psychopathology. Thus psychoanalysis sees personality as developmentally rather than environmentally determined, and emphasizes the importance of developmental tasks which are normally complete by adolescence, rather than examining psychological influences throughout the life cycle.

In psychoanalytic theory, personality is thought to evolve by a differentiation of the "psychical apparatus" into id, ego and superego. It is the relative harmony of these structures which is presumably responsible for psychological well-being, and the conflicts, interactions and compromises between these structures which result in individual personality dynamics. Though the superego represents parental and social rules, it does so through a process of internalization and becomes an entirely intrapsychic structure. Similarly, the ego, which mediates between the superego

and internal drives, allowing for interaction between the person and his environment, is assumed to be a primarily internal agent. Frequently in psychoanalytic writings the ego is characterized as influenced more significantly by intrapsychic events than by actual others in the environment.

Family systems theory assumes that individual development occurs within a social context and that for most people the most significant context to understand is the family. Presumably, the family system offers the most relevant data for an understanding of individual behavior and experience, as well as the dynamics of the system per se.

Family systems theory examines individual development and personality within the family context, and assumes that each individual is largely interdependent with other members of the family. Use of the entire family system as a unit of study allows for a broader perspective than is possible with psychoanalysis. On the other hand, it frequently implies a sacrifice of in-depth analysis of each separate family member. Whereas psychoanalytic theory views the ego as autonomous and responsive to internal stimuli, family systems theory defines the self of each person in relation to his family members, and sees the intrapsychic experiences of each person as determined to a great extent by external relationship events.

Family systems theory assumes that family relationships are complementary and reciprocal (Boszormenyi-Nagy & Spark, 1973), that is, that a change in the behavior of one member will produce

compensatory changes in other members. While the family system is in equilibrium, small shifts in the behavior of an individual member will be absorbed by the system, and both the individual and the family system will appear stable and internally consistent. But a major shift in an individual which changes the balance of family relations may lead to the development of symptoms in a previously stable member, or alternatively, to increased growth and positive change. Thus, the primary assumption of family systems theory is that the individual is in constant interaction with members of his family system, and can best be understood with reference to events within that system.

In family systems theory, interpersonal communication is assumed to play a central role in the developmental process. Where communication is relatively clear and unambiguous, allowing for exchange of information and adequate problem solving, families will function well and their children will develop normally. The ability of parents to clearly communicate their feelings and expectations to their child is central to the child's psychological health. On the other hand, mixed messages, in which contradictory information or demands are simultaneously expressed, put the child in a situation where he cannot know to which communication he should respond. When family communications are obscure or contradictory, and when the child can neither escape nor comment on the contradiction, he is in a "double bind" (Bateson et al., 1956) or no-win situation, which can result in psychopathology manifest by idiosyncratic or bizarre thinking. Thus schizophrenia, which

presents perhaps the greatest disorder in communication, is viewed by family theorists not as an individual illness, but as a "particular communication pattern inseparable from the communication patterns observable in the natural group in which it occurs" (Palazzoli et al., 1978), generally the family.

Conceptual Similarities and Differences Between Psychoanalysis and Family Systems Theory

Psychosexual development and the laying down of intrapsychic structures, which are given primary importance in psychoanalytic theory, are processes which begin at birth and are virtually complete by the end of the oedipal period. Refinements of the ego and superego take place at later points and the genital stage does not achieve full prominence until adolescence, but the essential building blocks for adult development are presumed to be laid down in childhood and the experiences of the early years are thought to exert a major influence on psychic functioning throughout adult life. Thus psychoanalytic theory relies on past experiences of an individual to explain his present. In terms of theory, the focus on the past is seen in concepts of regression and fixation used to explain adult pathology, while in psychoanalytic therapy, it is manifest in the techniques of remembering and reconstructing utilized towards resolution of conflicts presumably rooted in childhood. Though the ultimate goal of psychoanalysis is to enable the patient to live more productively in the present, analysis of past history is the primary means to this end.

Family systems theory also makes use of history in explaining present events. However, rather than delving into the developmental history of each individual, family therapy explores the history of the family relationships, often going back two or more generations. Just as fixation or regression can be used to explain individual neurotic symptoms, the discovery of multigenerational relationship patterns can help to account for current dysfunctions in marital or parent-child relations. While the primary focus of family systems therapy is on current communication and interaction patterns, family history is used to help in understanding the development of current family roles and relationships. What distinguishes family therapy from analysis in terms of historical data, is not so much that family systems therapy rejects the use of an historical perspective, but that it focuses on interactional history rather than intrapsychic, developmental history. Family theory is relatively more concerned with the present situation of patients than is psychoanalysis, because it views personality and pathology as interactionally rather than developmentally determined. Its concern with past events is centered on what actually occurred between people in the family, rather than on the internal reactions and experiences of each member of the family in relation to historical events.

Psychoanalytic and family systems theory differ in the "geometry" of their explanations. In psychoanalysis, behavior is generally explained in linear terms: that is, some event or experience is presumed to cause another, which results in a third and so

forth. For example, a mother's seductiveness may be viewed as the cause of her son's passivity and difficulty leaving home. Within the individual perspective, however, the mother's behavior cannot be explained, except by using her reaction to the son's behavior as a starting point; but then the reason for the son's behavior would be obscure. The framework of unidirectional or linear explanation, which views the individual only from his own perspective, limits the psychoanalytic process to the understanding of only one person at a time. Family systems theory, on the other hand, uses a circular scheme for analyzing the behavior of a family. Rather than viewing the mother's behavior as the cause of the son's (in the above example), a circular explanation looks at the way the mother-son interaction fulfills needs for both parties, and ignores the question of causality. In a circular model, the behaviors of two or more people are seen as complementary and interwoven, so that their interaction is maintained without any one person acting as the cause of the other's actions or feelings (Palazzoli et al., 1978). The task of therapy in linear terms might be to help the individual resist or cope with the influences of others, whereas in circular terms, the task involves interrupting the cycle of interaction which is maintaining maladaptive behavior and tension in relationships.

Psychoanalytic and family systems theory are similar in their view of symptoms. Whereas the symptom is viewed in some schools as the problem in itself, psychoanalytic and family systems theory share the view that the symptom is merely an indicator of a more

profound psychological or interpersonal difficulty. Rather than treating the symptom alone, both analysis and family therapy attempt to address underlying processes which are presumed to be at the root of symptom development. However, while psychoanalytic theory gives symptoms primarily an intrapsychic meaning, family systems theory sees them as relational phenomena, having significance for the entire family system of the symptomatic member. In psychoanalytic theory, symptoms are seen as a compromise formation, employed as a partial solution to intrapsychic conflict between the expression of and defense against an impulse. In family systems theory, symptoms are viewed as signals or communications about family problems. The symptomatic member alerts the family and/or the extra-familial world that something is wrong in his family. His symptoms are not so much a psychic compromise as they are a compromise between individual needs and the need to draw attention to and resolve the relationship problems of the family system.

Value Differences and Similarities

Systems theory views psychological health or illness as determined by the dynamics and needs of an entire interrelated group, not by isolated processes within an individual psyche. The assumption that individuals are always mutually dependent and reciprocally related to each other means that an individual's state of mind and his behavior cannot be understood as things unto themselves, but become intelligible in relation to his interpersonal context. Thus the context (family group) is valued as an existential

necessity. Underlying family systems theory is a dialectical philosophy in which the reality of one person has meaning only in relation to the lives of others (Buber, 1965). From this perspective, analysis of the individual without reference to his significant others is problematic, for his separateness is achievable only with an awareness of his connection with others to separate from. But this is not to say that systems theory has no concern with individuals. In fact, interdependence and relatedness are valued largely because it is out of one's mutuality with others that one emerges most distinctly as an individual. The value of individuation is one that family systems theory shares with psychoanalysis; it is in the definition of the process that the two theories differ.

In family systems theory, individuation is thought to occur in the process of maturation within a family context, in which the child is at first totally dependent on his parents and later assumes responsibilities commensurate with his age, until eventually, he can relate to his parents as equals. Ultimately, he may "parent" his mother and father in their dependent later years. Thus the relation between parent and child is seen by systems theory as an ongoing process, which evolves throughout the life cycle of the family. Physical distancing from one's family of origin, or an attitude of "rugged individualism" are often viewed by systems theorists as pseudo-individuation attempts, masking strong emotional ties to the family and a fear of accepting obligations or "unfinished business" with regard to family members.

Such a perspective is common among many analysts, too. But it is usually more than countervailed by an interpretation of individuation as a mastering of intrapsychic conflicts which results in emotional independence and the establishment of a unique identity. Although both theories see individuation as a process essential to psychological maturity, psychoanalytic theory sees it as primarily an intrapsychic process, whereas family systems theory sees it as occurring within the ongoing process of family relationships.

The conception of human nature reflected in psychoanalytic theory differs in important ways from that of family therapy. While Freud's theory acknowledges the importance of family in individual development and in the socialization process, it depicts basic human nature in terms of sexual and aggressive drives; "civilized" behavior depends on the suppression of natural instincts and the interaction of impulses with obstacles to their gratification.

Although modern analysts (e.g. Rapaport, 1967) believe that "motivating values" eventually gain autonomy from drive-reality conflicts, it is maintained that social values originate as defenses against more basic antisocial impulses. Rapaport (1967), for example, explains altruism as a reaction formation against anal-sadistic impulses. While the altruism is "mostly not lost in successful analysis" (p. 364), there is an implication that some of it is, necessarily, lost because the more fundamental trait is not the altruism, but the decidedly antisocial anal-sadism.

This conceptualization portrays each man as driven by impulses incompatible with collective living. The family provides the "nutriment for our . . . values and ideologies" (Rapaport, 1967, p. 729); yet no sooner is one cut loose from familial restraints than he becomes "prone to compromise and corruption" (p. 729).

Psychoanalytic theory implies that the attitudes of justice and mutuality learned in the family, while achieving some degree of stability in the personality, cannot be counted on, because they are not intrinsically human, but depend primarily on environmental restriction of inherent tendencies toward unchecked impulse gratification (Fromm, 1955). Psychoanalytic theory regards social living and human nature in largely conflictual terms. As Fromm puts it, in the psychoanalytic vision "man is confronted with the tragic alternative between happiness based on the unrestricted satisfaction of his instincts, and security and cultural achievements based on instinctual frustration, hence conducive to neurosis and all other forms of mental sickness" (Fromm, 1955, p. 74).

Freud did acknowledge that the security and refinements of civilized living were not altogether oppositional to happiness, and in fact provided some enjoyments not found in more primitive times. But the society he observed posed significant obstacles to the pursuit of pleasure, especially sexual gratification, creating conflicts for many persons striving for both personal fulfillment and social conformity. Freud saw some possibilities for achieving a more suitable balance, but was pessimistic about the possibility that changes in society's values or institutions

could reduce the tension between instinctual needs and social needs to any great degree. To avoid the state of frustration which can result in neurosis, one must be able to obtain instinctual gratification in spite of social restrictions, but necessarily gratification of a less intense sort.

Given the assumptions of Freudian theory, clandestine satisfaction of basic needs is a logical solution to the individual's conflicts with society. But the idea that this is the only way for individuals to cope with social reality is, I believe, largely responsible for the emphasis of psychoanalytic theory on individual, psychological autonomy. For through the achievement of psychic autonomy, one can secure some measure of gratification even in a hostile or restrictive environment.

Autonomy has become a psychoanalytic value and for some analysts, an ideal, stemming from the assumption that the primary factors motivating the behavior of a mature individual are intrapsychic, rather than interactional or environmental. This leads to viewing autonomy as relatively more important than accessibility to social influences.

Privacy is an implicit value in psychoanalytic theory, deriving from its emphasis on autonomy and individual functioning. Privatization of the self provides the detachment from society which is necessary for personal gratification within the analytic scheme. These values are expressed by the therapeutic practice of psychoanalysis: the analyst tries not to influence or direct the patient, but to help the patient direct himself; the patient's

"significant others" are excluded from the treatment situation; and often, the analyst attempts to divest himself completely of the helping role and stick strictly to the process of understanding and analyzing, so that the patient is obliged to develop a "certain reflectiveness about suffering" (Wheelis, 1973) and to grapple, essentially alone, with his fears and conflicts.

Most analysts exclude the patient's family members from treatment, contracting to see only the individual patient. Frequently, information offered by spouses, parents or children which could potentially help the patient, is rejected by the analyst, who fears this would contaminate his therapeutic objectivity. The isolation of the analytic relationship encourages the patient's exclusion of others from sharing his inner life and promotes an ethic of individualism that prompts one to face problems with an attitude of self containment.

The practice of family therapy is substantially different. The "patient" is not an individual, but an entire family group. The conjoint family treatment modality is consistent with the valuation of family interdependence and with the understanding of the family as a dynamic system of complementary relationships. The values underlying family systems theory run counter to those of individualism and privacy, stressing instead the importance of mutual aid, cooperative effort, and the function of family relationships as valuable resources for individuals with psychological and other problems. This view of the family, coupled with a belief in the human potentials for trust, sharing and mutual

responsibility, has provided a basis for family therapy in which the values of openness and honesty are explicitly promoted (Boszormenyi-Nagy & Spark, 1973). Unlike the analytic situation, that safeguards the individual patient's privacy and shelters him from the influence of family members through confidentiality, family systems therapy provides a setting for the shared exploration of interrelated family problems and encourages the revelation of family secrets.

The conjoint approach is consonant with the circular model of explanation, referred to earlier. A linear cause-effect model can result in moralistic judgments of other(s) who have been the "cause" of the patient's problems (for example, inadequate parents or spouses). The result is the sometimes explicit assignment of blame to significant persons in the patient's life. The tendency to blame or fault family members for a patient's difficulties can be reinforced by the transference alliance between patient and therapist, which allows patients to freely vent hostility toward family members "behind their backs," thereby weakening family loyalty bonds (Boszormenyi-Nagy & Spark, 1973).

By using a circular model in explaining pathological behavior, family systems theorists may avoid this ethical dilemma. Rather than viewing, for example, a man's inadequacy in the fathering role as the cause of his daughter's mannish, domineering (i.e. "pathological") behavior, systems theory might explain the behavior of both father and daughter as "simply complementary functions of the same game" (Palazzoli, 1978, p. 53). This formulation avoids

blame of either party and connotes an equal distribution of responsibility.

While systems theorists do not deny the existence of intrapsychic, individual dynamics, these are not central to their theory. There is an assumption that once the behavior of each member is understood in functional terms, and once the interlocking action and communication patterns can be changed so that symptoms are relinquished by all members of the family, then the intrapsychic dynamics will, in a sense, take care of themselves. Value is placed upon functional or behavioral change within the system, rather than on psychic changes within each individual. This does not mean that important changes within individuals do not take place; the systems perspective is not equivalent to an extreme behaviorist position in which notions of inner thought or experience are considered illusory. But it does mean that inner, psychic experiences are given less consideration than their outward manifestations in interpersonal behavior. From this view, internal change can be considered, but often as following from behavioral change.

Psychoanalytic theorists generally assume the reverse; that is, that changes within the person necessarily precede functional changes or changes in interpersonal behavior. Some contemporary analysts recognize the value of behavioral change and consider analysis incomplete unless there is some evidence that the analysand has actually altered the way he functions in the world; but behavioral changes are generally thought of as impossible, or at any rate insignificant, without the prior achievement of insight,

i.e. an internal change. Behavioral changes occurring in the absence of intrapsychic change are often looked upon as shams or "short cuts," the depth and durability of which are questionable (Wheelis, 1973).

On the other hand, intrapsychic changes in the structure of the personality are valued by psychoanalysts as the hallmarks of therapeutic success, and are thought to be relatively stable and enduring, regardless of situational variables. In psychoanalytic theory, structural changes which result in a healthier personality are believed to be largely immune to the vicissitudes of interpersonal relations and environmental fluctuations; inconsistent and erratic behavior is thought to occur when the personality is disorganized or deficient, and lacking autonomy from external forces.

In summary, psychoanalysis presents a way of thinking about "human motivations in terms of needs, drives, desires, wishful fantasies, and instinct--all of them individually based concepts" (Boszormenyi-Nagy & Spark, 1973) and all of them resting on the primary valuation of internal experience. Family systems theory offers a way of understanding human interactions with relationally based concepts, resting on the valuation of actions and intentions, by which the "bridge between closely related persons is built" and their feelings for each other "proved" (Boszormenyi-Nagy & Spark, 1973).

Social-Political Implications

The psychoanalytic ideal of structural change, as mentioned above, can lead to disinterest in or skepticism about changes in behavior and life style. Coupled with a focus on the individual in relative isolation from his environment, this ideal may also result in a lack of sensitivity to interpersonal, social, environmental and political factors affecting the lives of individuals, and can be interpreted as oppositional to social change. By downplaying the importance of the social environment and at the same time supporting an ideal of intrapsychic change, psychoanalytic theory does not provide a compelling rationale for social action in pursuit of health. By pitting man's basic nature against the demands of civilized living, psychoanalytic theory provides little incentive for trying to make society better, since it provides little hope that that would make people happier. The individual must eke out a morsel of satisfaction for himself and accept the "ordinary misery" of human existence. This can mean that he must accept as inevitable the social conditions impinging on his life, and recognize his inability to alter them. What this seems to point to is the need for a coping strategy, for adaptation, promoting individual psychological solutions to social problems while negating the value of direct attempts to change society itself.

The interlocking of individual and social dynamics, as viewed by the family systems perspective, suggests that much can be accomplished if individuals can alter their immediate social environments. Each family member plays a role in the process of family therapy,

where the explicit goal is to effect changes in the system as a whole. Likewise, the family system approach points to the relevance of systemic change in effecting changes within each individual. The notion that psychologically significant changes occur on individual and familial levels in a mutually influential fashion, means that a dysfunctional family can, through the effort of its members, be made more efficient in fulfilling their needs. An extension of this formulation into the broader social realm suggests that pathological dynamics in the community, or the society, might also be altered, producing an environment more conducive to the development of human potentials and the satisfaction of human needs. The implication here is not so much of revolutionary overthrow of social structures, but of alterations in family and society which allow for significant change, yet preserve the integrity of their basic organization.

In some ways, family systems theory lends itself quite readily to social applications. This trend is seen explicitly in the more expansive system modalities of multiple family therapy (Laqueur, in Sager & Kaplan, 1972) and family network therapy (Speck & Attneave, 1973), which go beyond the nuclear family and work for changes within extended families and communities. Change in social systems is seen as both desirable and ultimately achievable, providing an alternative to the more pessimistic view of the value and possibility of social change implicit in psychoanalysis.

Similarities Between Psychoanalysis and Family Systems Theory:

Another Look

A few of the more obvious conceptual similarities between psychoanalysis and family systems theory were mentioned at earlier points in this chapter. It was noted that in both theories, symptoms are regarded as indications of a deeper problem, and that past history is considered to have some relevance for understanding current dynamics. While it was stressed that family systems theory interprets symptoms as communications, and analysis as intrapsychic compromises, it is apparent that psychoanalysis, in regarding symptoms as signs of an underlying pathology, is also assigning them a communicative function; i.e. they tell the analyst that something is wrong. Here the concept of the unconscious is relevant, since it is assumed that the symptom, rather than direct communication of conflict, is employed because the conflict is unconscious. Yet, with a different epistemological slant, it could be said that if the conflict is expressed in any way, then the person must "know" about it. In other words, what is "unconscious" is equivalent to what one has chosen not to acknowledge. A more volitional interpretation of the "unconscious" process brings this concept into harmony with systemic explanations of the behavior of individuals within family groups.

