league and friend in the adventure with schizophrenia. He also wrote, with Don D. Jackson, one of the earliest reports on outcome with the family of the schizophrenic."

I am indebted to Braulio Montalvo for many ideas in the approach I have to therapy. We spent innumerable hours together discussing therapy issues over the years. I am particularly indebted to him for taking the time to read this manuscript and for offering many helpful suggestions for revision.

Many other colleagues and students contributed ideas to this approach. Only a few are mentioned in the text, when I quote their interviews. Many families, by succeeding or failing, also contributed to our learning what should be done with this problem. The families remain anonymous, and all those mentioned in this work have had names and circumstances changed to protect their identities.

The family interviews presented in these pages are verbatim except for editorial corrections to eliminate redundancies.

Important Note

There is a point that must be made clear to avoid any misunderstanding. With some therapy approaches it is assumed that the philosophy of the therapist, and how he behaves in relation to a client are directly relevant to normal living. That is not assumed in this approach. What is done in therapy and how one normally lives are not directly related. The therapy presented here is designed to increase the power and authority of the parents in relation to the problem young person. That does not mean that it is assumed that "normal" families should be authoritarian or that parents should have extreme power and authority when raising children. As I have said elsewhere, the fact that one puts a plaster cast on a broken leg to heal it does not mean that children should be raised with casts on their legs. This book is not about how to raise children correctly; rather, it is about how to do something for them when they have gone mad.

" D. D. Jackson and J. Weakland, "Conjoint Family Therapy: Some Considerations on Theory, Technique and Results," *Psychiatry*, 24:30–45, 1961.

Chapter 1

Ideas That Have Handicapped Therapists

Therapy techniques for problem young people have been improving over the years. Many ideas that caused consistent failure have been discarded, and new strategies have led to more success. Discarding ideas and theories that one has learned in training from respected teachers is never easy. It would seem that only when the social milieu of a therapist changes is it possible for him or her to change ideology and behavior.[1] The illusion that the individual freely chooses his ideas and theories, no matter what his social network, is in itself a difficult idea to abandon. A review will be offered here of the ideas that handicapped therapists of young people, particularly those defined as schizophrenic, and which have been abandoned over the last twenty years, at least by therapists who learn from experience.

Whether an idea is useful for a theory of therapy can be determined on the basis of certain criteria. The most obvious criteria are the following:

1. The ideas should be relevant to a theory which leads to successful outcome. Not only should the theory lead to better results than some other theory, and to results superior to no therapy at all, but it should not lead a therapist to acts which cause people harm.

This chapter, in a somewhat different form, was originally a paper given at the 1977 conference called "Beyond the Double Bind." It was published as part of the proceedings of that meeting in M. M. Berger (ed.), *Beyond the Double Bind*, Brunner/Mazel, New York, 1978.

[1] It is not appropriate to use only the pronoun *he* in referring to a therapist or a client, since they come in both sexes. The author uses *he* routinely for reasons of convenience and acknowledges the inequity of the traditional use of the masculine pronoun.

2. The theory should be simple enough for the average therapist to understand. When important issues are clearly understood, the therapist is not distracted by clients who are experts in complexity and obfuscation.
3. The theory should be reasonably comprehensive. It need not explain all possible eventualities, but it should prepare a therapist for most of them.
4. The theory should guide a therapist to *action* rather than to reflection. It should suggest what to do.
5. The theory should generate hope in the therapist, client, and family, so that everyone anticipates recovery and normality.
6. The theory should define failure and explain why a failure occurred when it did.

Given these criteria as the most obvious ones for a theory of therapy, their opposites are what a sensible therapist should avoid. A therapist should not accept a theory that prevents a definition of a goal, leads to poor therapy outcome, or does harm. He or she should avoid any theory so complex it is incapacitating, one that attempts to explain everything, one that leads to philosophical speculation rather than action, one that does not generate hope, or one that causes everyone to be uncertain about whether they have succeeded or failed.

UNFORTUNATE IDEAS

A few of the ideas which most handicap therapists who work with problem young people can be summarized.

Organic Theory

There is a tradition from nineteenth-century European psychiatry that there is something organically or genetically wrong with deviant young people, particularly those who have been diagnosed as schizophrenic. Although there are those in psychiatry, especially among clinicians doing therapy, who do not take this idea seriously, still it remains a major assumption in the field. The impression given in the literature and in the teaching of psychiatric residents is that there is solid evidence for a genetic or physiological cause of psychosis. That is simply not true. In fact, the literature contains statements that there are "indications," "leads," "expectable trends," "possible pathways for research," and "hopeful possibilities" in that direction. There is no physical test that shows that a person diagnosed as schizophrenic is different from any normal person, nor is there any solid genetic finding. The clinician who doubts this should ask that his patient by physically examined to determine whether he or she is schizophrenic or not. The response will be a discussion of vague hopes for the future.

Millions of dollars went down the drains of research laboratories to find evidence of organicity, and that research was necessary and important. Unfortunately, the public-relations job to raise money for the effort persuaded many professionals and the lay public that something must be physically wrong with people diagnosed as psychotic. Probably no class of people was ever so stigmatized on so little evidence. Monthly announcements continue to appear, saying that the breakthrough promised for a hundred years is about to occur; the biological and biochemical discussions have become more complex and mystifying; and the results remain negligible. (There is more evidence that being a psychiatrist, or certainly being a doctor, is genetic than there is that being a schizophrenic is genetic.)

Today the argument between the organic and social views is not a minor one. The consequences for adopting the idea that there is a physiological cause for madness have been significant.