A frequently heard formulation in family systems treatment is that a child is "sacrificing" himself (i.e. his health, growth, freedom) for his parents (i.e. to protect them from emotional pain). This is not a dynamic that the child could express directly; yet the

child "knows" what his behavior accomplishes. Often the fact of his sacrifice is no sooner verbalized by the therapist, than the child gives it up, allowing his parents to fend for themselves. At this point, another child may offer himself for sacrifice, as if he, too, "knows" that this behavior is needed by the family system. Yet direct communication of this fact is not forthcoming, just as in individuals, a symptom substitutes for direct communication of conflicts. Thus, one could describe unusual or symptomatic behaviors of an individual as expressions of a "familial unconscious," defined as an unwritten rule about what is and is not safe or permissible to acknowledge openly.

This volitional slant on the unconscious is in some sense not that foreign to psychoanalytic thought. After all, psychoanalysis as a treatment is based on bringing the unconscious into the realm of conscious awareness. That this can be accomplished at all, speaks to the fact that volition, will, or reason ultimately determines one's degree of awareness. In other words, we have a choice with respect to what will be admitted to awareness and what will remain buried. The line between the unconscious and the conscious is ours for the crossing.

Inherent in this view of unconscious-conscious dynamics are the ethics of responsibility and truthfulness. It was one of Freud's hopes that psychoanalysis would lessen man's hypocrisy, prejudice and self deception, by helping people to face the truth about their needs and motivations and to accept greater responsibility for their actions. The values of responsibility and honesty and the

view that these goals result in greater human freedom, are basic to the ethics of family systems theory as well. What differentiates the two approaches along this particular dimension is the level of responsibility; while Freud primarily emphasized personal responsibility, systems theory diminishes it by attributing the major causal influences of not-knowing to a pattern larger than any single person; in this sense it emphasizes collective responsibility. But the ethics of honesty and accountability are important in both, and these provide one part of the foundation on which to base an ethically meaningful integration.

Other values shared by psychoanalysis and family systems theory are those of love and work. Specifically, analytic theory promotes the value of heterosexual love and of work which is not mere drudgery, but provides an outlet for creative expression and meaningful productivity. The former is obviously fundamental to a family systems approach, since families originate and are maintained by the heterosexual bonds which lead to parenthood (some family groups arise through homosexual or friendship ties, but these also stem from commitments based on love and/or sexuality). More generally, love may be seen as the basic human need and motivation for all types of social cohesion. Both psychoanalysis and family systems theory imply the value of love not only in personal fulfillment, but also in the promotion of productive social interactions.

The capacity for work, as a theoretical and therapeutic value is also basic to both approaches. Work, whatever the type, is essential for survival, not only of the worker, but of those who

cannot work--children, the aged, the sick--and who depend on others for their daily needs. Thus work serves collective as well as individual needs; it is an ethical responsibility, a social obligation. The ability to work efficiently and to obtain some personal gratification in the process of fulfilling one's social duty is considered an essential by both analytic and family theories; and the value of work provides yet another channel for integration of these theories around an ethical-social framework.

CHAPTER THREE

INTEGRATION ATTEMPTS:

A LITERATURE REVIEW AND CRITIQUE

Practical Problems for Integration: Therapeutic Differences

Several differences between psychoanalytic and family therapy are routinely mentioned as a preamble to attempts at differentiation as well as integration of the two modalities. Most obvious of these is that while psychoanalysis is a one-to-one situation in which a special relationship develops between analyst and patient, family treatment involves the therapist with a family system, and thus multiple relationships with the patient-family.

This situational difference results in a different set of data for the family therapist than for the analyst. The analyst sees his patient alone and must rely exclusively on the patient's verbal reports in conceptualizing his interpersonal relations (although the patient's way of relating to the analyst can be directly observed, the special conditions of the patient-therapist relationship make it difficult to generalize from this to extratherapeutic relationships). The family therapist, by contrast, takes the family as his patient and can directly observe the interpersonal behavior of each member in relation to those significant others with whom he spends his daily life. The family therapist has access to more behavioral data than does the analyst, while his exposure to detailed verbal report from each family member is more limited than that obtainable in psychoanalysis.

The behavioral data set of family therapy provides information about the actions of each member, about the interpersonal consequences of these actions, about events in the family's life, and about relationships between members; these are outer-directed, relatively objective phenomena. In psychoanalysis, the data is more subjective, consisting of information about feelings, thoughts, fantasies and dreams. Psychoanalysts look at happenings within a person, whereas family therapists observe the goings on between people.

In addition to the different types of data gathered in family therapy and psychoanalysis, there are differences in the treatment techniques and goals of these approaches. In psychoanalytic therapy, the furtherance of insight and understanding in the patient is a primary goal, and is "passively" facilitated by the analyst. While the analyst makes interpretations about the patient's inner dynamics (the patient may actually experience these as quite "active"), he does not attempt to direct or prescribe changes in the patient's behavior. In family therapy, the primary goal is behavioral in that therapy aims at modifying the interactions and relationships between family members. This goal is usually met through therapeutic "activism" which intervenes directly in the family's actions and interactions.

Other differences between family therapy and psychoanalysis have been enumerated in Chapters 1 and 2 and need not be repeated here. A final difference bearing on the practical problems of integrating these modalities regards the time span of treatment. Much

of family therapy is of brief duration, or consists of a small number of sessions spread out over a long period of time (Palazzoli et al., 1978), whereas psychoanalysis requires numerous sessions and generally continues over several years. Analysts tend to question the relevance of brief therapy (e.g. Kohut, 1968) and family therapists frequently doubt the validity of working with a family for an extended period of time (e.g. Roman & Blackburn, 1979). On the other hand, psychoanalytically oriented therapists have experimented increasingly with a number of brief approaches to treatment (e.g. Malan, 1976) and some family therapists do long term treatment. So while differences in length of treatment are sometimes cited as an obstacle to integration, it appears that there is already substantial overlap on this dimension.

In addition to the problems for integration which are outlined above, it seems to be the case that family and analytic modes of therapy tend to attract practitioners of such varying dispositions that even when integration is a sincere intellectual goal, incorporation of concepts from the less familiar modality can be so distasteful that failure is guaranteed. An analyst may find the idea of working with a family a threat to his "sense of mastery in the exclusive one-to-one relationship" of psychoanalysis (Ackerman, 1962), while a family systems approach can become a "religion" whose followers refuse to recognize even the existence of intrapsychic phenomena (Halleck, 1978). Merely receiving training in a highly specialized theory or technique can create difficulty in assimilating alternate ways of thinking and doing.

Nevertheless, some clinicians have tried to break down the barriers between psychoanalysis and family therapy and in various ways combined or blended these modalities in search of a more effective and comprehensive treatment. In the following, I review the major works along these lines, pointing out where such efforts have failed and where genuine progress has been made.

Psychoanalytic Family Therapy

One approach to the integration of family and analytic psychology involves the application, in family therapy situations of concepts and principles derived from psychoanalysis. In Individual and Family Therapy (1979), Fred Sander uses this approach to develop a model of psychoanalytic family therapy.

Sander points out the responsibility of therapists to incorporate new knowledge for the benefit of the patient-consumer, and the special need for utilization of family systems therapies in this time of "almost epidemiclike instability of the family" (p. 60). Nevertheless, Sander's primary concern is the understanding of individuals, albeit in a family context; and for such understanding, he finds psychoanalytic theory indispensable. The main thrust of his work, therefore, is aimed at introducing psychoanalytic concepts and goals into the practice of family therapy. He believes that the theoretical breadth of psychoanalysis lends itself to a much wider range of therapeutic applications, including family therapy.

Secondarily, Sander points out that psychoanalysis is to some extent a family theory, in that it describes individual development

as it occurs within a nuclear family, ascribing paramount importance to the developing child's relationships with his parents and siblings. Unfortunately, Sander uses his insight only in one direction, stressing how psychoanalytic ideas can be brought into family therapy, but not how the theoretical perspective derived from family therapy can be applied in the analytic situation. He does remark on the fact that chances for successful analysis can be improved by understanding the patient's family circumstances, and the effect that his analysis is likely to have on his family members. But his integration is largely a one-sided affair, and this results in a prescription for an analytic style of working with families, rather than a real merger between family and individual therapy. In addition, he feels that clinical situations which call for family therapy and those which require individual psychoanalysis can be clearly differentiated, so that the two modalities need not be incompatible. But if the clinical indications for family therapy and psychoanalysis were so clearly separable, integration might not be needed at all. Sander here seems to opt for a "separate but equal" approach, rather than an integration which could account for both the intrapsychic and systemic factors in any clinical situation.

Family therapy is not really granted equality in Sander's book, but is frequently relegated to second class citizenship, revealing an analytic bias that creates insensitivity to certain facts and potentialities regarding family therapy. For example, Sander repeatedly speaks of marital and family therapy as means for creating motivation or preparedness for "more intensive psychoanalytic

treatment," while the possibility of individual therapy paving the way for family treatment is nowhere considered. It is further implied that family therapy is less "intensive" than psychoanalysis, a subjective judgment that has been seriously called into question by important family therapists (see for example, Framo & Boszormenyi-Nagy, 1965). Similarly, Sander faults the behavioral emphasis of family systems therapists as "seriously flawed by the therapist's imposition of his own values and need to manage others" (p. 206), while the value position implied in the psychoanalytic goals of greater autonomy and individuation (and the neutrality with respect to the survival or dissolution of relationships which such goals demand (p. 206)) is not acknowledged.

Finally, Sander suggests a course of personal analytic therapy for both analysts and family therapists as a remedy for the tendency to "influence (often unconsciously) the outcome of their patient's life circumstances" (p. 206). This not only displays a disregard for the potential of personal family therapy to make therapists aware of their values and blindspots, but exposes another unacknowledged value judgment concerning the undesirability of influencing patients' lives. To be sure, one would hope the therapist's interventions would be based on conscious judgments rather than on unconscious wishes or fantasies. But Sander seems to eschew all judgments. As a practical matter (cf. elsewhere in this study and also Wachtel, 1977), this is not really possible, and in advocating this goal, Sander strays from the thrust of the family therapy perspective. Sander seems to suggest that the family therapist's

interest in directly effecting positive outcomes be analyzed out of would-be family therapists.

Sander's work clearly demonstrates how psychoanalytic goals, values, and conceptualizations can be superimposed on a family therapy situation. In developing a model for psychoanalytic family therapy, he has taken an important step towards reconciliation, showing effectively that these modalities need not be mutually exclusive. Further progress towards this goal is blocked, however, by Sander's inflexibility in applying family based concepts to psychoanalytic work, and his inability to put family therapy on an equal footing with psychoanalysis. For even his brand of psychoanalytically oriented family therapy is viewed essentially as a means for helping "those patients with whom classical psychoanalysis is not possible" (p. 234). Despite this acknowledgment of its limitations, Sander seems committed to keeping psychoanalysis protected from any influx of family systems ideas. His loyalty to the position that psychoanalysis is the *creme de la creme* of psychotherapies effectively undermines his ability to fully incorporate family therapy principles into an integrated family-individual approach.

In Psychoanalysis and Family Therapy (1977), Helm Stierlin presents a collection of his own previously published papers which trace a "journey that led from psychoanalysis to family therapy" and outline his conception of a "psychoanalytically oriented family therapy" (p. 9). Like Sander, Stierlin emphasizes the compatibility of analytic theory with family therapy, but Stierlin's focus includes

family theory as well; and he concludes that many analytic notions are subsumed by concepts derived from family theory, which "imply, yet also transcend a psychoanalytic point of view" (p. 14).

In the early part of the book, Stierlin discusses the ways in which individual psychopathology is influenced by family factors; how for example, schizophrenia may result from a child's adaptive efforts to cope with his mother's distorted version of reality, and the conflicts this creates when the child is faced with the reality of the extrafamilial world. These early efforts, however, tend to get bogged down by moralistic statements about what the parent (and especially the mother) is doing to her child, "because of her own pathology" (p. 67). Later, Stierlin shifts into a more interactive mode, exploring how disturbances in interpersonal relations within the family can be reflected in the symptoms of an individual family member, for example in the formation of delusions.¹

In a discussion of the separation process in adolescence, Stierlin extends this interactional view to include not only the notion that disturbed parental relations form a template for their child's psychopathological manifestations, but also the idea that parents' perceptions and expectations of their child can actively contribute to the child's internalizations, that is to the formation

¹ R. D. Laing graphically describes this mirroring process in the case of a girl whose delusion involved seeing herself as a tennis ball in a game of mixed doubles. In fact, the role she played in her family system was one of intermediary between father-grandmother and mother-grandfather subsystems, whose communication depended on her mediation (in Lomas, 1967).

of a positive or negative self image. In other words, Stierlin views the parents' projections onto the child as important determinants of what the child internalizes and sees the parents' behavior as influential in the child's pathology, often manifested by his difficulty individuating himself and separating from his parents. This view of parents as active participants in the child's intrapsychic organization differs, in Stierlin's opinion, from the classical psychoanalytic view which "held that the primary locus of influence was the child" (p. 171), that is, that the defensive operations of the child alone were responsible for his internalization of parental conflicts and his difficulty in achieving psychological separation. In Stierlin's view, both parent and child contribute to the family process which results in delayed separation; this problem in turn is seen as a disruption of the entire family's development, rather than merely the child's developmental lag.

Stierlin conceives of these projections as defenses in the analytic sense, that is, as the parents' attempt to displace unwanted aspects of themselves. But Stierlin here does not hold to the unidirectional reasoning of psychoanalysis and opts instead for the concepts of circularity and reciprocity central to family systems theory. He suggests that the child's acting out of his parents' negative projections through his failure to make an adequate adult adjustment, can become a powerful "guilt lever," allowing the child to reproject his "badness" onto his parents. By failing to develop a separate and healthy self, the child continues to burden his

parents with his own dependency, and effectively shows them up as failures in their parental roles.

Thus Stierlin sees the individual intrapsychic problems of the parents and those of the children as pieces of a mutual interpersonal problem in their mode of interaction, and conceives of the adolescent separation process as "part of a continuous movement toward relative mutual individuation in which parents and children participate. The ultimate aim is mature interdependence of the parties" (p. 173). The above analysis integrates the psychoanalytic concepts of projection, defense, internalization, and individual dynamics with the family systems notions of reciprocal relations, interdependence, and mutuality, to create a more comprehensive understanding of a developmental process which is a "normal crisis" for both the adolescent and the family.

Stierlin also tackles the problem of incorporating concepts of "transference" and "countertransference" into a psychoanalytic family model. He defines transference as the process in which patterns of interpersonal relating originally learned in the family are repeated in extrafamilial contexts. In family therapy, the unfolding of these patterns is observed, and transference occurs to the extent that the family members treat the therapist as if he were a part of their system. Rather than projecting onto the therapist a particular role, as might happen in individual therapy, the family "transfers" onto the therapist a set of expectations and assumptions about interpersonal contacts; it projects onto the therapist its own relational mode. Countertransference in family therapy is defined

by Stierlin as any deviation from a stance of "involved impartiality." The latter does not mean neutrality, but rather an equal apportioning of compassion and involvement with each member of the family; taking sides with one member against the others would be an instance of countertransference. "Involved impartiality" implies the recognition that the family can be bound up in a vicious cycle of exploitation and counterexploitation, attack and counterattack, without anyone being to blame; release from this emotional bondage requires "mutual understanding, forgiveness, and reconciliation" (p. 282).

Finally, Stierlin suggests that a "training family therapy" (p. 319) be substituted for a training analysis for therapists who wish to work with families in this modality; he believes that this would decrease countertransference and otherwise make the therapist more effective. This recommendation reflects Stierlin's regard for family therapy as a modality on equal terms with psychoanalysis. His attitude of respect for the contributions of both modalities has allowed Stierlin to develop a concept of psychoanalytically oriented family therapy which departs from the strict traditions of each approach without losing sight of its fundamental value.

Family Systemic Individual Therapy

Other combinations of family and individual therapy involve the application of family theoretical concepts to psychotherapy with individual patients. In Family Therapy in Clinical Practice (1978), Murray Bowen outlines his approach to "family psychotherapy"

with individuals. This includes a view of family theory that is the reciprocal of Sander's with regard to psychoanalytic theory, that is that family theory can be applied to a broad spectrum of situations, including individual therapy. When Bowen works with a single family member, as opposed to a couple or family group, the goal is the same: to help each member differentiate from the "family mass." Consistent with the systems theory concept of change in one part of the system yielding compensatory changes in another part, Bowen assumes that moves toward differentiation, even when initiated by only a single family member, will automatically tend to "pull up" the level of differentiation of the other family members.

Bowen finds it useful to work with a single motivated family member in order to begin the process of differentiation and "detri-angulation" central to restoring the family's functioning and in some cases successful in creating the motivation for family members to work together. While the therapeutic session itself includes only one individual, he is in fact partaking of family therapy; in Bowen's view, "a theoretical system that 'thinks' family and works towards improving the family system is family psychotherapy" (p. 157).

Bowen's approach to family therapy is in general very didactic; he teaches his patients about how family systems operate, and about the theory of family dynamics that he will use in working with them. This is true particularly in the family psychotherapy of one member, which is a "teaching-supervising method throughout the entire course"

(p. 233). The family member is not a "patient" but a trainee, who in many respects becomes the "therapist" for his own family. Emphasis is placed on "coaching the young adult in differentiating a self from his family of origin" (p. 235). This involves teaching him some family systems theory, developing formulations about his place in the family system, and supervising his efforts to test out and revise these formulations through actual family contacts, and later, to change his functioning in relation to family members, thereby stimulating changes in the entire family.

Bowen's method does not make use of transference, nor the interpretation of intrapsychic conflicts or defenses. Individually directed techniques instead include teaching the family member how to control his emotional reactions to others in the family and how to take self differentiating steps in words and actions. These methods bear greater resemblance to those used in cognitive and behavioral therapies than in psychoanalysis. In fact, psychoanalytic concepts and techniques have virtually no place in Bowen's family psychotherapy, perhaps because he has found that "the more one detaches from individual therapy, the easier it is to see family patterns" (p. 156). So, in a manner which is, again, the reciprocal of Sander's approach, Bowen superimposes a family theoretical approach on a one-to-one therapeutic situation. And although this results in a therapy which is novel, exciting, and reportedly effective, it does not incorporate psychoanalytic concepts in a way that facilitates their use as part of the treatment approach. Thus while demonstrating the applicability of family

theory to therapy with individuals, Bowen's work makes only a limited contribution to an integration of family theory with the individual theory of psychoanalysis.²

Multiple Treatment Approaches

In addition to the integrative efforts discussed above, there exists a mixed bag of theoretical and practical methods for putting together family and psychoanalytic psychologies. I have dubbed these "multiple treatment approaches" because, while they represent a movement towards integration, they involve primarily combinations of analytic and family elements. These are significant contributions because they highlight the fact that a single treatment is not always sufficient to "cure" a particular human problem, and show how a

² It should be noted that Bowen chose to put aside this particular task for the following reason:

"...In the early years I worked toward some kind of correlation of family concepts with psychoanalytic theory. In writing and professional communication, the use of certain familiar terms would evoke vigorous discussion about the proper definition and use of terms. When the discussion went beyond productive exchanges of views and into nonproductive cyclical debates that consumed both time and energy, I elected to describe the family phenomenon in terms that did not stir up debates, to advance the research as far as possible, and to leave the integration of individual and family concepts for some future generation" (p. 159).

This statement alludes to some unfortunate obstacles to integration which lie outside both theoretical and clinical considerations and have more to do with the political and social functioning of academic systems; this point will be further addressed in the next chapter.

flexible application of several treatments can often be more effective than either family therapy or psychoanalysis alone.

One group of therapists and theoreticians has emphasized that any given clinical situation can be understood on a variety of levels, stressing in particular the intrapsychic and interpersonal levels as affording the best explanation of psychological phenomena. Larry Feldman (1979) for example, has developed a model for analyzing and treating marital conflict that requires an appreciation of both psychodynamic and systemic factors (his model includes a behavioral understanding as well). Theoretically, Feldman conceives of marital conflict as a defensive maneuver, occurring in response to each spouse's internal conflict between the wish for intimacy with the other and the anxiety which intimacy arouses. A cycle is set in motion when, after marital tension reduces the intimacy anxiety, the wish for intimacy returns, along with anxiety about further marital strife; this results in moves toward reconciliation, but soon the level of intimacy becomes threatening again, and the marital conflict begins anew.

The reduction of anxiety, alternately by conflict between and reconciliation of the spouses, is conceived in behavioral terms as a powerful "reinforcer," which maintains the cyclical pattern, while the anxiety itself is viewed psychodynamically as an unconscious occurrence, and the conflict-resolution-conflict cycle is described systemically as the interpersonal process which makes the marital system "tick."

Therapy for couples presenting this pattern involves a combination of behavior modification, exploration of family history, and analysis of spouses' dreams. This multilateral strategy has potential for breaking into the destructive cycle on any or all of the three levels hypothesized by Feldman--the unconscious, the behavioral, and the interpersonal. Presumably such an approach has a greater chance of success than one which attacks the problem on only one level. (These levels or areas are probably less distinct than they are depicted here, and because of their overlap, intervention aimed at any one of them is likely to touch on aspects of the others as well. Still, a treatment plan which explicitly aims at all three may have a greater impact than one which is based, theoretically at least, on a unilateral strategy.)

Although Feldman explains this model specifically for marital conflict, it could be generalized to other intrafamilial or interpersonal conflict situations as well. Feldman successfully shows how an interpersonal relationship pattern can be understood as a defense against anxiety present in both parties, and how this intrapsychic experience feeds into an interpersonal pattern of action (and vice versa). His multi-level model is a well thought out attempt at integration of analytic, family and behavioral concepts.

Samuel Slipp (1973) has used a multi-level model to explain the development of schizophrenia. His theory combines the analytic concept of schizophrenia as the outcome of a structurally defective ego, and the family systems notion that schizophrenic behavior is a response to a family relationship pattern which essentially demands

pathology from one of its members. In Slipp's view, the latter process compounds the difficulties of a family member with a pre-existing "arrest in early ego development," and it is the combined effects of intrapsychic and interpersonal deviations which result, ultimately, in the symptoms of schizophrenia.³

According to Slipp's theory, a "symbiotic survival pattern" can develop in families where the parents have never achieved full self and object differentiation. These parents did not successfully integrate their parental introjects; their ego identities remain shaky and they feel their self esteem to be dependent on the actions of others. Internal stability is maintained by the development of a mutually controlling external (family) system, and through the projection of introjects onto their children.

A child who has failed to resolve the developmental conflicts of early childhood, and whose ego identity therefore remains dependent on his family relationships for a prolonged period of time, is particularly vulnerable to parental projections and is more likely than his normally developing siblings to be chosen as their target. Due to his emotional immaturity and the inadequacy of his defenses, he can be seriously affected by the projection process and his maturational progress further impaired; additionally, his cognitive

³ Slipp notes additionally that the hypothesized ego defect makes the schizophrenic individual more dependent on his family and thus more susceptible to their influence. This factor, he contends, may be responsible for the clinical impression that the pathology is solely within the family unit, rather than partially within the symptomatic individual.

development will be retarded, as the magical quality of his parents' attempts at control reinforces his tendency to use primary process thinking. He is thus further handicapped in the formation of a separate identity, and his symbiotic relatedness is reinforced. Individual needs which tend to pull the child away from this symbiotic pattern are then perceived as threatening his own survival and that of his parents. The conflict into which this situation puts the child may be intense enough to precipitate an overt schizophrenia.

Slipp incorporates psychoanalytic and ego psychological ideas into a relational theory of schizophrenia. Like Feldman, he demonstrates an interaction effect between intrapsychic and system levels of pathology, and explains how "intrapsychic conflicts are acted out in the interpersonal sphere," yet he demarcates clearly what is "in" the identified patient (the ego fixation) and what is "in" the family system (projections and mutual controls). In elucidating the influence of family interaction patterns on individual pathology, and the role of individual pathology in reinforcing disturbed systemic functioning, Slipp's theory moves towards integration. Yet the theory retains a basic conceptual dichotomy between the individual and the relational system, failing to fully integrate the two.

Another multiple treatment approach is presented by Seymour Halleck in The Treatment of Emotional Disorders (1978). Halleck calls attention to two elements which are conspicuously absent in the usual process of treatment choice for patients with emotional problems: 1) scientific data that provide indications of which

treatment to use in a given clinical situation, and 2) an ethical system that provides guidance on the uses and abuses of various interventions.

Halleck reviews the limited data available, and discusses the numerous difficulties in doing valid outcome research on psychotherapies. Given the current state of our knowledge, which for the most part fails to demonstrate the superiority of one therapeutic modality over another (but does show that some treatment is usually better than none) and given the complexity of human problems, Halleck concludes that utilization of multiple interventions is a more practical and ethical approach than adherence to a single brand of therapy applied indiscriminately to all sorts of problems.

Application of Halleck's model demands that the clinician be familiar with most currently available treatment modes and have the ability to recognize when a patient could benefit from any one or several types of intervention; if the clinician cannot provide the appropriate treatment himself, he should be able to refer the patient to someone who can. The clinician is expected to provide or coordinate as many treatments as are necessitated by the nature of the particular clinical problem; thus a full evaluation of the medical, psychological, interpersonal and environmental factors affecting the patient is required for the planning and implementation of a treatment strategy. And while Halleck acknowledges the great demands this model makes on the practitioner, he believes that the effort is rewarded by the greater effectiveness he can have, if he is able

to intervene at "all levels of the patient's dysfunction: biological, psychological, and social" (p. 20).

Halleck refers to his approach as "multidimensional" treatment, distinguished from eclecticism by the fact that it employs a specific model "for making rational decisions as to which of many interventions are to be used" (p. 28). This model includes a basic definition of human problems as individual-environment interactions and generates biological, learning, informational, and environmental hypotheses regarding the causes of emotional disorders. The model attempts to: 1) understand how a particular problem is related to a specific intervention; 2) understand how the intervention works; 3) be aware of the treatment's effects on long term adjustment and quality of life, as well as on the immediate symptom; and 4) make interventions and their alternatives explainable to the patient so that he can participate in treatment choice.

In addition to these general guidelines, Halleck suggests several values to be considered in applying a multidimensional model. These are the following: efficiency, economy, protection of the patient and the patient's environment, compassion, and respect for the patient's autonomy. He believes that "if the clinician makes an effort to define a set of values that will fully protect the patient and then tries to use these in prescribing treatment, the issue of ethics then becomes an integral factor in treatment choice. Ethics simply means doing what is right or what is good for the patient. Determination of what is right or good is made by comparing therapeutic outcomes with previously stated

values" (p. 159). Often these values conflict, and when they do, the clinician must base treatment choice on a judgment of what is most important. Both moral and practical considerations will play a part in resolving value conflicts.

The guidelines set forth by Halleck's model often require a combination of family and individual therapies; and Halleck's focus on individual-environmental interactions makes a family interview an essential part of the evaluation phase for every patient. When the patient's improvement necessitates a change in the family system, then family therapy is added to individual therapy; similarly when an individual family member cannot be adequately helped in the context of family therapy, without some special intervention (e.g. when one member is organically impaired), then some form of individual treatment is combined with the family sessions.

Halleck's use of interventions on multiple levels is similar to the efforts of Feldman and Slipp, but its inclusion of almost every possible biological, psychological and social intervention makes it much broader clinically. As a theoretical contribution, however, Halleck's work is limited; he has not developed concepts that unify family and individual dynamics in a manner conducive to the production of a treatment that includes both family and individual dimensions simultaneously. The split between individual and family is retained in his work; and despite his awareness of social determinants of emotional problems, Halleck's basic orientation to psychotherapy is individual. His first commitment is to the solitary patient, and interventions in social systems are undertaken

only when they serve the particular needs of that patient. His approach views the patient as part of a social context, and by intervening in those parts of the social system which impinge upon his welfare, it can produce dramatic changes in the patient's total life situation. But because it does not address the problems of the social system itself and does not make the system a direct target for intervention, its potential for changing the systemic processes detrimental to every individual whom they affect is limited. This means that while family therapy may be successfully utilized to treat a patient who has sought help, any benefits received by the family members will be incidental byproducts of the intervention; their gains could perhaps be far greater were the family in its entirety the primary therapeutic target.

If the clinician is alerted to potential negative effects of family intervention, as Halleck is, then working with the family is not likely to do any harm to its members. But by tailoring the family intervention to the treatment needs of one member primarily, potential benefits to the rest of the family may be overlooked. (This is true on a broader scale as well. If a therapist manages to manipulate a legal, medical, or financial agency to the benefit of a particular patient, he may help the patient enormously, but does little for other individuals who may have similar difficulties

with those agencies.⁴

To summarize, Halleck's multidimensional model provides guidelines for a more pragmatic and ethical approach to treating emotional problems, and contains some valuable insights into the political and social aspects of psychological problems and treatments. It draws on a wide range of currently available treatment modalities in an effort to create integrative therapies which will best serve the needs of patients with a variety of emotional disorders. The combination of individual and family therapies is only one of many multiple treatments possible with Halleck's approach; his model regards the family in terms of individual needs and does not provide a basis for integration of family systems and psychoanalytic theories.

Summing Up: Problems for Integration Revisited

This chapter began with discussion of some differences between psychoanalysis and family therapy commonly cited as obstacles to their integration. The review of integration attempts that followed revealed that these differences were indeed problematic to a greater or lesser extent for each attempt. While various therapeutic and theoretical concepts were offered to overcome these obstacles, one fundamental problem was unresolved: none of the authors reviewed

⁴ Actually, Halleck spoke more explicitly of the need for changing social systems in an earlier work, The Politics of Therapy (1971); his suggestions for ways in which psychiatrists can influence, and help their patients to influence, larger social systems, are discussed in Chapter 4.

was able to fill the gap, in theory or method, between inner (individual) and outer (family-relational) realms. In each attempt, this dichotomy was left intact, and the intrapsychic and interpersonal aspects of psychology were assigned to different levels or systems.

Construction of a conceptual bridge between these levels is obviously no easy task; yet the difficulty in reconciling them may result more from our definition of the problem than from its inherent complexities. The problem of synthesis may be substantially simplified if we stop looking at intrapsychic and interpersonal aspects of psychology as sharply demarcated, mutually exclusive domains, and see them instead as open channels of the same circuit or system. This system may be conceived as a higher level of organization, encompassing both intrapsychic and interpersonal subsystems.

A conceptual dichotomy between inner and outer, or self and other(s) cannot be resolved by simply finding a middle ground or building steps from one level to the next. Synthesis of individual and relational concepts, transcending the boundaries of each, requires a larger theoretical organization incorporating both inner and outer "levels" and dissolving the distinctions between them. Ideally, this macrostructure would provide a way of understanding individual and family processes as simultaneous (going on at the same time) and as interdependent parts of a single system (existing in the same theoretical "space"). It would, in other words, conceptualize family and individual dynamics not as multiple dimensions, but as interconnected cohabitants of the same dimension.

Among the obstacles to the conceptualization of an integrated individual-interpersonal psychology are the shortcomings of written and spoken language in expressing holistic concepts. The inherent limitations of language have been compounded in psychology by the tendency of each new theorist to borrow concepts from other academic fields, not necessarily applicable to psychological phenomena outside his particular area of study. Thus "family theorists and therapists needed to create a new language that befitted their subject" more than the psychoanalytic language of physics and neurology (Stierlin, 1978, p. 13); but the differences in language served to further separate these theories. Language presents a potent though not too obvious obstacle to theoretical synthesis, and the success of integrations depends "not least on the language and concepts that reflect as well as shape our clinical experiences" (Stierlin, 1978, p. 13). The invention of a new terminology, or the creative use of existing jargon might facilitate the formation of an integrated theory.

Related to the problems of "linguistic conditioning" (Palazzoli et al., 1978), are the obstacles to integration posed by the factor of academic specialization, a phenomenon based on the rather arbitrary construction of boundaries between and within disciplines. In the social sciences, the split between sociology and psychology (those disciplines most immediately relevant to individual-family relationships) came about partly as a result of academic and economic pressures for conformity with the model developed by the natural sciences. The division of these disciplines was a division

of the human field into social and psychological, group and individual domains. The model for social scientific investigations came to rest on the polarization of self and society. The result was that, rather than approaching a human problem in a pragmatic and holistic fashion, social scientists defined a priori their areas of specialization, and then dealt only with those aspects of the problem that fell within their "limits" (Holland, 1977).⁵ Academic institutions grew up around these disciplinary divisions, and further incentives for channeling social studies into one or another of these categories came from funding, hiring, and licensing practices which powerfully affected the social scientist's ability to work. Sociologists and psychologists were in the position of competing for a piece of the academic and economic pies. And this trend filtered down to the intradisciplinary level (note, e.g., the numerous Divisions of the American Psychological Association) so that there was no accepted place for interdisciplinary study, and superspecialized psychological theories flourished to the neglect of integrative work (Holland, 1977). Thus the integration of family and analytic psychologies is impeded not only by differences inherent in their theoretical structure and application, but by extrinsic factors of linguistics and academic/economic pressure for specialization.

⁵ The inappropriate application of specialized theories to problems whose solutions are to be found elsewhere (Simon, 1970) is the other side of this coin; it occurs perhaps when intellectual curiosity about problems outside one's academic "limits" comes up against the fear of "breaking the rules" by utilizing the tools of a discipline other than one's own.

Economic and social factors which mandate intradisciplinary specialization account in part for the counterproductive arguments over terminology that led Bowen (1978) to abandon his attempts at conceptual integration of individual and system dynamics. To be sure, other theorists are similarly motivated to stay within the safety zone of either analytic or systems theory. Unfortunately, these artificial boundaries perpetuate the dichotomization of individual and social dynamics, generating theories whose representation of the human situation is heavily skewed, and whose practical applicability is severely curtailed. In circular fashion, these theories reinforce the academic and conceptual polarities which molded them in the first place, increasing the potential for distortions in interpretations of existing knowledge and in the creation of new work.

As theoretical work becomes increasingly narrow in focus, it is liable to lose its frame of reference regarding both the extra-theoretical forces influencing its development and the practical implications of its concepts. In particular, specialized theories often ignore their ethical roots and implications, and present evaluative and moralistic ideas as if they were based purely on scientific observations. These unacknowledged values play a powerful part in maintaining the separation of psychoanalytic and family systems theories, and the fact that value questions are often argued as if they were scientific ones serves to perpetuate academic conflicts and mask the more generally important issue of how to use,

in a constructive fashion, those values which inevitably influence the formation of theories.

In Sander's work, for example, the values of autonomy and individuation were presented as objective goals, based on a theory of mental health and illness quite divorced from any ethical system. Yet it was these and other essentially value based considerations (e.g. the "intensiveness" of therapy) that made the integration of family systems concepts problematic for him; these concepts were based on a value system different from Sander's own, and repugnant to his sense of ethics.

Values and psychological theories cannot help but intertwine, and the confusion of value judgments with more objective observations is a problem for every theorist. Ultimately, psychological theories of mental health and illness are inseparable from ethics, since such concepts are intrinsically notions of value, defining good and bad ways of living and experiencing life.

Thus viewed, the problem of values in psychology may seem to be unresolvable; but this is not the case. What is true is that the traditional "solution," consisting of vigorous attempts to banish all values from psychological theory amounts to a ceaseless and futile battle. I would propose an alternative to the rejection of values, and suggest their inclusion in psychological work, not only because they are unavoidable, but because they can play a most significant and facilitative role in theoretical and therapeutic developments.

A full incorporation of values into psychology is at least a twofold task. It requires firstly, an analysis of the values implied by theory (which was begun in Chapter 2) and an understanding of the ethical and social consequences of such values when a theory is applied in treatment (to be discussed in Chapter 4). Secondly, it demands the delineation of an ethical system which can serve as a model for identifying those theoretical and therapeutic constructs that will produce the most favorable social consequences, and the use of that model as a framework for integration of various theories. Implicit in the second task is the idea that psychological theory holds potential for contributing to social progress, and a concept of the psychologist's role as a social, as well as personal healer.

The task of developing a value based psychology, like that of integrating intrapsychic and familial dynamics, involves the synthesis of two aspects of reality normally cast in dichotomous terms. A dialectical framework provides some hope for resolution. Thus, while values and theory are conceptually divided in order to examine the influence of one upon the other, they must also be perceived as essentially united, in terms of their actual effects. Similarly, social and political effects of therapy may be analyzed apart from the specific therapeutic process, yet it is also true that every therapeutic encounter is itself a social intervention.

The remainder of the present work is devoted to the development of a value-based psychology, incorporating and integrating aspects of psychoanalysis and family systems theory. Theoretical

integration and the growth of an ethically and socially meaningful theory, I suggest, are tasks that go hand in hand. Failure to come to terms with this relationship has in various ways curtailed the integrative efforts reviewed in this chapter. Consciousness of values and socio-political context are generally lacking in the work of psychoanalysts and family theorists alike. In the following chapter, I address this lack of awareness by looking at some specific ethical and social issues relevant to the theory and practice of psychoanalysis and family systems therapy.

CHAPTER FOUR

ETHICAL AND SOCIAL ISSUES IN THEORY

Overview: Some Forces Shaping the Theory and
Practice of Clinical Psychology

Economics

In the previous chapter, intradisciplinary specialization was mentioned as a potentially distorting influence on psychological theory. The root of this process is economic rather than simply academic. Our economy, based on competition and a mentality of scarcity, forces psychologists into selling their theories to prospective professionals in much the same way that other commodities are sold in this country, that is, by reaffirming the self images and mental constructs of reality which people want to maintain, and by pointing out the shortcomings of the other "brands." Not only do psychologists have to peddle their goods to academic institutions and potential clients, but also to agencies that sponsor research. Granting agencies are concerned primarily with their own aims and allocate funds according to their own priorities. These may not always coincide with the needs of the psychologist nor those of the people he serves. Economic survival of psychologists requires some degree of compromise in reconciling their own goals and values with those of the funding agencies. If one's work is unpopular or could result in politically threatening implications, it is not likely to be funded. Thus psychological research is forced to conform to political and economic aims, and theories of human behavior are

often shaped by organizations with a vested interest in promoting psychological models that support adaptation to prevailing economic and political structures. In other words, those agencies whose interest in keeping the status quo is greatest are often responsible for deciding which interpretations of human behavior will be popularized.

Economic factors also influence the distribution and availability of psychological services. In this country, where health care remains a basically private industry, costly health insurance is the only way to protect against health emergencies, chronic illness, and significant mental or emotional problems. Apart from the fact that many people cannot afford this option, and that poor people are chronically underserved in the area of mental health (Tancredi & Slaby, 1977), there are restrictions inherent in health insurance policies regarding the type of professional who may dispense such services, and the framework to be used in diagnosis, prescription and administration of treatment. Clinicians who want to treat insured patients are made to comply with these specifications and while this may in many cases protect the patient-consumer from receiving substandard treatment, in others it inhibits the clinician in serving the patient's best interests. For example, coverage for family treatment is often available only if one member of the family is designated the "patient"; there is no acceptable family diagnostic terminology that will ensure third party payment (Sander, 1979). A clinician who views the entire family as his patient, with a sound theoretical basis for doing so, is still

locked into a framework of individual diagnosis which may subtly undermine not only the treatment of the family, but the integrity of his theoretical position. In the case of individual therapy, insurance limitations perpetuate a standardized format for mental health care delivery and by discouraging psychotherapeutic innovations, hamper the development of theoretical and treatment modalities. Most insurers, for example, will not pay for therapy unless a traditional psychiatric diagnosis is recorded. This obliges the clinician to give a psychiatric label to each patient, and thereby support a medical model, even if he does not believe in it. This not only does a disservice to the patient who must live with the label, it also exerts control over the therapist's treatment options, and by limiting the data available in his practice, may curtail the development of his theoretical thinking.

Legal Issues

The practice of psychotherapy and the theoretical developments arising from it are also affected by the legal system. Laws governing the practice of psychotherapy have recently given more consideration to ethical as well as economic factors. A general trend towards liberalization in treatment of psychiatric patients, particularly with regard to institutional care, is apparent in recent legal action to protect patients' rights in the areas of informed consent, confidentiality, availability of treatment, and the right to legal assistance (Tancredi & Slaby, 1977). The "Patient's Bill of Rights" published by the American Hospital Association, reflects

the interest of institutional care providers in fostering awareness of patients' rights and meeting more of their demands (Tancredi & Slaby, 1977).

Along with legal advances in protection of patients have come some decisions favoring the rights of the public over the specific privileges of psychiatric care. In the case of *Tarasoff vs. Regents of the University of California*, university psychotherapists were held liable for failing to warn an individual whose life had been threatened by their patient and who was subsequently murdered by the latter. The state supreme court ruled that the privilege of confidentiality in the patient-therapist relationship must be yielded in cases where disclosure is essential to prevent danger to another person (Van Hoose & Kottler, 1977). This case illustrates a conflict between the demands of professional ethics and a mandate of the legal system, and shows that the balance between private and social responsibility deserves careful consideration.¹

Social Policy

Overall social policy is broader than just economic and legal considerations, including the combination of political and attitudinal factors which together determine society's treatment of psychological issues. The making of social policy involves the direct

¹ It also points out the vulnerable legal position of the therapist, who can be penalized for needless disclosure as well as overly rigid confidentiality.

proposal and implementation of service, training and research programs, and the making of choices between alternatives when resources are limited. Delicate ethical and value judgments come into play when a choice for one alternative is also a choice against another, and when the "lesser of two evils" must be determined. This occurs when public moneys are allocated for research or treatment of particular mental health problems; limitations in available funds make it necessary to decide which groups or diagnostic classes of patients are most deserving of mental health attention, and to distribute manpower and funds accordingly.

Such determinations are often based on values of utility, economic gain, or professional interest, rather than on the needs of the public. In fact, social policy in mental health care has favored precisely those groups in which psychological and psychosocial difficulties are less prevalent, and for whom psychotherapeutic services are most readily available (Tancredi & Slaby, 1977). The bases for decisions of this kind require reevaluation if therapy is to become a socially progressive endeavor.

Social policy regarding psychological issues is also influenced by the medical establishment and the political use to which it lends itself. The prevalence in our society of a medical orientation to human problems means that politically "undesirable" or deviant behaviors and attitudes can be controlled if they are labeled and treated as "sick" or "neurotic." When this occurs in therapy, it becomes an agent of political control, for example, when feminism is seen as a neurotic conflict over sexual identity, or when a black

person's strategy for coping with racism on the job is viewed as "passive aggressive" behavior.

Related to the process of political control through psychological means is the emphasis placed on contentment by the medical model (anxiety is a disease) and the economic system supporting it (selling cures is good business). Television commercials exemplify our culture's lack of tolerance for discomfort of any sort: the woman whose husband "gives her" a headache reaches for aspirin, the child who fusses gets a cookie, the man with "occasional insomnia" welcomes a sleeping pill. Anxiety is regarded as an aberration, to be gotten rid of as quickly as possible; there is little awareness of anxiety as a sign that something is amiss in one's environment or of its use in prompting creative problem solving. When anxiety is eliminated without consideration of its meaning or benefits, the potential of the anxious person is compromised and his capacity for social action diminished. By too quickly obliterating anxiety, the therapeutic process may inhibit the patient from recognizing its sources and developing a plan of action to deal with them directly. Frustrations and anxiety are catalysts for action, and when these feelings are eliminated before the sufferer can identify their cause, social passivity is the likely result.

Psychiatric labeling affects social policy through economic as well as political channels. The tendency to redefine social and moral problems (e.g. teenage pregnancy and delinquency) as psychological ones results in the creation of an increasing number of areas over which to spread an already inadequate supply of

resources. An economic strain is put on the mental health care system to the extent that it is expected to treat nonpsychological problems; professionals and funding may be drawn away from areas where intervention is more appropriate. Secondly, the expectation that psychological treatment will ameliorate broad social problems, in the absence of sufficient economic and social support, gives mental health workers an impossible task, and at the same time allows society to disown its responsibility for widespread problems.

Of course, mental health professionals are not mere pawns of society. Despite legal, economic and social restrictions brought to bear on psychological research and practice, there remains a considerable degree of freedom in how psychologists work, and there are several channels by which psychologists can influence and change society. The theories and practices of psychology, for example, affect public attitudes concerning right and wrong ways to behave and the meanings to attach to various thoughts and acts. Psychologists act as consultants to government, industry, and educational institutions, helping to shape attitudes and policies on psychological issues at various levels of social organization. And psychologists devise theories and corresponding treatments which directly affect thousands of patients and indirectly influence many more of their family members, friends and associates.

Psychologists do have social power and with it, a burden of responsibility. They can sanction social institutions or change them, support people or oppress them; they are constantly faced

with choices and decisions of an ethical nature. Theories of psychology reflect various systems of ethical judgment which can have long range effects on social attitudes and practices and more immediate effects on "psychology consumers"--students, counselors, patients, readers. The social problems and value questions relevant to psychological theories are discussed in detail below.

Social-Ethical Problems in Theory

Cultural Biases

A psychological theory like any human product, is inescapably influenced by its cultural context. The language, religion, art, customs, family structure and history of a given group are bound to be influential in any psychological theory constructed by a member of that group, reflecting notions of normality, abnormality, development and relationships that are most compatible with his cultural background. A theory that lucidly describes and explicates the psychology of a particular cultural group may be misleading when applied to the psychic life of another.

It is perhaps especially important for psychologists to be aware of cultural differences in this country where there is an abundance of cultural subgroups, and at this point in history, when movements from one place to another are so frequent. Coming to theoretical conclusions too quickly may lead to clinical mistakes and possibly do social or emotional damage to people using psychological services.

Psychological health ideals are one aspect of theory in which cultural biases are potentially problematic. The conflict between the ideal of "appropriateness" and the cultural conditions which make it difficult if not actually dangerous for a person to approach the ideal, serves as an example (Sarnoff, 1955). Sarnoff discusses the case of a black man, raised in the South, who was self-effacing and incapable of asserting himself with others. As his self-esteem improved with therapy he was expected to display more assertive (appropriate) behavior. On returning to the South, the patient found that expressions of his self esteem aroused violent reactions in whites, and he was forced, in the interest of self preservation, to withhold what from another perspective would be seen as appropriate behavior.

There are many situations in which mainstream ideal health goals are inappropriate or unattainable for members of minority groups or subcultures. This does not mean that goals such as self esteem are unattainable or not to be expected from such persons; but self esteem may be developed and expressed in ways which vary from those deemed most appropriate for majority members. In the case above, for example, the therapist helped the patient identify those areas where it was safe to be assertive and to find means for trying to change those cultural conditions which prevent blacks from enjoying full self expression (Sarnoff, 1955). Thus, definitions of "appropriate" and "healthy" must be cast in light of the specific cultural conditions to which a person is subjected.

Similarly, the ideal of self actualization as it is usually formulated in the West is meaningful in cultures of extraordinary material wealth, where individual development and creativity are highly valued. In economically poorer cultures oriented toward collective production and development, individual achievements and satisfactions are less relevant; the communal goals of material advancement, public health and group cohesion may be more conducive to mental well-being than the expansion of individual awareness and creativity.

Psychoanalysis and family systems theory share enough culture in common so that many of their mental health ideals (though not necessarily their ideas of how to achieve them) are the same. Individuation is an important goal of human development in both models. This is due in part to the fact that individuation contributes to optimal functioning in a culture based on economic competition and the nuclear family structure. Individuation in this context is highly adaptive, increasing one's chance for social acceptance and material gain; but it is not necessarily an inherently healthy achievement. In certain subcultures of society, family solidarity is valued more highly than individuation and ensures greater success in the community. Existence of extended family relationships makes individuation less important and desirable than in nuclear family systems, and cultural sanctions against leaving the family or community network make increased loyalty and a greater degree of interdependence more appropriate.

Family structure is particularly relevant to cultural limitations and problems of both psychoanalysis and family systems theory. The psychoanalytic theory of development is based on the assumption of a traditional nuclear family in which the mother is primarily responsible for child rearing and the father is the wage earner and authority figure. In a matriarchal culture or extended family situation, psychoanalytic formulations may require redefinition. As women gain greater social power, and men take on more responsibility for raising children, developmental norms may be expected to vary considerably from the stages outlined in psychoanalysis. Similarly, as a-traditional family structures become more prevalent and accepted (e.g. single parent, step-parent and gay parent families), the need for new theories of personality is likely to be felt (Zinberg, in Post, 1972). Recent developments in psychology which attempt to conceptualize and treat the specific problems of these new family types (e.g. Krestan & Bepko, 1980) display a sensitivity to cultural change and a willingness to adapt theory and therapy to new sociocultural norms. Responsiveness to changes in culturally accepted patterns of behavior means that psychological theory and therapy are open to revisions in their concepts of health and illness; behaviors that were once regarded as "neurotic" because they deviated from the norm are now considered "healthy" largely because they have gained popular acceptance. The career woman whose decision to forgo or delay motherhood was once seen as a neurotic rejection of femininity is now dubbed "normal;" this is liberating to women because it allows them greater freedom of

choice--to accept or reject a career--and enables them to examine other psychological issues for themselves more clearly without believing that any difficulties they have are simply part of a "syndrome" in which wanting a career is the primary "symptom." A similarly liberating effect can occur when psychologists take into account variations among subcultural groups such as Hispanics or Native Americans, whose norms with regard to male and female roles, aggression and achievement diverge from those of the prevailing culture.

But along with the positive consequences of abandoning diagnostic labels when they no longer apply, come the potentially negative effects of giving up mental health ideals merely because they no longer are supported by current cultural patterns. While it may be incorrect and even harmful to give psychiatric labels to patterns of behavior or experience which are common in a particular cultural group, and while it may be accurate to speak of these as normal, it does not necessarily follow that these behaviors are conducive to optimal human functioning; although anemia or dysentery are endemic in some parts of the world, prevalence alone doesn't make these conditions healthy. The danger of cultural relativism in psychological theory is that psychologists will lose their vision of what human experience can be at its best and their motivation to promote cultural and social conditions more compatible with human growth (Fromm, 1947; 1955). With an allegiance to a particular view of mental health, and commitment to a set of health ideals or values, psychologists have a basis for efforts to change those cultural

elements which are inhibitive or destructive to the development of healthy personalities.

Horney (1937) recognized the interaction of culturally and individually determined aspects of psychological disturbance, characterizing the neurotic as someone who "not only shares the fears common to all individuals in a culture, but . . . also has fears which in quantity or quality deviate from those of the cultural pattern" (1937, p. 25). This points to the need for an orientation in psychology towards both adaptation to and alteration of cultural conditions; that is, for changing the conditions which create the common fears and contribute to the neurotic ones, while at the same time helping individuals make an adjustment to social conditions that allows them the greatest opportunity for secure and healthy development. In other words, while psychology is inevitably influenced by cultural conditions, it must maintain a degree of autonomy from the dictates of culture in order to work in the best interests of human health and happiness.

Sexual and Racial Prejudice in Theory

Sexism and racism are culturally determined attitudes, which may become incorporated into theories of personality or interpersonal relationships. If psychological theory is to be liberating, rather than oppressive, its potentials for promoting prejudicial attitudes and practices must be exposed and reduced.

Psychoanalytic theory has led to sexually biased views by failing to examine fully the social conditions that shape women's

feelings and behaviors. The behavior Freud observed in his female patients often resulted from their inferior social status and sexual oppression; yet because he did not analyze social factors, but only intrapsychic ones, he came to view women's struggles with their social situation as attempts to compensate for an innate inferiority. Rather than examining the ways in which women's psychology has been influenced by adverse social circumstances, psychodynamic theorists have tended to describe the psychological effects of society's sexist practices as if they were natural female characteristics. Thus the popular psychological profile of women as "inconsistent, emotionally unstable, lacking in a strong conscience or superego, weaker, 'nurturant' rather than productive, 'intuitive' rather than intelligent" is one that "adds up to a typical minority group stereotype" (Weisstein, 1971, p. 6).

Many psychological writers have dealt with the potentials for sexism in psychoanalytic theory. Tennoy (1967) points out how ignorance of factors like women's unemployment and lack of education can result in psychological formulations reinforcing their self hatred and fear of social action. Horney (1967) and Roman and Blackburn (1979) discuss the sexual prejudice implied by Freud's concept of penis envy, which promoted the notion that women were biologically inferior to men, while ignoring the real social disadvantages in terms of education, employability and sexual gratification to which women were subjected. Others (Yarrow & Sherefsky, 1973; Horney, 1967) have pointed out the lack of attention paid by psychoanalysts to the significance of pregnancy and childbirth in

women's lives, except in terms of notions such as "compensation" for womanhood or realization of naturally "masochistic" tendencies (Halleck, 1971), concepts which serve to keep women in a socially inferior position.

Additionally, the focus on sexuality in psychoanalysis, particularly on women's sexual significance for men (exemplified by the oedipal complex), plays down the importance of women as people to love, and views them primarily as sexual objects (Fromm, 1955).² Although Freud contributed to the sexual liberation of men and women by bringing sexuality into the open, many of his superficially liberal attitudes toward sexual behavior had negative consequences for women. In the case of Dora (Freud, 1901), for example, Freud gave implicit approval to his patient's sexual exploitation. He knew that her suffering was due in part to being "handed over to this strange man in the interest of her father's own love affair" (p. 104); but instead of dealing with this situation, Freud chose, "because he shared in her exploitation . . . to work within the confines of her psyche" (Simon, 1970). Lack of objectivity with regard to male-female relationships was a limitation in Freud's understanding of feminine psychology and resulted in theoretical formulations which implicitly reinforce the sexual and social exploitation of women.

² Actually, Freud's belief that love is always "aim-inhibited" sexuality is relevant to both sexes, and offers a narrow view of the affective range and potential of men, as well.

Potentials for racial bias are found more in the applications of psychoanalysis than in the theory per se. Classical psychoanalysis was put forward as a universal theory, though in fact it was based on observations of behavior within a small cultural group. Many of the cultural givens on which analytic theory rests are absent in the subcultures of American minorities; thus their psychological norms and problems are radically different from those presumed by the theory. In addition to cultural differences, the socioeconomic status of minorities and their entire social milieu is at odds with that of the white middle class. Yet norms of behavior have been geared to cultural and social options open only to the majority, and racial minorities have often been thought of as ill or deficient when they fail to meet psychological standards unattainable in light of their limited opportunities. Without sufficient recognition that social limitations can result in psychological ones as well, traditional psychoanalytic psychology can seem to imply that minority members are to blame for psychosocial problems more accurately attributed to social or environmental factors than to intrapsychic or constitutional ones. This can lead the victims of racism to feel responsible for problems which in fact derive far more from social conditions than personal pathology. By directing clients to look within themselves for the cause of their emotional suffering, rather than recognizing the source as external, psychoanalytic therapy may unwittingly perpetuate the destructive consequences of societal racism, leading clients away from avenues of social change that might be of direct psychological benefit to

them (Bitensky, 1969). The lack of sufficient attention in psychoanalytic work to the disparity between the social circumstances of different ethnic and racial groups is thus potentially harmful to minority members.

Psychoanalysis often effectively excludes minority patients on the grounds that they do not fulfill special conditions necessary for such treatment: e.g. geographic stability, middle class patterns of language usage, sufficient income to pay for treatment, and the willingness to manifest restraint on action during an extended period of exploration. Yet some therapists believe that these criteria are mere excuses for analysts who are too inflexible to treat patients of a different class or race than themselves (Sager et al., 1972; Adams, 1970). Sometimes, the therapist has trouble accepting the priorities of black patients and grappling with their real-life problems (Sager et al., 1972); yet reluctance to combine psychotherapy with interventions into the patient's social system can spell therapeutic failure (Sager et al., 1972; Carter, 1972). These critics maintain that psychoanalysis can, with certain modifications, be helpful to black patients and that the concept of "unanalyzability" is prejudicial (Adams, 1970). Damage to the psychotherapeutic process is frequently the result of therapists' "suppressed . . . feelings about black people" (Sager et al., 1972) and black patients may appear "difficult" because they are responding to the analyst's negative countertransference (Adams, 1970).

Willingness of therapists to discuss racial differences openly in the therapeutic encounter, and to take responsibility for certain social interventions on their patients' behalf are likely to increase the effectiveness of psychoanalytic treatment with minorities (Adams, 1970). Yet many analysts conceive of such actions as breaches of psychoanalytic method and believe that attention to the patient's actual social problems will decrease his psychic gains. Some analysts contend that acknowledgment of the therapist's superior status, such as that implied by using his own leverage in the patient's interest or lowering fees for poor patients, would undermine the equality of the therapeutic relationship (Zinberg, in Post, 1972). Ironically, this emphasis on equality virtually prohibits analytic work with minorities, making psychoanalysis "unabashedly elitist" (Zinberg, in Post, 1972).

The acknowledgment of economic and social reality, and the provision of social as well as psychological assistance does not necessitate taking a superior or condescending attitude towards one's patients. In practice, however, when working with lower class or minority members, the "psychiatrist tends to assume the authoritarian role of the patrician or benefactor . . . rather than the egalitarian role he usually adopts with patients of his own class" (Halleck, 1971, p. 111). Even in situations where money is not an issue, black patients are less likely than whites to be selected for psychodynamic therapy and more likely to be treated with drugs or other impersonal therapies (Halleck, 1971).

Psychology's potential for negative attitudes towards or oppressive consequences for minorities is by no means confined to psychoanalysis. Although family systems theory ascribes to the family system an essential role in the determination of individual health or pathology, it frequently ignores the role played by extra-familial social factors (e.g. institutionalized racism) in shaping the miniculture of the family. This is in part responsible for the fact that black therapists have greater success with black families than do white therapists, and that generally speaking, the chances for successful treatment are improved when therapist and family have a common ethnic background (Zuk, 1971).

Unfamiliarity with the family's cultural norms may be compounded by the therapist's (not necessarily conscious) attitude of racial superiority that results in the desire to obliterate, rather than understand the unfamiliar. Greenhill (in Ferber et al., 1972) discusses a family therapy case in which he "had misunderstood the situation because I was white . . . I found it difficult to get involved with this family because . . . neither the family nor I wanted to discuss the color problem . . . it would have been better to talk about my negative, critical reaction to their authoritarian stand and to their color" (p. 523). The point is that negative reactions to racial differences as well as differences in values and expectations, can lead to therapeutic failure, and that open acknowledgment and discussion of racial tensions in therapy can increase the likelihood of success. While such openness does not abolish racist feelings in the family or the therapist, it

contributes to the dissolution of misconceptions and stereotypes, and so at least diminishes them.

The imposition of particular moral standards and values on minority group families for whom they are irrelevant may occur as a result of rigid adherence to apparently benign concepts of normality. A therapist's usual manner of handling mourning in a family serves as an example. While in general it may be "good for" a father, recently bereaved by the death of his own mother, to express grief in the presence of his family, a black father encouraged to grieve in front of his children might experience this as shameful and suffer a loss of esteem in the eyes of his children that would be detrimental to, rather than supportive of family integrity (Anderson J. Franklin, personal communication).

Another illustration can be found in the value of individuation. It has been observed that individuation is more easily achieved in some ethnic groups; for example, Jewish families ensure a high level of achievement in their children by "paradoxically, managing to encourage individuation in children while at the same time inculcating a sense of identity with the family and ethnic community" (Zuk, 1971, p. 126). But individuation has become a value for Jews, I believe, in proportion to the level of their assimilation and acceptance by society. In the U.S., where Jews have had opportunities for social and economic advancement, individuation is a value because it fosters successful competition in these areas and is no longer a threat to survival of their cultural or family life. This is not so for other underprivileged minority

families. In black families individuation is valued less than in white families and is often discouraged because of necessity (mutual dependence is often essential to economic survival) or because cultural standards, such as strong ties to the extended family, oppose it. In such families, individuation may be "purchased at the price of a painful dislocation from the family unit" (Zuk, 1971, p. 126). This may result in emotional bankruptcy for the individual who breaks away as well as for his family. The concept of individuation as a therapeutic ideal must be reevaluated, if well intended treatment is not to become coercive.

Family systems theory cannot, any more than psychoanalysis, remain neutral on issues of women's rights, and the distribution of labor, power, and affection between the sexes in a family. Often it is a power struggle between husband and wife, or the dissatisfaction with their respective roles that brings a couple into family counseling. How the therapist conceives of male-female roles, behaviors and obligations will be important in shaping the outcome of therapy--towards more egalitarian family structure or towards one based on the dominance of one sex over the other.³

The egalitarian ideal may be defined differently by the therapist and the family, especially where cultural differences exist.

³ Here it is appropriate to note that "sexism," though generally used to denote the oppression of women, includes the dehumanizing effects on men which result from the overly rigid role structure society imposes on women and men. The same point applies to racism; while the latter is most detrimental to the oppressed group, it also has a psychologically restrictive and morally corrosive effect on the oppressors.

The therapist needs to help the couple negotiate a solution to their role conflicts that is satisfactory to both husband and wife, even if theirs does not fit with the therapist's image of marital equality. More important is the therapist's sensitivity to and opposition of role restrictions which are experienced by either spouse as oppressive, or cause obvious physical or psychic damage.

Different cultures provide varying channels for gratification and different compensations for sacrifices required in men's and women's roles. Roles that are exploitative in white middle class culture because they are demanded, but not valued, may provide fulfillment and respect in other subcultures. Thus a marriage that is totally "stereotyped" in terms of sex role divisions, may in certain groups ensure equal satisfaction, power, and dignity for both partners.

In the abstract, family systems theory condemns oppressive roles for men and women, but in practice it is rather hard to identify solutions to family conflicts that are truly liberating for all members. Social and economic pressures present obstacles to role flexibility and it is often the path of least resistance that leads a family to accept traditional role assignments. It is easier for the therapist to support this option than to make waves in an already troubled family. In an effort to help the family deal with another type of problem, conflicts stemming from sexist practices in the family may be ignored or avoided by the therapist. In attempting to "clarify" familial roles, a therapist may assign tasks to parents along the lines of his own role preferences or

stereotypes; in trying to create positive identification between a child and his same-sex parent, a therapist may foster adoption of parental role behavior without preserving any sense of options for the child; and couples presenting a "role reversal" may be urged to adopt more familiar patterns, even when their real difficulties have little to do with their atypical role assignment.

Therapists may increase tension between the sexes in a family if they make the family members feel solely responsible for failures that are ensured by social and economic conditions as much or more than by their own personal shortcomings. As in the case of psychoanalysis, family therapists must recognize the social conditions responsible for family stress. Otherwise the family may blame itself, mistakenly, for all of its troubles, aggravating its members' sense of helplessness, and decreasing their motivation to change oppressive environmental conditions.

Political and Social Power

A theory of personality or interpersonal dynamics cannot maintain neutrality on the question of the individual's relation to society without becoming highly abstract and compartmentalized. Individual persons constantly interact with a social system which they influence and which influences them. Any statement concerning the nature of this interaction and its bearing on the psychological well-being of individuals leads to conclusions about the best design for social living; "personality theories imply sociopolitical

theories just as sociopolitical theories imply certain models of man" (Holland, 1977).

Some argue that psychology is the study of individuals and that social systems should be left to sociologists. In clinical psychology, this argument is bolstered by the medical model which focuses attention primarily on the intrapsychic aspects of personal difficulties and only secondarily on the nature of their interaction with social forces. Professional ethics in psychology, based to a great extent on this model, demand that therapists give priority to the needs and problems of individual patients; this may lead to an interpretation of the therapeutic role that largely excludes social, political, and moral considerations. Intervening in a patient's social environment or passing judgment on his political stance is regarded as unethical behavior by many psychotherapists; aside from being a breach of professional boundaries, social interventions demand a forfeit of confidentiality. Such behavior may detract from the therapist's concern for his patients' psychological welfare with detrimental results. Moreover, a therapist who takes an active role in examining his patient's sociopolitical situation may be tempted to force his own political ideologies onto the patient, exploiting the patient's emotional dependency to promote change that is not necessarily therapeutic.

The counterargument states that the division between psychology and sociology is an artificial one, that the best understanding of personality results from an examination of both intrapsychic and interactional factors and that political and social processes are

integral determinants of the mental health or pathology of individuals. According to this view, personality theories constructed without regard for social conditions are misrepresentative; if their aim is to further optimal development, psychological theories must discuss plainly the social and political conditions which are most conducive to mental health (Fromm, 1955). Proponents of this position believe that it is unethical for a therapist not to deal with the political-social aspect of a patient's life and that disregard for the latter may result in therapeutic failure or contribute to social oppression from which many patients suffer. Therapeutic "neutrality" can communicate acceptance of current sociopolitical conditions, and detract from the potential of the therapeutic relationship to help the patient improve them (Halleck, 1971).

Psychoanalytic and family systems theories have somewhat different views on the matter of social power. Psychoanalytic theory emphasizes the motivation and meaning of actions for the acting individual and is less concerned with the actions per se or their consequences for others. The individual is largely viewed as a closed system. Intent rather than effect is seen as the more crucial element in behavior, and intention is sought primarily within the mental processes of the individual, not in the social systems or interpersonal dynamics of which he is a part.

This focus on motivation along with emphasis on intrapsychic structure and unconscious processes implies a lesser role for social action. By stressing intent rather than behavior and its consequences, the analyst is less concerned with the patient's influence

upon the environment, and he is also less attentive to the ways in which the patient's intrapsychic state is influenced by the environment. The psychoanalytic focus is primarily on the self and tends to disregard the social world as a source of emotional support or stress. Thus psychoanalysis can be read as discouraging social change; it may burden the individual with a belief in total self determination that can become self limiting.

Unlike psychoanalysis, family systems theory looks for motivational factors within the context of interpersonal dynamics rather than in the unconscious of the individual. The individual is viewed as an open system, continuously affected by and affecting the workings of his family system. While in one sense this model sees the individual as dependent on his family system, it also assigns him an important and powerful role within that system; his actions are believed to count not only for himself and his own psychological status, but for the others with whom he interacts. Within the family, each individual is seen as having substantial power to influence and change the system, by changing his own behavior in relation to that system.⁴

Family systems theorists are only beginning to deal with the political relationship of individuals and families to the larger

⁴ Although it appears in some families that power is vested in only some of the members, while others are "weak," examination of familial dynamics often proves this to be illusory. The types of power in family systems are infinite and true powerlessness in family relationships is probably intolerable (Olga Silverstein, personal communication).

social system (e.g. Boszormenyi-Nagy & Spark, 1973; Roman & Blackburn, 1979). Yet the family may be seen as a microcosm of society (Roman & Blackburn, 1979); and because it is the primary agent of socialization through adolescence, its relational patterns and dynamics form a model for extrafamilial relationships. A theory which views family members as mutually influential, and sees the connections between people in terms of actions and responsibilities (Boszormenyi-Nagy & Spark, 1973) implies that individuals have the capacity to bring about social change through their own actions, and thus have some real power in relation to social and political systems.

Defining Normality

Concepts of power and powerlessness implicit in psychological theory are linked with various definitions of normality. These definitions are easily swayed by social and cultural influences. Even attempts to define normality on a strictly medical basis can have unanticipated social consequences and ethical implications. Thus it is important to examine our "clinical" notions of normality and to ask to what degree they are based on morality as well as what the consequences are of defining behavior in moral or medical terms.

Clinical psychology and psychiatry have focused on pathology and largely ignored the study of normal or healthy behavior. In fact, there is considerable controversy about whether "normality" and "health" are equivalent terms, and over which goal to strive for in treatment. The World Health Organization defines health

rather ambitiously as ". . . a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (in Dunn, 1961, my italics), yet few people would call this state normal in terms of an average expectable human condition. Some clinicians equate normality with an adequate, rather than ideal level of functioning: "The temptation is to want our clients to have what none of us have, total competency and some ideal of complete mental health. But the purpose of therapy . . . is to free people to function competently, not for therapists to judge whether they're 'healthy'" (Walters, in Roman & Blackburn, 1979, p. 117). Definitions of normality which avoid ideals demand less than those which equate psychological normality with "complete mental well-being," and in this respect may be more liberating. In their applications, functional definitions of normality tend to encourage patients' independence and prevent therapy from becoming an endless quest for psychic perfection. On the other hand, the avoidance of ideals may result in a lack of concern with real psychic pain that nonetheless does not significantly impair functioning.

Many theorists and clinicians rely on a medical definition of normality while claiming neutrality on moral issues, for example labeling homosexuality a "disease" while withholding any judgment of it as right or wrong (Bieber, in Post, 1972). The explicit use of morals and values in judging behavior may be less deceptive. Fromm (1947) for example, developed a system for evaluating people and society based on humanistic ethics. He believes that gains in health and happiness can be made by acknowledging the values implied

in theories of personality, e.g. in recognizing that Freud's "genital" character is not only "more normal" but in some respects more moral in relations with others than the "pregenital" character. Similarly, Ramzy (in Post, 1972) states that psychoanalysis shows "certain patterns of behavior are more conducive to a better way of life than others" (p. 222). These theorists believe that the recognition of values in clinical definitions of normality can lead to their use as positive criteria for mental health which go beyond the "average expectable" and avoid the use of pathology to define wellness. An open acknowledgment of values allows others to accept or reject one's judgments of behavior without implicitly condoning "illness."

Values are inherent in the process of choosing what to change about people, whether one uses a functional, medical or moral approach to clinical judgment, and regardless of whether one's framework is the individual or the family. Given this situation, definitions of health or normality that are most explicit in presenting their underlying value systems are likely to be least problematic. Individual, familial and social context form a backdrop for notions of pathology; at the same time, our conceptions of normality and health may include positive values and ideals which go beyond current realities. In this way we can retain the potential for improving our basic condition rather than limiting ourselves to the simple reduction of pathology.

Social-Ethical Problems in theApplication of TheoryExcluding Significant Others From Therapy

An ethical issue of particular significance to psychoanalytic therapy concerns the problems of treating one person while excluding those people with whom he shares significant relationships. The ethical question in this regard is twofold: what are the potentially negative consequences to the patient of being treated individually, and what potential is there in such treatment for emotional harm to the people who are excluded?

First, what problems arise for the patient as a consequence of individual treatment? One difficulty stems from conflicts between the patient's loyalty to his family and his loyalty to the therapist. In analytic treatment, the conflict is intensified through its encouragement of transference whereby the patient reexperiences past relationship events by relating to the analyst as if he were another significant person, usually a parent. Transference is a requirement of analytic therapy; yet positive transference may be experienced by the patient as disloyalty to his actual parents, resulting in increased guilt and conflict in his relationship with them (Boszormenyi-Nagy & Spark, 1973). The freedom to ventilate negative feelings about his parents (or others) without actually having to confront them face to face, may also play into this conflict of loyalties. Attempts at conflict resolution may involve the failure to get better (i.e. to let oneself be "parented" by the analyst), or an acceptance of the analyst as a "good parent" and an

"emotional cut off" (Bowen, 1978) from one's "bad" actual parents. Problems also arise when an individual's difficulties stem from interpersonal circumstances over which he has little control, for instance, when the patient is a child. Because of his dependency, the child is particularly vulnerable to all family stresses, which need not include physical abuse to be psychologically damaging. Many therapists have felt the frustration of making a "breakthrough" with a child patient only to find that his emotional gains were soon undone by destructive interactions in the family. Similar difficulties can arise with adolescents and dependent spouses.

If a therapist finds that his patient is the victim of emotional and/or physical abuse, he can be fairly certain in ascribing psychopathology to the abuser as well as the patient. It is tragic that family members who may actually need help even more than the patient are never treated by the individual therapist--in fact, confidentiality may preclude any sort of contact with them. Not only is the patient at risk when the family is excluded from treatment, but family members are denied the opportunity for much needed help.

Institutions offering individual treatment sometimes contribute to this problem by regarding the patient's family members as the instigators of his problems. By refusing to include them in the patient's treatment, they allow those family members to "repeat and pass on debilitating and self-debilitating behavior without being offered the opportunity for help. In becoming advocates for their patients, such institutions unwittingly become enemies of their patients' families" (Roman & Blackburn, 1979, p. 129). When it is

likely that such debilitating patterns exist, the most responsible course of action would seem to require at least some direct assessment of the patient's family, if not referral to a family therapist.

When, if ever, does the therapist's moral responsibility extend beyond the interests of his particular patient? A problem arises when therapy that is judged successful from the vantage point of individual psychological development results in negative emotional consequences for the patient's family or other people close to him. This may involve the divorce of a couple following one spouse's experience in psychotherapy, though less dramatic marital problems are a more common result (Hurvitz, 1967; Fox, 1968).

Analytic therapy may threaten a marriage by requiring the sacrifice of time, money and energy that the patient would otherwise direct toward his spouse (Fox, 1968) and by fostering an intimacy between patient and therapist that is likely to arouse the spouse's jealousy (Hurvitz, 1967). When a patient's improvement in therapy is accompanied by a weakening commitment to his spouse, such that break up of their relationship is imminent, the therapist has to choose between remaining "neutral" or involving the spouse in therapy. The latter course allows him to obtain a clearer picture of the relationship and the degree of harm to which the spouse may be subjected by a divorce. In cases where the non-patient spouse does not want a divorce, or would be seriously hurt by it, it may be more responsible for the therapist to help the couple reach a solution, rather than continuing to support exclusively the goals of the individual patient. This does not mean that the therapist

should take a moralistic stand on divorce, or try to prevent it. But when a patient's relatives are endangered by the outcome of his therapy, the therapist has some responsibility, it would seem, to consider their needs along with the patient's.

A related but somewhat different problem arises when a previously healthy relative of a patient becomes emotionally disturbed as the patient improves. Some individual therapists have noted psychological deterioration of one marriage partner following the improvement of the other (Fox, 1968), and family therapists have observed a similar phenomenon among siblings--as one child improves, the other develops symptoms. Of course, a certain degree of stress in the patient's family is expectable particularly when the patient is in a period of rapid change; and such stress does not necessarily produce lasting negative effects. Sometimes the family "disequilibrium" caused by one member's treatment leads to a readjustment of family functioning at a higher level than previously (Glasser, 1963). But in less stable families, an imbalance caused by the psychological growth of one member can result in another's psychological distress. The family system may "need" a patient (in which case the switch in roles is equivalent to "symptom substitution"), or the new patient's problems may be seen as the frustration of neurotic needs that he cannot satisfy in the absence of the old patient's pathology. Whatever the cause, the extent of the therapist's responsibility, when he is aware of this process, remains an important issue. One may argue that the therapist's responsibility is to the individual who has explicitly requested

his services, but services are of questionable value if they merely trade one person's problem for another's. While the individual therapist's primary responsibility is to his patients, the fact that his work has repercussions for others requires some degree of accountability to those affected, at times adversely, by his interventions.

Extended Family and Social Networks

It used to be that father, mother, and children living under one roof defined the "family." But alternate configurations have always existed, and in recent years have become more prevalent. "Family" has come to include a variety of cohabiting groups, some related by birth, others by emotional commitment; a single concept is no longer sufficient to describe the reality of multiple family types.

These alternative configurations represent a change in family structure and challenge the notion that a family relationship is necessarily based on genetic or marital bonds. The definition of "family" in terms of size may also be challenged, and the conceptual boundary around the nuclear family can be seen as arbitrary from both biological and psychological perspectives. All of us have extended family, whether we live with them or not; and our relationships with these relatives may have a significant impact on the emotional functioning of our nuclear family as well as on our individual development.

The psychological importance of extended family, particularly grandparents, was apparent to several early family therapists (e.g. Bowen, 1978), and some believe that, at least in terms of the theoretical framework applied in work with families, "the minimal context of therapy should be the three-generational family unit" (Boszormenyi-Nagy & Spark, 1973). Finally, a small group of therapists, notably Speck and Attneave (1973) have included entire family networks in a unique, brief, intensive family treatment.

The expansion of family therapy and theory beyond the confines of the nuclear family unit has opened up the question of family size. Just as individual therapists are faced with the social and ethical dilemmas concerning the exclusion of significant others from treatment, family therapists must face the psychological implications of therapy limited to nuclear units--as well as the consequences of doing therapy with ever larger groups.

If one accepts the theoretical rationale for treating a family as a system, then it makes poor sense to treat a nuclear family apart from its extended network in cases where the family is structured as a multi-unit system (which is the case in many subcultural groups). Such an approach would pose the same problems arising in treatment of an individual outside of his immediate family group. Even in families where nuclear groups are close, though not structured as one unit, difficulties can arise when one group is treated in isolation. The patient group forgoes potentially valuable support, while the nonpatient group may be falsely blamed for the family's failure. In these situations, inclusion of extended family

members in therapy may maximize chances for success and protect the extended family from undue blame, guilt and emotional isolation.

Secondly, some therapists have found nuclear family treatment inadequate for helping certain individuals within the family. Nuclear family treatment may fail to alleviate individual difficulties that deplete the resources of a nuclear family--emotional, physical, or financial. Terminal illness, drug addiction, psychosis, or suicide attempts in one family member may result in psychological strain and practical inconvenience that is too much for a single nuclear family to bear. When the family cannot cope with the increased burdens of a severely impaired or potentially dangerous member, they may resort to institutionalization of that person. While this may be necessary in some cases, its effects in terms of emotional isolation of the patient and a sense of failure and hopelessness in the family make institutional care less than optimal. In such cases, network therapy (Speck & Attneave, 1973) can be an alternative.

Network therapy usually involves 40 to 50 people and draws on available resources within the extended family for both emotional support of the individual and the nuclear unit, as well as for planning of solutions and execution of specific tasks. The goal is to solve the immediate crisis in the family and to set up a self sustaining support structure that will be able to cope with future problems.

Once the boundaries of a family system are opened up, deciding where to close them is not so simple; theoretically, systems therapy

could be applied to family units defined ever more inclusively, or to whole communities. There are obvious practical difficulties with such expansion, however, as well as ethical questions regarding such extended treatment.

One danger of making ever larger relationship networks the targets of professional intervention is identical to that inherent in identifying greater and greater numbers of individuals as "patients." The capacity for social influence and control is dramatically increased with 50 people in treatment as opposed to two or five; and this capacity can be abused by therapists with a particular ideological axe to grind. When mishandled, the network approach can backfire, resulting in group dependency and a shared sense of being a "problem family," instead of the increased strength and self reliance that is intended.

Additionally, by broadening the base of responsibility and the area over which problem solving is spread, extended family or network therapy may detract from attention to the problems of particular individuals to an even greater extent than therapy with nuclear families. The intense emotional involvement of numerous group members may result in the original "index" patient getting lost in the shuffle. "Family therapists . . . sometimes forget that there are aspects to the patient's symptomatology . . . which are refractory to systems intervention. When they insist on using family therapy as the sole mode of intervention, their ideological commitment deprives the patient of essential treatment" (Halleck, 1978, p. 485). This danger can increase in therapy with larger family

units, as attention to multiple relationships dilutes the perceived severity of individual difficulties.

Network therapy has potential to act as a medium for social change in addition to the danger it poses for social control. The philosophy of this approach is that people can help themselves within a family or community context. It is focused on increasing the capacity for self help rather than fostering dependence on mental health professionals. It sets up a positive social process which may flow in many directions, functioning more as a social therapy than family or personal treatment, more as a preventive than a curative effort. As such, "therapy" with extended families and networks provides opportunities for positive social change, based on the fortification of social support systems available to patients. Rather than family size, what is important to expanding the social potentials of family therapy is the willingness to utilize strengths inherent in "familiness" among people--whether blood relations or not--in order to improve the mental health and well-being of all.⁵ In this regard, most family therapists have been as rigid as individual ones, regarding the nuclear family as a "sacred cow" (Scheflen, in Ferber et al., 1972), and rarely challenging the basic premise of the nuclear family as a way of life.

⁵ Network therapy is currently done with smaller select groups of "significant others" and has some of the same positive effects, as well as practical advantages over the original network intervention (Carolyn Attneave, personal communication).

Scheflen and Ferber (in Ferber et al., 1972) point out that the nuclear family is not a universal or biologically given structure, but one that evolved as a consequence of complex social processes. The social structure of society--military, economic, professional--discourages extended family relationships, and the therapeutic establishment reinforces the mainstream bias towards nuclear family structure; both individual and family therapists often look upon close extended kinship ties as signs of immaturity or pathological dependence. Yet, as these authors show, there are many psychological stresses associated with nuclear family life, and it may result in some environmentally and socially damaging processes. Each family, for example, purchases duplicates of goods and services, contributing to pollution and waste of valuable resources.

A reinvestment in extended family relationships for the sharing of both emotional and material goods has potential to relieve much of the stress of nuclear family life and to encourage the reversal of unhealthy social trends. Obviously, changes in social policy are needed to allow this process to occur. But psychotherapists can begin it by respecting the validity and psychic significance of extended family ties where they do exist, by encouraging their establishment when they are absent, and by becoming open to the healing potentials available in various familial and family-like relationships. While consistently considering the needs of individual families, therapists can consider, too, the ethical and social consequences of glorifying them.

Facilitating Social Action and Modeling Values

Although the primary focus of psychoanalysis is on achieving insight, many analysts believe that the translation of insight into action is of equal or greater importance (e.g. Wheelis, 1973). Even in its most orthodox form, psychoanalytic "working through" generally aims at helping the patient translate his newly acquired consciousness into an altered way of acting or living. When insights revolve around personal and relationship issues, the necessary behavioral changes are easily recognized and set in motion. But when therapeutic progress brings awareness of the social problems affecting a patient's life, it may be less clear how to alter his behavior or channel his energies in order to effect environmental change. As indicated previously, this is the point at which therapy often fails, either because the therapist discourages his patient from trying to change social circumstances, or because he doesn't know how to help his patients deal with social problems effectively.

Direct political or social action may not always be necessary or desirable in order for a patient to cope with problems stemming from social factors; psychological adaptation may be more therapeutic than direct action in a particular case. If therapists are willing to discuss social problems and realities as part of therapy, they must also be alert to what is best for the patient, regardless of what they believe is a more noble or politically correct course of action. It is the patient who must have ultimate responsibility for his choice to act or not, while the therapist's job is to guide

him toward a rational and self-benefiting decision. In other words, the therapist's responsibility is to present the option of social action solutions to patients who may not be aware of existing avenues for changing their environments. Hopefully, those patients who do become involved in social action will do so with a greater sense of the potentials, limitations and consequences of their behavior.

Bitensky (1967) advocates social action itself as a primary treatment mode. He believes that traditional therapy with poor people fails because environmental stresses and lack of opportunity for education and employment make it difficult for them to actually apply what is learned in treatment. He points out that social action is beneficial to poor people not only because of its ultimate ends, but because the process of social involvement itself provides varied opportunities for interpersonal contact, group support, training in communication skills, and a basis for identity formation.

Additionally, social action provides opportunities for catharsis that are more meaningful than "ventilation" in therapy (Bitensky, 1967). While psychotherapy gives patients a chance to voice their grievances, "there can be a satisfying release of aggression only if the victim retaliates against his task-master" (p. 506). Social action allows the patient to direct aggression towards the appropriate agencies in a constructive, productive manner, rather than through random, aimless, or destructive acts.

Halleck (1971) believes that therapists can facilitate changes in social systems that hurt their patients, not only by changing

the patient's behavior in this area, but by altering their own behavior. An example is the withholding of the "psychiatric excuse," i.e. the refusal to label people as psychiatrically ill in order to release them from unwanted and perhaps unjust obligations. By refusing the psychiatric excuse (e.g. to help a person avoid the draft, be released from a contract, or escape criminal charges), the therapist can encourage patients to use more appropriate social and political means to alter repressive military, legal or criminal justice systems, rather than dodging the social issues by feigning irresponsibility. Other ways in which therapists can facilitate positive social changes include working on the same social problems that their patients are struggling to ameliorate, and working directly for reforms in mental health policies for the benefit of patients, such as improving mental institutions, making psychotherapy more available to the needy, etc. (Halleck, 1971).

The actual involvement of the therapist in social action which can directly benefit his patient, or indirectly benefit all patients by changing social systems, raises the issue of modeling social values and behaviors as part of treatment. Many therapists are reluctant to disclose their own values, actions or lifestyles to patients, for fear that this modeling will have an irresistible, essentially coercive effect on the patient. Despite the conviction that the values and principles by which they live are conducive to health and happiness, they may resist sharing these with the patient because they feel that doing so would limit the patient's freedom of choice.

The argument that modeling or self disclosure is coercive appears fallacious. Patients may be more ready to accept the direction or suggestions of the therapist than those of other people--this is one reason they consulted a professional--but unless the therapist is using rather unethical techniques, the patient retains some degree of freedom to agree or disagree with what his therapist states and does. If the therapist reveals his values and behaviors without imposing them, he models honesty, tolerance and courage for his patient in addition to those values contained in the particular content of his behavior.

Recognition of modeling as a factor in therapy is important from an ethical standpoint because even when a therapist is trying not to reveal himself, he is inevitably modeling certain behaviors and attitudes for his patient. Adams (1970) points to the need for therapists to change themselves in order to be the models they want consciously to be for their patients. He urges therapists, for example, to lessen their negative countertransference to black patients by educating themselves about black life and culture, becoming involved in social and community relationships with blacks and working on civic issues relevant to black people. This "personal action research" (p. 42) remedies past misconceptions while it serves as a model for patients to do the same and as a demonstration of the therapist's personal commitment to change and to the provision of unbiased treatment.

A therapist's attempts to change his own values, attitudes and behaviors have therapeutic effects on his patients by making him a

more genuine model of those values he verbally supports. By changing himself, the therapist can say "Do what I do," a more honest and effective instruction than the usually implicit "Do what I say." This is one rationale for making a personal therapy experience a part of each therapist's formal training, a practice which most therapists advocate.

Some Moral Choices and Dilemmas

Clinical psychologists are in a particularly ambiguous position with respect to human values. As a scientist trained in objective research methodology and the production of knowledge for its own sake, and as a healer committed to the amelioration of human suffering, the psychologist's priorities often conflict. Choices between the values of science and those of human welfare must frequently be made.

We have reached a point in history where technological and scientific advances, for all their potential to improve our material and emotional lives, pose a threat to our survival. The commitment to knowledge and discovery, unchecked by an equal commitment to human well-being has resulted in the use of potentially liberating and creative scientific means for highly destructive ends--nuclear weapons, environmental contamination, political oppression, economic exploitation.

Psychology, to be sure, has contributed far less to this state of affairs than the "hard" sciences, and clinical psychology, because of its twofold task has perhaps retained a broader and

more humane perspective than other sciences. Still, psychotherapists can further this destructive trend by allowing their theory and research to take precedence over the emotional needs of patients and over the human needs of people in general. Kohut (1968) for example, plays down the work of therapists known to be gifted with borderline patients; he mistrusts their quick therapeutic successes, which are "unscientific" from an analytic point of view, and believes that prolonged treatment is necessary in order that "new analytic insights" and "scientific progress" can be made. Kohut gives scientific progress a higher value than therapeutic benefit, exemplifying the tendency to let scientific means and the ends for which they are intended become dangerously detached.

Holt (1974) regards the conflict between scientific and humane values as a pressing moral issue for psychologists. He points out that the process of valuing is an integral part of scientific judgment, and notes that the values of the scientific method, while not incompatible with broader human values, are not sufficient to prevent misuse of the knowledge produced by that method. Thus, there must be a "new commitment--not only to the values of science, but to the goal of directing our scientific work towards coping with disasters that threaten the survival not only of science, but of all civilization, perhaps that of life itself" (p. 47).

The scientific value of seeking knowledge is consistent with the value of searching for and expressing the truth, which is basic to the spirit of psychotherapy. Truth is one value which several traditional psychoanalytic therapists will admit to modeling (e.g.

Stern, in Post, 1972) and which some consider the supreme value of psychoanalytic work, overriding all other moral considerations (Ottenheimer, in Post, 1972). Truth is the value underlying the process of making the unconscious conscious; the idea that truth leads to greater freedom is the motivator of much therapeutic work.

In treatment, truth can at times conflict with other values, posing new dilemmas for the therapist. Truth in therapy is subjective, an agreement between therapist and patient about "pursuits which are somehow right" (Erikson, 1964, p. 112). Sometimes, in the interests of "cure," what feels true is merely a reflection of what we would like to be, a distortion of objective reality. This is especially likely to happen when dealing with psychological issues that are related to social processes, for pain and unhappiness are inevitably experienced in facing the social realities of our time. Garcia (1974) believes that truth is often traded for the happiness of illusion, and that psychotherapy, in its mission to give patients a sense of security and certainty, may prevent their confrontation with truths about their own personal psychological reality as well as the broad social reality. He contends that therapy which makes individual happiness a higher priority than the acknowledgment of disquieting social realities is "psycho-fraud" and that only by seeking truth and knowledge can we be truly happy.

The choice between action and thought is another choice for psychologists. At one extreme is the position that psychological insight, understanding and a correct mental outlook on the world

are sufficient to cure all human problems. At the other end, is the view that behavior, or action is all that matters, while awareness is insignificant. Most psychologists, however, recognize the necessity to address both activity and awareness. The ability of man to use efforts of will and reason to express insights more passively achieved, has been stressed by several theorists (Erikson, 1964; Wheelis, 1973; Fromm, 1955). They believe that action as well as truth or awareness is essential for the attainment of freedom and the fulfillment of psychological potentials.

Thought, insight, and awareness are internal phenomena, which in themselves, neither help nor harm others. What goes on in a person's mind is of no social consequence except insofar as it is translated into communication or action--there is no ethical basis for accountability regarding inner experiences (though subjective "facts" of these experiences are important in the therapeutic process). Action, however, including all forms of communication, implies consequence, and thus responsibility; we are accountable for what we do (and what we fail to do in some circumstances). While in thought and fancy there is infinite freedom, in action there is not. Thus when encouraging patients to act on their insights, in order to enhance their freedom, therapists must also confront with patients the limitations and restraints on individual freedom arising from the ethical responsibility of one person to another.

The values of freedom and responsibility can appear to conflict, and often we are faced with a choice between expanding our

personal options or limiting ourselves in order to fulfill social obligations. Much of what happens in the life span of an individual as well as in our collective life, hinges on the thoughtfulness with which we resolve this conflict. Paradoxically, it is often the avoidance, rather than the "burden" of responsibility that limits our personal freedom. Our sense of psychological freedom seems to depend, in part, on our recognition and discharge of social responsibilities. The less one faces the ". . . obligations accumulated in the past . . . the more he will be at the mercy of these invisible forces" (Boszormenyi-Nagy & Spark, 1973, p. 68).

Therapists must not only be able to facilitate the resolution of patients' conflicting values with respect to freedom and accountability, but must also balance these values in their own relationships to patients. One view states that "ethically, the therapist cannot assume decision making responsibility for the client, but must facilitate client self-understanding and self-direction" (Van Hoose & Kottler, 1977). This position allies the therapist with the patient's pursuit of freedom. On the other hand, the therapist, if he is acting both freely and responsibly, may want to discourage patients' decisions and philosophies when he believes these to be immoral or damaging to the rights of others, and may "consider therapy a failure or incomplete for those patients who continue to uphold these views" (Sarnoff, 1957, p. 197). The therapist's consciousness of his own social obligation to protect the freedom of others means that he must at times work against the unchecked freedom of his patient.

The issue of freedom and restraint brings us back to the question with which this discussion began: how can we balance the forward thrust of progress with the limitations necessary to retain our humanness and ensure our survival? The quest for increased knowledge, control and mastery over the environment seems basic to our human nature, just as the search for emotional truths, and the expansion of psychological potential seem like "natural" spiritual values. At the same time, our commitment to these values has resulted in developments which threaten our psychological health and physical survival. "In our era of limitless technological expansion, therefore, the question will be what man can afford and decide not to use, not to exploit--and yet save his identity" (Erikson, 1964. p. 126).

If we are to survive as a society and especially if we hope to improve our material and emotional condition, people of all walks of life must contribute answers to this question. Psychologists, concerned with human identity, freedom and fulfillment, can use their expertise, not only "on the couch" but in a broader sense, by helping to direct society and individuals away from "robotization" (Fromm, 1955) and towards greater humanization, away from an overinvestment in scientific progress for its own sake, and towards a more contained and directed use of knowledge for life enhancing and truly liberating purposes.

CHAPTER FIVE

UTILIZING THE STRENGTHS OF INDIVIDUAL AND FAMILY APPROACHES:
TOWARDS INTEGRATION WITH A VALUE BASE

The purpose of this chapter is twofold. Firstly, it works towards developing a perspective by which the strengths of psychoanalytic and family systems approaches can be integrated, drawing on the conceptual similarities discussed in Chapter 2, and expanding on the dialectical framework introduced in Chapter 3. Secondly, it presents a framework of values which may guide and enrich theoretical integrations, and which can be used towards resolution of some of the ethical dilemmas and value conflicts presented in Chapter 4.

Towards a Value-Based PsychologyValues of Human Ecology

Ecology is a science of relationships, concerned with the interactions between organisms and their environment. Applied ecology is the study of survival, aimed at discovery and maintenance of those interdependent exchanges that allow an organism and its environment to flourish harmoniously over time.

Just as physics was a model for Freud's theory of the mind, and cybernetics was a model for the study of human communication, so can ecology be used as a model for integrating individual and family theory. "Ecological psychology," or human ecology, can be conceived as the study of relationships between individuals and their social environments, the analysis of interactions and

exchanges allowing for the psychological survival and development of individuals and social units sharing the same niche.

Although scientific ecology analyzes relationships between organisms and environments as they unfold in nature (including man-made environments), its applications in preserving ecological systems and existing life forms imply a unique set of ethics. In fact, ecology has been called the only value-conscious science (Beavers, 1977). Ecology views humans as part of a natural order, dependent on a network of connections between themselves, the inanimate environment, and other living things. Unlike other sciences geared towards the discovery of knowledge about the physical universe, ecology, especially its environmentalist branch, concerns itself with how the process of discovery and the uses to which knowledge is put alter the universe, and how these consequences affect the ultimate survival of human and other species.

Ecological studies indicate that the survival of humanity depends not only on the ability to tap available resources, but also on the ability to limit consumption in order to reserve and replenish resources as well. Survival demands a balance between human desires and the needs of the environment; it requires give and take, rather than the limitless utilization of environmental offerings.

This principle applies in the psychosocial realm as well. Maintenance of the human ecosystem involves a delicate balance between individual and social priorities. Just as we are sustained by the resources of the physical environment and so obliged to

maintain them, so are we nurtured by the social environment that is essential to the continuity of our individual and species existence. Here too, respect, protection and replenishment are necessary for the maintenance of resources. Repression or exploitation of other people, while it may temporarily serve individual aims, ultimately results in social consequences detrimental to the individual and the human community, for example, violent revolutions on a national level or disowning or abandonment of group members on a smaller scale. Ecological equilibrium in the psychosocial sense requires fair and balanced relationships, in which love, respect and esteem are given to as great an extent as they are received; and this depends on the value of reciprocity.

Reciprocity is a basic principle in nature (e.g. in the exchange of oxygen and carbon dioxide between plants and animals) and a fundamental value in the ecological study of human relations. Yet reciprocity and fairness in social interactions are antithetical to mainstream American values which stem largely from our competitive economic system. Prominent among these values are those of individual aggrandizement: wealth, power and prestige (Sarnoff, 1966), in pursuit of which unilateral consumption and exploitation have been seen as hallmarks of social adjustment and success.

Psychological and social goals can be distorted by a "Depression mentality" which sees human survival and growth primarily in terms of freedom to advance economically (Auerswald, in Ferber et al., 1972). Psychological change motivated by an economic value

system (wanting to take, get or be given a better psychic "deal") may result in the expansion of an individual's image of himself (an "ego trip" perhaps) but is not likely to further genuine personal development (Sarnoff, 1966). The "success" of this process is illusory, alienating the individual from the reality of his connectedness to other human beings. Ultimately, failure to concern oneself with the welfare of others may lead to personal impoverishment through the loss of supportive relationships and the thwarting of creative potentials sparked by mutual nurturance, contribution and problem solving.

The principle of reciprocity in human relations means that successful development occurs in the context of ethical concern for others, and not as a unilateral, totally self-centered project. Reciprocity is a group survival value, working against unfair imbalances in social relationships that may disrupt or destroy life sustaining human bonds.

Reciprocity is actualized through cooperation, sharing and fair distribution of resources. Environmentalists have emphasized the usefulness of car pooling, recycling of materials, food cooperatives, and other efforts to eliminate wastefulness and inequality in the consumption of natural products. These efforts stem from an ethical concern with the well-being and development of the human community as opposed to an exclusive preoccupation with the satisfaction of individual needs and wants. The values of cooperation and sharing are equally relevant to the application of psychological

theory in dealing with problems of inequity, destructiveness and waste in human relations.

Family and network approaches to psychology, while they have not generally studied families in their natural (community) settings, have clarified the correspondence between psychological and biological survival in this respect: focusing on individual health and the best interests of individuals alone, does not necessarily promote survival of the group (Auerswald, in Ferber et al., 1972). Without an appreciation of broader social dynamics and concerns, an exclusive focus on individual needs may be detrimental to the integrity of the group, and ultimately to its individual members. The concessions which individuals must make to family and other social groups may not be to their immediate advantage, yet because individuals are ultimately dependent on social systems (particularly families) for the fulfillment of their various physical and emotional needs, compromise and cooperation with the demands of group cohesion are in the long run generally beneficial to the individual.

The integration of individual and family psychology may facilitate expression of reciprocity, cooperation and fairness; for the family, much more than the larger society, depends upon these values for its emotional survival and hence its ability to raise emotionally healthy individuals. The absence of these values in society at large creates social institutions that in many cases fail in the support of emotional needs and the provision of human concern. An ecological approach to social change aims at making

social institutions more responsive to and responsible for biological and social needs on both individual and familial levels. By approaching psychosocial issues with an eye to fostering the cooperative values on which the health of the family depends, we can contribute to the development of the values required to shape a more equitable, ecologically balanced society. The fostering of such values may be regarded as part of the therapeutic process and their establishment as part of a positive therapeutic outcome.

An ecological perspective implies a concern with unintended consequences of alterations in a complex, interdependent system. Such consequences are evident both in the sphere of technological development, where there have been numerous incidents of physical and biological damage resulting from incautious tampering with the environment (e.g. nuclear accidents, contamination of waterways, etc.), and in the area of psychosocial interventions undertaken without consideration of their potential repercussions in related social systems. The potential impact of individual therapy on the patient's family system, the effects of individual and family adaptation to repressive social institutions, and the consequences of therapeutic modeling of values and actions are examples of clinical considerations relevant to an ecologically oriented psychology.

Awareness of the complexity of social systems means that treatment efforts should err, if need be, on the side of caution. The clinician should attempt to gather information about his patient's physical and social setting before intervening in a manner that might needlessly disrupt it, or unwittingly encourage

adjustment to a destructive situation. He should be alert to connections between people and events that might not at first glance seem relevant, rather than making hasty judgments based only on obvious circumstances.

Caution may dictate intervention at a family or organizational level, or require the observation of clients in their natural setting, for example, the dinner table observations popular with some family therapists and the in vivo assessment and treatment used by behavior therapists. But it has implications for traditional individual therapy as well. It means that the therapist cannot assume superiority of knowledge about the patient's interpersonal system (of which he is a part) and that he can be most helpful by accepting the patient's perception of the therapeutic relationship rather than dismissing it as mere "projection" or "transference distortion" (Levenson, 1972). By acknowledging that he and the patient are both part of the same larger system, and by being honest within the limitations of that framework, the therapist can facilitate the patient's awareness of interrelationship and uncertainty, helping him to come to terms with these aspects of living in his own unique way. In such work, ". . . one seeks no longer a Garden of Eden . . . but a workable ecology with balance and pattern . . . and with respect for the intricate and frequently untraceable relationships between parts of an organic system" (Levenson, 1972, p. 116).

A workable ecology demands anticipation of the consequences of actions. Taking into account that we cannot always know exactly what these will be, we are still responsible for using the available

information to plan interventions that have the greatest likelihood of benefit and the least risk of harm over the long run. The value guidelines suggested by Halleck (1978; see Chapter 3) can be helpful in this respect; for example, concern with the effects of therapy on long term adjustment and quality of life, protection of the patient's environment, and allowance for patient participation in treatment choice. More broadly, anticipation of consequences must be directed towards formulation of long range goals for the future of society as well as attention to current social problems. Ecological values--admission of uncertainty and vulnerability of human systems, primary valuation of human life, belief in the ethics of reciprocity, responsibility for the future and preservation of the environment--can facilitate the emotional survival not only of individuals, but of society as a whole.

As a total human system, we have been remarkably destructive of ourselves and our environment, and despite superior intellect, we seem incapable of protecting our future through prevention and planning. Though the means exist to reverse these self negating tendencies, our cultural values have precluded their constructive use. The values of ecology provide an alternative to those of our current system. These values and the goals of an ecological psychology are centered more on benefiting human systems than on catering to specifically individual needs. Their realization depends on the interdisciplinary efforts of professionals and frequently on the breakdown of barriers between theoretical and therapeutic categories.

The integration of individual and family perspectives, which represents the fulfillment of these goals on a smaller scale, is an important step towards a psychological framework of much broader relevance, oriented towards preventing and repairing damage occurring at all levels of society.

Humanistic Values

An ecological perspective is practical and necessary for the remediation of present problems and for the protection of the future. Survival is the priority of all living beings; we must attend to basic needs before we have leisure to consider the quality of life. But in planning for our future as a group, those values that contribute to living as well as mere survival, must not be neglected. For the individual, enriching the quality of life is of paramount importance. Whether this enrichment is material, spiritual, physical, intellectual, or artistic, its expression will be evidenced as soon as basic survival needs are met. The drive to expand upon the quality of our lives and to express ourselves in ways which are superfluous from the standpoint of sheer survival is a fundamental part of being human. In the absence of opportunities for self expression we are apt to feel bored, apathetic, numb. A society which provides for basic survival but prevents individuals from pursuing more varied, "higher" human aims, will impede its own development and the realization of its potential. While the values of ecology are useful in guiding us towards a fair and balanced society in which the basic physical and emotional needs of all members are

ensured, another system of values is necessary to facilitate achievement of its fullest potential, both on individual and social levels.

Whereas survival values can be derived from the scientific framework of ecology, qualitative values are more clearly implicit in the philosophical framework of humanism. Humanism is concerned with maximizing what is healthy, productive, and creative, rather than mending what is sick or bad. Humanists assume an innate potential in man for spirituality, which broadly speaking, includes "all functions and activities which have as a common denominator the possessing of values . . . such as the ethical, the esthetic, the heroic, the humanitarian, and the altruistic" (Assagioli, 1965, p. 38). This potential might also be defined as creativity, or the capacity to evolve, become, transcend, to qualitatively reshape one's life.

Humanistic values are oriented towards the exploration and expansion of human possibilities rather than the mere maintenance of minimum standards for human life. Optimization rather than normalization of the conditions for individual and social life is the goal implied by a humanist perspective. This has implications for changing the focus of psychological theory which has been based on the study of abnormality or "sickness." Focus on dysfunction and disease can skew the image of what people are like, and hinder the exploration of what they might optimally become; whereas humanism is a framework within which normal and healthy people can be subjects for psychological study focused on the understanding of

circumstances and conditions that result in emotional fulfillment and maximize psychological development.

Humanism views people as having innate potentials for self affirmation, social affiliation and productivity, and sees violence, destruction and hatred as the consequences of inadequate conditions for the expression of human nature (Fromm, 1947). Humanism counts opportunities for mutuality and individuality among the optimal conditions for development; this value system is consistent with an integration of family and individual theories, recognizing the value of both individual growth and social welfare.

Humanism also has important implications for social change. Because it views the loving and creative capacities of humans as basic potentials thwarted largely by economic, political and social conditions incompatible with their expression, humanism implies that individual growth and development could be enhanced by altering social conditions. Thus, social and political reform become inseparable from psychological goals, and the maximization of human potentials requires change in the conditions of life on multiple levels. Humanistic philosophy provides direction for a "systematic study of the optimal human condition" (Halleck, 1971, p. 197) which may lead to formulation of specific goals for social reforms.

Creativity is a basic value of humanistic ethics, a value whose expression has many forms. It may be realized through productive work, artistic or intellectual activity, physical development, or individual lifestyle. Creativity is also realized in the formation of interpersonal relationships and in the reinvention of their

structure and character. The ability to experiment with new forms of relating and living together is uniquely human, and can result in the formation of group structures which are more conducive to individual growth (Jourard, 1971). Human interaction itself increases the creative possibilities of individuals; frequently two or more people can collectively solve a problem, produce an artwork, or invent a tool which would have been an impossible task for a single individual (Cole & Sarnoff, 1980).

"Generativity" (Erikson, 1964) is a related value; it refers to the activities of caring, giving, teaching and producing, which occur in all creative pursuits, particularly in the education and nurturance of children. Producing and raising the next generation may be seen as both an ethical responsibility and the fulfillment of an innate potential, which enriches the personal lives of individuals while it contributes to the evolution of society.

Another humanistic value is nonviolence. While humanistic psychologists generally do not deny the existence of aggressive impulses, they believe that these can be utilized for constructive purposes and need not necessarily result in violence between people. Of course, the reality is that people are frequently violent towards one another, on both individual and social levels, and violent acts in self defense may be justified by the abuses they redress. But unless the cycle of attack-counterattack-attack is somehow broken, energy and creativity will continue to be tragically wasted in the production of weapons and the strategies of war and self defense. Humanism favors nonviolent solution to social and personal problems

and sees peace as a necessary condition for the realization of individual and social potentials. Only in a state of peace can we attend to the quality of life and to improvements in social conditions which extend beyond the immediate demands of survival.

The values of humanistic psychology can be summed up by the concept of "high-level wellness" (Dunn, 1961), which looks past the normal or average human condition towards a vision of optimal human development. Rather than focusing on the amelioration of gross disease and unhappiness, the goals of high-level wellness center on increasing health and fulfillment. Instead of settling for what is in the ways people live, the values of high-level wellness strive for what could be; they are geared towards making life more exciting, fulfilling, and rewarding, rather than merely tolerable.

Taken seriously as guidelines for living, humanistic values have implications as challenging as their ecological counterparts. Applied on a societal level, these values demand greater efforts towards world peace, social and economic equality, and increased opportunity for education, particularly in values, morals, and esthetics. They require fundamental alterations in social and political institutions which would make them more supportive of loving, creative and spiritual activities, and less concerned with profit, mass production, and social conformity.

In terms of mental health and psychotherapy, humanistic values guide treatment towards concern with the quality of patients' lives and the expansion of their individual and interpersonal options, in

addition to the relief of immediate symptoms. Humanistic therapy attends not only to psychopathology but also to existential dilemmas and conflicts regarding self expression and the search for meaning, value and purpose in life; such therapy fosters the "transcendent values" (Beavers, 1977) which sustain optimism and the motivation for change, and avoid apathy and despair.

Humanistic values have implications for the application of psychotherapeutic principles in work with normal populations. Humanism views mental health as a process rather than an achievable end state, and because it is concerned with maximizing potentials, a humanistic approach to psychology must include educational and self help programs, as well as psychotherapy. In the field of medicine, the "well-baby clinic" is an example of this approach. In psychology, attention to the well-person is rare, though some self help and self improvement programs have been suggested or attempted (e.g. Beatman's "positive developmental program" for improving family competence [in Ackerman et al., 1961] and Papp's family education project [Papp et al., 1973]). The recent trend towards teaching psychology and mental hygiene courses in junior high and high schools is another step in this direction and the educational model adapted from Kohlberg's work (1981 and previous) on moral development aims at facilitating value consciousness and expanding the capacity to use moral reasoning.

Psychological intervention is always based on a judgment of what is helpful for a person or persons, and a rational judgment must include elements of both science (theoretical or empirical

knowledge) and value (moral, ethical, or spiritual knowledge). Open acknowledgment of the role of values in guiding clinical decisions and choices, and open allegiance to a particular framework of values can increase the rationality of clinical judgments, avoiding the extremes of "value-hostile science" on the one hand, and "anti-rational mysticism" on the other (Beavers, 1977). The emergence of values in the therapeutic process need not be seen as troublesome; valuing, after all, combines cognitive and emotional functions, perhaps the "magic" combination for accurate therapeutic judgment. Valuing may be defined as the expression of our capacity "to respond to the noxious or beneficial aspects of life with conscious experiences which serve to organize behavior, facilitate learning, and promote survival of the individual, the society and the species" (Holt, 1974). Without this capacity there could be no psychotherapy, for there would be no basis for deciding what is helpful, good, growth producing or healthy for people. Likewise, to the extent that we can clarify the process of valuation and the value decisions which inform our work, we may do more honest, rational and effective therapy.

The ecological and humanistic values set forth above may be used as guidelines for therapy and for the integration of psychoanalytic and family systems theories. The next section of this chapter presents a theoretical framework for such integration which is consistent with and limited by these value considerations.

Individual and Family IntegrationA Dialectical Approach

"Dialectic," as I use the term here, refers to an opposition of ideas or things which is necessary to their interaction and to the maintenance of their separate existences. Our perception of light and darkness illustrates a dialectic; neither light nor dark can exist without the other, and the rich variety of patterns perceptible to the human eye would have no meaning in the absence of their contrast.

Dialectics can be applied to the relationship of individual and family, or interpersonal and intrapersonal, in that individual identity is irrelevant in a vacuum, deriving its meaning from the presence of others. Likewise, the family, group, or tribe means nothing unless the concept of individuals separate from or outside the collective can also be imagined.

By a dialectical approach is meant the effort to resolve conflicts between ideas and to synthesize apparently oppositional viewpoints by looking at the dialectic that exists between them, i.e. by showing how the one necessitates the other. When it is clear that an idea cannot be fully understood without reference to another, presumably oppositional idea, then the perception of conflict may be replaced, at least in part, by the notion of complementarity. This is one approach by which the disputes between individually oriented and family oriented psychologies may be resolved.

The distinction between theories of personality and theories of family interaction results largely from a splitting of human

experience into separate levels or pieces, a process presumed to foster conceptual clarity and a fuller grasp of a particular psychological domain. These benefits are not to be discounted; nevertheless, theoretical splitting has led to the portrayal of intra- and inter-personal theories as either/or alternatives, resulting in the oppositionalism and polarization described earlier. In fact, intrapsychic and interpersonal aspects of experience are not that readily separable and arguments for the importance of one over the other do little to further the understanding of their interaction. A dialectical approach to synthesis attempts to look at their mutual influences simultaneously, to study the individual and the family in their ongoing, reciprocal relationship. From a dialectical perspective, the choice of family or individual focus is seen as arbitrary; the study of one to the exclusion of the other represents a serious limitation on our ability to fathom complex psychological phenomena.

Psychoanalysis and family systems theory represent only two versions of reality, among the myriad interpretations offered by various psychological theories; psychic reality is both ambiguous and difficult to describe. Yet many psychologists are unable to accept this ambiguity, which is anxiety provoking and conflicts with the scientific model we are taught to emulate. They frequently opt for a single version of the "truth" in the form of one established theory, defining theirs as the "right" one and then needing to see all others as "wrong." Once this occurs, it is virtually impossible to acknowledge limitations in the "right" theory and

awareness of alternatives is greatly impaired. These limited notions of reality may then become hardened into "delusions which we spend substantial parts of our daily lives shoring up, even at the considerable risk of trying to force facts to fit our definition of reality instead of vice versa. And the most dangerous delusion of all is that there is only one reality" (Watzlawick, 1976, my italics).

This trap can be avoided by acceptance of uncertainty as an inherent property of life, a principle basic to the ecological perspective described above. This "uncertainty principle" allows for the existence of multiple realities, relaxing the concepts of "right" and "wrong," so that various perspectives may be seen as "true" and valid while their limitations are also acknowledged. By itself, neither the psychoanalytic nor family systems perspective gives a full view of the individual or family, because these are inextricable entities. Instead, both are required for an adequate picture of the individual-family gestalt, a complex pattern of intra- and inter-personal events, feeding back and spiraling on one another.

Approaching psychological phenomena from a perspective that includes psychoanalytic and family systems points of view may yield a greater comprehension than either approach alone. The varying interpretations of psychological "reality" from an individual viewpoint and the same "reality" from a family viewpoint, may be seen as complementary rather than dichotomous. "Complementarity" describes a dialectic in the relation between two modes of explanation.

It means that we are "restricted in our descriptions of 'reality' to complementary pairs of . . . descriptive concepts . . . no single overall descriptive concept is ever possible to precisely represent all significant aspects of the behavior of an individual system" (Chessick, 1977, p. 254). Chessick uses complementarity to bring together scientific and humanistic views of psychotherapy; but if we take the individual-and-the-family as a single system, then the concept applies equally well to the pairing of analytic and family systems concepts. This becomes clearer if one considers the kinds of data used by family versus analytic theorists. The person-as-individual presents a different picture than the person-in-family, and behaviors that look pathological to an analyst may make good sense to a family therapist (or vice versa) merely because they see different sides of the same person; yet each side is as "real" or "true" as the other. Similarly, their view of the family will be different; the family therapist sees the family as it is presented with participation of all members, while the analyst "sees" the family as the individual presents it. Taken together, the different facets which emerge in each setting yield a fuller picture of the family-individual totality.

Laing (1967; 1969) has made significant contributions to the dialectical study of individual-family psychology; he views relationships as the "ground" of being, wherein an individual can integrate the inner and outer aspects of himself and move towards psychological completeness. Laing's notions echo the philosophy of Buber (1970) which explores individual being from the perspective

of relationship. Buber speaks of the experience and recognition of wholeness as something emerging from the relation of person to person, the "I-Thou" relation which recreates unity in a world perceived as multiplicitous. "Persons appear by entering into relation to other persons" (p. 112); personal integration requires such relationships. In their absence, experience is fragmented, belonging to the realm of the "I-It."

Laing (1966; 1969) brings this philosophy to bear on the study of the interactions between individual and family dynamics. Studying the individual-in-family, it is necessary to look at "what a person does to his own experience" (the psychoanalytic notion of defense) as well as his attempts to "regulate the inner world of the other in order to preserve his own," i.e. his "transpersonal defenses" (Laing, 1969). The interweaving of individual dynamics within the family can be mutually confirming and facilitate personal integration and growth, or the combination of individual defenses can lead to a "transpersonal system of collusion" by which individuality and interpersonal conflict are denied (1969).

In either case, individual and family are a dialectic; the psychology of one cannot be understood without reference to the other. The behavior of any person is made more intelligible, therefore, if his intrapsychic dynamics are explored in conjunction with his actual family. Clinically, this means that individuals should be treated with the knowledge of the family context in which their pathological behavior originated or in the light of which is found its meaning. Similarly, disturbed families can be treated best with

an awareness of the intrapersonal dynamics active in each member. Where the parents are concerned, these internal operations can often be traced to the mode of being encouraged in their original family system (Esterson, 1970). Thus the individual-family unit represents a pattern of interactions and experiences passed from family to individual and back again, linearly through the generations, and circularly within the lifespan of a single family.

Boszormenyi-Nagy and Spark (1973) also see the individual and the family as interwoven systems and attempt to maintain a "consistently multilateral" perspective in their analyses of psychological material. While acknowledging the individual as his own psychological center, they see him also as dependent on and existentially indebted to the others with whom he interacts; specifically, they view the interdependence of the family as a basic ingredient in both personality development and family dynamics.

The concept of balance is central to the dialectical theory of these authors--balance between individual and relationship priorities, give and take, dependency and dependability, obligation and fulfillment of obligation. Balanced relationships are seen as facilitating individual growth, without eliminating intrapsychic conflict or the need for individual developmental struggles. Similarly, although individual psychological health contributes to the formation of balanced relationships, it does not eliminate the need for continual balancing of relational "accounts" of give and take, merit and debt. This is consistent with the ecological value of reciprocity in human relationships. Using reciprocity as a guiding value, relationships

may be rebalanced in therapy so that they protect the functioning of the group as well as the pursuits of the individual members.

Rather than presenting a compromise between individual and family concepts, the dialectical approach incorporates both. Dialectical reasoning sees opposition as a tool of synthesis; conflicts are resolved in this method by looking for the "rightness" on each side, rather than attempting to prove the truth of one argument against the falseness of the other (Esterson, 1970).

A truly dialectical analysis of a social situation requires the observer (researcher or therapist) to acknowledge and utilize his own participation in the group in coming to understand the group dynamics. This can be done in the study of individuals as well, if the observer allows himself and the subject to constitute a social field, rather than attempting to remain an outsider. Psychoanalysis as well as family therapy can be a dialectical enterprise, one in which a person "makes sense of himself in and through making sense of the system" (Esterson, 1970, p. 245). In this type of psychoanalysis, patient and therapist recognize each other as parts of the same system and the distinction between the observer and the observed breaks down; "successful psychoanalysis is, thus, a therapy for the analyst, too" (Esterson, 1970, p. 246).

The therapist and patient are both, of course, embedded in their own family systems, occupational systems, and numerous other subsystems of society, all of them parts of the larger social organization, with all its complexity, changeability and unpredictability. This macrostructure, or macrosystem is acknowledged in

the "organismic" paradigm (Levenson, 1972) as a unifying structure, and family and individual dynamics are seen as subsystem manifestations of processes occurring on this much broader level. Symptoms are viewed as reflections of problems originating at a higher level of social organization. It is difficult to comprehend the overall problem, since we are all deeply enmeshed in it; but this personal enmeshment is consistent with dialectical reasoning. The individual-family dialectic is embedded in the relationship of individuals and of families to the larger society. Though we cannot know the exact nature of the relationship between similar events occurring at different levels of the system, it is often clear that they are reproductions or "transformations" of each other (Levenson, 1972).

In therapeutic work with individuals or families, the organismic model can broaden our view beyond the immediate symptoms of the client(s) towards some of the social organizations which both mirror and stimulate them. This perspective integrates individual and familial dynamics by including both within a larger structure. In practice it may help clients to resist the recreation of destructive social processes at the level of their own personal experiences and relationships; "orientation to the macrostructure, the larger social systems that embrace both the therapist and patient" is "only the first step of the therapeutic process, not to be confused with its entirety, but requiring elucidation before one can move on to the contemplation of the microstructure which is the core of the idiosyncratic therapy experience" (Levenson, 1972, p. 155).

The macrostructure concept is an extension of the dialectical approach--from individual-family to individual-society and family-society. Dialectical reasoning about human relationships leads naturally to greater levels of organizational complexity and to the awareness that each social group is embedded in a larger world system by virtue of which all subsystems are interconnected.

The concept of a macrostructure unifying various levels of social experience has been applied in a system of "integrated psychotherapy" (Knobloch & Knobloch, 1978). This is a formal treatment protocol including individual, family, group and residential therapies. As opposed to Halleck's (1978) multidimensional treatment (see Chapter 3), the Knoblochs' therapy is an organized system of definite stages through which each patient proceeds, rather than a set of guidelines for developing individualized treatment combinations. The Knoblochs see as illusory the question of "individual or group? . . . if the apparent dichotomies are analyzed, different approaches can be accommodated within one epistemology" (p. 13). They view individual and group (or family) processes as different manifestations of the same psychological events--because internal, subjective events are identified and validated by external, objective ones (i.e. action, behavior), then "whatever can be confirmed privately can also in principle be confirmed interindividually" (p. 315). The individual, family and group processes are expressions of identical conflicts at multiple system levels. Successful treatment involves change that transforms

relationships at each level, potentially producing a transformation in the macrosystem itself.

The macrostructural and dialectical approaches to psychology change the goals of therapy, whether it is done with individuals, families or larger groups. If the problem is conceived to be within the overall system, then it is no longer sufficient to make restoration of function a primary goal. Adaptation alone is of questionable value if what is adapted to is fundamentally deranged. Awareness, involvement and the capacity to struggle are alternative goals, more consistent with a dialectical approach to living and with the values of ecology--reciprocal relatedness in a changing and unpredictable universe. The dialectical study of human relations, as it includes greater levels of social complexity, is in fact indistinguishable from the approach described earlier as "ecological psychology"--the interaction of human beings with their social surroundings.

Basic Issues in Individual-Family Integration

Many facets of psychological experience can be described in terms of the interaction of individual and family dynamics. Since I cannot enumerate all of them here, I have chosen to discuss a few psychosocial issues which illustrate a dialectical approach to understanding and helping people, and bring to light the importance of an ethical framework in making theoretical and clinical decisions.

Psychological autonomy is basic to the development of every person, so much so that the degree of an individual's autonomy is often used as an index of his psychological health. The ability to function independently, to make self guided decisions, to pursue individual goals, to stand up for one's beliefs in the face of opposing views--all these capacities are associated with psychological maturity, health and autonomy. By contrast, the absence of these abilities in an adult is frequently viewed as a sign of psychological distress, lack of ego strength, inadequate personality, or mental ill health.

Autonomy is a central issue for theorists and therapists of many persuasions. For many therapists, the achievement of autonomy has become a therapeutic ideal and autonomy as an end in itself has been the goal, rather than autonomy as a means for expressing particular values or specific goals. The capacity for autonomous functioning has also frequently been dissociated from its consequences for others in the social field, as discussed in Chapters 2 and 4.

The detachment of autonomy from specific goals and values and from ethical issues surrounding independent undertakings diminishes its meaning. While it is true that autonomy is psychologically significant, it is also true that autonomous functioning does not develop in a vacuum.

Autonomy is always relative; absolute independence is a myth. Yet "dependence" is not an accurate antonym for autonomy; this unfortunate pairing of concepts contributes to misunderstanding

and overvaluation of autonomy. "Dependence" has many negative connotations in psychological and common language. It implies the inability to function without others; unlike interdependence which connotes the ability to function with others. Rejection of psychological dependence results in a concept of autonomy as independence from, while the valuation of interdependence leads to a notion of autonomy as independence for. In this latter sense, autonomy is freedom to interact reciprocally with others, rather than the ability to do without or ignore their influence. When dependence is the quality against which autonomy is measured, autonomy takes on "too many connotations of isolation or separation from alien forces" (Wachtel, 1977, p. 279); the zealous pursuit of autonomy can then become self limiting and socially counterproductive.

All relationships involve a degree of interdependence, and the more intimate or extended the relationship, the greater this will be. Family relationships, enduring over much of an individual's lifetime, are perhaps the most fully interdependent, particularly since families are geared towards the satisfaction of so many human needs. Yet each individual begins life in a fundamentally dependent position. Although the infant participates in a relationship with parents and siblings that is in many respects mutual, he receives infinitely more than he is capable of giving at that point in his life. As he matures, he becomes increasingly in-dependent, i.e. able to provide for his own needs, and increasingly inter-dependent, i.e. capable of fulfilling the needs of others as they do his. Simultaneously, he gains autonomy, that

sense of separateness, uniqueness, and self reliance which allows him to interact with others in a non-dependent manner. In the family, the child achieves autonomy through interdependence--being cared for and encouraged to reciprocate at the level of his capacity--and he becomes more fully interdependent through gains in autonomy--the ability to experience himself as a separate and independent contributor in his relationships with others.

The issue of autonomy, then, is more accurately an issue of autonomy-and-interdependence. Autonomy and interdependence are opposite sides of the same coin; a dialectic. In therapy, maintenance of the balance between these qualities may be more productive than facilitation of either autonomy or relatedness alone. Individual and family concerns can be evaluated jointly, so that issues relevant to autonomy and family relatedness can be dealt with at the same time. It is possible to utilize this dialectical approach within the context of family or individual therapy. In family treatment, the development of individuals' psychological autonomy can be utilized towards improvement of family functioning; while in individual treatment, the encouragement of increased reciprocity and interdependence in intimate relationships may enhance self expression, individual choice, and autonomy. Autonomy and interdependence are part and parcel of each other, and when family membership vectors seem to oppose autonomy, they are likely to impair the family's real cohesiveness as well; similarly, when attempts at individuation seem to require unusual distancing from the family system, they are likely to serve a defensive function

rather than actually increasing psychic autonomy. We learn to define our separate selves through relationships with others, and relate to others more completely as we become increasingly aware of ourselves as individuals. Within this framework, the aims of individual and family therapy appear to be mutually enhancing.

An integrative framework, which attempts to address individual and family issues simultaneously, is able to meld elements of both perspectives into a new, though not all-inclusive synthesis. For example, the "selective use of psychodynamic concepts" in conjunction with specific family systems concepts can yield an approach to marital therapy that "does not set up an artificial dichotomy between individual change and relationship change" (Gurman, 1981). Marriage may be seen as a developmental process for each partner; through the resolution of relationship conflicts, each partner grows and changes as an individual, and through the individuation of each, the relationship is deepened. Conflict and struggle between the marital partners reflects the "growth-oriented purposiveness of their initial attraction and commitment to one another" (Gurman, 1981); the interdependence of the partners serves their autonomy and their autonomy permits increased intensity in their relationship.

Because autonomy and interdependence mature as two sides of the same developmental and relational process for both marriage partners and growing children, an integrative approach may be applied in the treatment of whole families as well as in couples therapy. Families in treatment may define their own difficulties

in systems terms (e.g. "we can't get along") but more often they present an "identified patient" (e.g. "our family's fine but John is a real problem"). In both cases, however, successful treatment involves changes in the individuals as well as in the system, particularly within the value system I suggest, which includes both the maintenance of the family as a viable group and the encouragement of individual expressivity and growth. Seemingly autonomous moves must be evaluated in light of their relation to and consequences for the rest of the family. Unilateral actions which ignore the psychological and ethical demands of the family system often circumvent responsibility owed to the family; they may be seen as counter-dependent, rather than truly autonomous. Likewise, the mutually defensive system of a family in which members avoid personal autonomy and the risk of isolation it implies, may masquerade as cohesiveness; the superficial image of a "happy family" may hide sadness and fear in individual members.

Treatment of such families requires an "unsticking" of the members prerequisite to the development of genuine interdependence. This means focusing on individual autonomy, perhaps by treating one member outside the group and subsequently "reintegrating" his progress into the family system (Kadis & McClendon, 1980). "Family members who become autonomous themselves can detect and help to change, by their own behavior, debilitating coalitions between other family members," while those members "who are blinded to their own needs by the pressure of those of others find it difficult to resolve personal family relationships, and carry the

difficulties with them as serious limitations on the success of their relationships outside the family" (Roman & Blackburn, 1978, p. 105). Lack of autonomy impairs one's capacity for mutually gratifying relationships within and outside the family just as impaired family functioning inhibits autonomy. In an integrative therapy, based on a dialectical view of individual-and-family, both deficiencies may be addressed, without the sacrifice of individuality or family continuity.

A related, yet distinguishable issue in psychological development is the formation of identity. Our individual identities are formed not only by the perception and valuation of our own unique, personal characteristics, abilities and beliefs, but also by our affiliations with social groups and our identifications with other people. We identify ourselves on many levels--as individual beings, as male or female, as members of a particular family, race or culture. Religious, political, occupational, and intellectual (among countless other) affiliations are additional elements in the identities of many people.

Unique to race, sex and family membership of all social groupings is that they are inherited, rather than chosen. We cannot alter the fact of being black or white, male or female; and although we can physically distance ourselves from family members and legally divorce our mates, we cannot escape the biological and psychological inheritance of the family in which we are born and raised. Family membership contributes fundamental elements of our individual identities, whether we strive to emulate or

differentiate ourselves from the family group. The emergence and evolution of identity remains, throughout the life cycle, partially traceable and related to developments in the family of origin and the family of procreation.

The formation of individual identity appears to be primarily an intrapsychic process and may be subjectively experienced as such; but interactions with significant others are also relevant to identity formation. Psychoanalysis emphasizes the importance of identification with a stable parent figure as the forerunner of identity formation (Brenner, 1974). Identifications with both parents contribute to development of the ego ideal or superego, an essential aspect of individual identity (Freud, 1923). The superego gives "permanent expression to the influence of the parents" and accounts for "social feelings" which "rest on identifications with other people, on the basis of having the same ego ideal" (Freud, 1923, p. 27).

These formulations point to the crucial role of parents in the process of identity formation and imply that identity consists not only of a definition of self as individual but also of self as a member of a social group. These concepts may be furthered by looking at the reciprocal nature of identity formation. Reciprocity in this context refers to the fact that identity evolves not only through the individual's incorporation of parental qualities, but also by the acceptance and cultivation of those qualities and characteristics by which his parents (and other social figures) identify him. The individual identifies

with others and allows himself to be identified by them (Erikson, 1964). Ideally, these processes are mutually confirming--roles assigned and attributes ascribed to him by others are largely consistent with those the individual has made a part of himself. Of course, complete consistency would mean an end to individuality, and is in any case impossible. But some degree of congruence between one's self identification and the way one is perceived by others is required for the maintenance of a personally and socially meaningful identity. Through such congruence, the self is confirmed and validated; a total absence of congruence results in an "identity crisis" or an identity that excludes social input altogether, becoming psychotically centered on the self.

A relatively stable but still growing identity requires both active striving on the part of the individual and receptivity to the feedback (either confirming or challenging) that comes from significant others. Such feedback goes both ways--as the individual makes plain by his behavior that changes are occurring in his self identity (e.g. in changing from a shy to an assertive person, from a "confirmed bachelor" to a husband, from a liberal to a conservative), others in his social environment will modify, to some extent, their expectations of him, and identify him differently. Well functioning social systems are in general able to accomodate changes in individuals just as individuals adapt to changes in social rules and expectations. Systems incapable of tailoring their demands and rules in light of input from individuals become rigid and totalitarian, impeding the potential for

individual identity formation. Cut off from the creative strivings of individuals, such systems are dysfunctional, just as the person who shuts out input from his social world is functionally impaired.

Individuals seeking psychotherapy frequently experience feelings of depersonalization, aimlessness, or a sense of being "out of touch" with themselves. These are existential problems revolving around the struggle to know oneself more fully, to forge an identity. Difficulties in this area are frequently related to obstacles existing in the patient's family of origin, e.g. his parents' inability to confirm his identifications or their inconsistency in role expectations. In family therapy, these obstacles may be observed. The disturbed family is typically a rigid system, incapable of absorbing changes in its members stemming from normal developmental processes. As individual members are repeatedly invalidated, they are likely to experience confusion about their roles and identities and may defensively withdraw from family interaction. This prevents them from accepting affirmation when it is forthcoming, and confirms the negative expectations or prophecies of the family system. Additionally, by giving up his struggle for identity, a family member's input into the system is effectively terminated, increasing its rigidity in a vicious cycle. The identity of the family as a group may be shaken by withdrawal or other symptoms of an individual, such that all members feel a disruption in both their familial and individual identities.

These considerations suggest that problems in individual identity formation may be resolved in the context of individual or family treatment, as long as both the social and intrapsychic aspects of identity are addressed. Therapy focused on the family system can produce dramatic changes in the self image and identity of individual members, even during relatively brief treatment (Selinger and Barcai, 1977). As the family becomes more communicative and receptive to the needs of its members, each is free to develop individually and to reap the benefits of group validation. Similarly, significant alterations in the identity of one member as a result of analytic treatment may have a positive effect on the family's identity as a group and on other family members; it has been suggested that "individual treatment could be seen as an intervention in a family, via one of its members" (Barcai, 1977).

If identity formation is viewed as a relational process, individuality and participation in family group identity are not conflictual. The intrapsychic and interactional components of identity may be given simultaneous consideration, so that each individual can come to know himself and to be recognized by significant others in a process that is mutually challenging, educational, and ultimately confirmative.

The last issue to be dealt with here concerns the balance of freedom and accountability. This is primarily a matter of ethics and values, but is related to the psychological issues of autonomy, identity, interdependence and family group membership. Without some measure of psychic autonomy, one's freedom is limited,

regardless of external prohibitions or possibilities; and in the absence of an interdependent social group, accountability has little relevance.

Individual freedom is a fundamental of American culture. Freedom is a value we are taught to cherish, a goal to which we aspire, a *raison d'etre*. Struggles for political, religious and other freedoms were responsible for the creation of this country as an independent nation, and regardless of the degree to which we have actually realized or failed to realize our ideals of freedom, it remains a firmly established American value.

In psychological theory and psychotherapy, freedom is a major goal. Freedom is implied in the concepts of autonomy, identity, awareness, and growth. Psychoanalytic theory deals with freedom as an intrapsychic achievement; through making the unconscious conscious, the ego is freed to act volitionally, without compulsion or inhibition. What one can actually do is obviously limited by external factors as well as internal ones; but psychoanalytic theory stresses the importance of inner, psychic freedom in enabling the individual to cope effectively with the constraints of external reality and to choose wisely among available options. Most types of individual psychotherapy aim at increasing patients' awareness and options while decreasing the self imposed prohibitions and limitations that prevent them from living more freely.

This goal is consistent with humanistic values, and one worth striving for. In reality, however, freedom is not an entirely individual or intrapsychic matter, for one's choices, decisions

and actions generally involve other people. Relationships make absolute freedom impossible, not only because they are beyond individual control, or because they impose external restrictions on individual behavior, but also because accountability and responsibility are as much a part of our psychic makeup as is the will to freedom.

Whereas individual theories emphasize man's attainment of inner freedom and his battle with the social institutions that threaten it, family theories have focused more on the positive aspects of social groups and explored the psychic factors allowing for social responsibility. Accountability as a psychological value is based on the assumption that within each person there exists "genuine concern for at least a few closely related individuals" (Boszormenyi-Nagy & Spark, 1973, p. 171), and that social bonding is basic to humanity. This can be contrasted with the analytic model of conflict between social groups (civilization) and the innate propensities of the individual. Due to the conflict model, psychoanalytic thinkers tend to see an individual's concessions to the needs of his immediate social system in terms of guilt motivation (though they view his compromises with social restrictions as adaptive), and indeed there are instances in which this is the case. Accountability, however, is based not on neurotic guilt, but on the voluntary ethical concern and responsibility one feels towards family members and others with whom one shares a social-emotional bond. Accountability does not eliminate individual freedom, but implies that freedom is proportional to

the fulfillment of responsibility, that an individual who gains freedom by taking without giving or by acting in a manner harmful to the freedom of others is not truly free. Accountability involves a sensibility to the emotional resources, requirements, and responses of the immediate social system; it means that when we have received from another more than we have given, or hurt another without recompense, we carry a psychological debt--not "neurotic" guilt, but an actual imbalance in relational "accounts"--which limits our psychological freedom (Boszormenyi-Nagy & Spark, 1973). As continual participants in relationships, our individual freedom hangs constantly in balance with the discharge of responsibility to others. Insofar as we fail to be concerned with the needs and freedoms of others, our individual freedom is restricted. Fulfillment of social responsibilities enhances our personal freedom; and our freedom from guilts and inhibitions which are truly self imposed increases our ability to be accountable to others. Here again, a dialectic is at work; freedom and accountability are complementary, rather than mutually exclusive goals.

Psychosocial Support for Changing Families

The relationship of families to society as a whole may be viewed in much the same way as that of individuals to the family unit, i.e. as a reciprocal relationship in which there is mutual influence and interdependence. In the application of a dialectical and value based approach to psychology, it must be remembered that the family is currently undergoing major changes in its structure

and function. This presents psychologists with the tasks of integrating concepts of "normal" family process with the reality of multiple family types, and helping to make social systems more responsive to the emotional needs of changing families, for example, single-parent, multigenerational, gay, and communal families.

Currently, there is a great discrepancy between what our society permits (for example in terms of sex role changes for men and women and rising divorce rates) and what it is willing to support in terms of social, economic and emotional aid. Psychologists can help to bridge this gap by recognizing the unique emotional needs of "deviant" families, and working on social changes that may facilitate their psychological well-being.

One study (Roman et al., 1978) found that a majority of therapists had revised their concept of a "normal" family in light of altered sex roles, and viewed male and female role flexibility as having a beneficial effect on family and marital relationships. Psychologists might contribute to the social support of couples in which the emotional and economic burdens of parenting are equally shared by researching the effects of this arrangement on their psychological health and social productivity as compared with traditional couples. If the research supports the feeling of many therapists that there are indeed beneficial effects, psychologists would have a rationale for supporting social changes such as increased availability of day care, job sharing, fathering education, paternity leaves for men, and affirmative action programs for women, all of which might benefit nontraditional couples.

Similarly, psychologists might alleviate some of the stresses of divorce by working with the legal profession to provide pre-divorce counseling, and to research the effect of various custody arrangements on children of divorced parents. Psychologists can play a role in the psychological support of all families by providing preventive mental health care and family education programs which could be useful in family planning, prevention of child abuse, and the detection of individual and family problems before they reach crisis proportions.

Psychotherapists can act as consultants to community based self-help groups, and as family/community specialists assisting families in their interactions with legal, educational, employment and other extra-familial systems (Mannino & Shore, 1972).

Finally, psychologists can lend social support to families and communities by working with other professionals in medicine, industry, education and government, researching the psychological effects of various social policies and advising others on how to make their practices more conducive to the emotional needs of those served and affected by them.

Obviously, psychologists cannot ameliorate all social problems. The formation of a more humane and ethical society is a task shared by all individuals. Yet psychologists have a unique perspective on the psychological impact of social and political systems. By focusing some of their energy on the dynamics of social systems, rather than maintaining an exclusive focus on individual clinical problems, psychologists can apply their

expertise to the "therapy" of social organizations. In this way, they may shift the focus of the profession towards a concern not just with individuals, but with the welfare of human systems.

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