1. The assumption of a physical cause for psychosis has determined the custody settings for many problem young people. They were called "sick" and placed in hospitals under the care of doctors and nurses, even though nothing was found to be physically wrong with them.
2. Because of a supposed physical problem, massive doses of medications have been used in ways which civil libertarians would not have allowed with any other deviant population, such as criminals. These medications have proved to be not only incapacitating in many ways, because of their side effects, but actually dangerous. Irreversible neurological damage, such as tardive dyskinesia, is being caused in thousands of people by both the irresponsible and responsible use of these drugs. Many medical people continue to drug people even when they would rather not because the focus on medication in their training has left them not knowing anything else to do. Nonmedical people are unable to prevent the use of these drugs because of the power of medical people in the field and because of their own doubts about whether the organic theory is a myth.
3. The organic theory required a family-oriented therapist to believe that a schizophrenic behaved in strange ways because of a mysterious disease and also in response to his family. That is, the disease theory held that the patient was responding inappropriately and maladaptively because he suffered from an internal defect. The family view held that the strange behavior was adaptive and appropriate to the person's social situation. Attempting to combine these views led to a therapy of mystification and confusion, not only for the therapist but for the clientele. While taught that psychotics had an underlying biological defect which was incurable, the therapist was also taught that he should do therapy to cure them. This meant the client faced someone who was trying to cure him with a theory that he was incur-

able, which was a rather classic double bind and provoked strange and bizarre behavior.

4. The therapist with an organic theory would think of the schizophrenic as a defective person who was limited in intelligence or ability. Since such young people were typically failures, the organic theory seemed reasonable to young professionals, who thought there must be something wrong with someone who was not striving to succeed. If, however, one recognizes that the social function of young psychotics is to fail, in spite of having nothing wrong with them to give them the excuse to fail, their abilities deserve more respect. Such young people are more skillful interpersonally than the average therapist, and so they are able to fail more successfully than the therapist can cause them to succeed. A theory that they were defective caused the therapist to underestimate their interpersonal skill and so to lose in the struggle with them. To assume a crazy young person is defective, and then try to win in a contest with him or her, is like entering a chess championship match with the idea that your opponents are retarded.

These objections to findings that remain mythical does not in any way imply that a mad young person should not have a careful physical examination. There should also be the most sophisticated neurological investigations whenever they are indicated. One of the objections to psychiatry departments today is that they are so quick to assume a chemical imbalance as a causal factor that they do not carry out the obvious neurological investigations.

A final argument is that the medical theories and the medications that have followed from them have not solved the problem, and hundreds of thousands of young people continue to fail in life and behave in strange and bizarre ways. The wisest strategy for a therapist is to assume that there is no organic basis for mad behavior and to proceed as if the problem is a social one. His success will increase.

According to the criteria of a theory of therapy, the organic theory was obviously a disaster and has become a heavy burden to psychiatry. Since the approach confused social control and therapy, it did not lead to success and even prevented spontaneous remission in clients who would have changed if they could have gotten away from the professional. Treatment by custody, medication, and pessimism because of a supposed physical defect reinforced the need for custody, medication, and pessimism. The biological theories were not simple, and even medical researchers did not seem to understand them. No hope was encouraged in client or family, and the theory could not define success. If a person called schizophrenic became normal, he or she was said to be either temporarily in remission or to have been misdiagnosed.

Psychodynamic Theory

Another theory that proved unfortunate was an ideology which, like organic theory, was based on the notion that the individual had something wrong with him independent of his social situation. That was the psychodynamic theory of repression and the therapy that followed from it. Although it is difficult to describe that theory simply, without seeming to parody it, the relevant points for the therapy of young people can be mentioned. According to that theory, a person behaved as he did primarily because of past ideas and experiences that were repressed outside awareness. He was secondarily influenced by his current social situation, although the emphasis was largely on how he viewed that situation through the conceptions built into him by the past. The merit of the theory was that it offered researchers interesting explanations for different varieties of strange behavior. When the ideas were brought into the therapy situation, however, the theory was a handicap. With the theory of repression, it was difficult for a therapist to view the family members as interrelated in their responsive behavior. The unit was a single individual, not a dyad or triad. Each person was viewed as a repressed individual responding to projections and misperceptions. The symptoms of a person were not seen as responsive and appropriate to his social milieu, but as maladaptive, irrational, and a response to past experiences more than present circumstances. Therefore the present, which is all that can be changed, was not focused on as the area to be changed. How extreme this view can be is illustrated by therapists I knew who worked in hospitals and did therapy with individuals, and who were so focused on the past that they did not know if the patient was married.

It is difficult to take a positive approach in therapy with a psychodynamic theory, because the orientation is toward the negative side of people. It is the darker side that is repressed, including fear, hostility, hatred, incestuous passion, and all that. When the primary therapy technique available is to make interpretations to bring this repressed material into awareness, it forces a focus on hostile and unpleasant aspects of people. (I recall a family therapy team presenting a case with a schizophrenic. They reported proudly that after three years of therapy the mother finally admitted that she hated *her* mother. This seemed to me to be irrelevant to getting the son and family back to normal, but to them it was a triumph, because they operated from the theory of repression.)

Psychodynamic theory tends to encourage a therapist to be an exploring consultant to the family rather than someone involved in giving directives and getting changes to happen. The tendency of the therapist to explore the past leads to the parents being blamed, since the past was their responsibility. When past actions are the issue, the parents are implicitly accused

of causing the young person's problem. The therapist with a theory of historical causes often sees himself as a savior of the patient from parents who were a noxious influence, and so his exploratory interpretations tend to antagonize parents and make it difficult to win their cooperation. When the therapist observes their lack of cooperation, it confirms his idea that the past behavior of difficult parents caused the problem, and he feels he must save the young person from them.

Another therapy procedure following logically from the theory of repression was the idea that people would change if they expressed their emotions. It was thought that if people expressed their bad feelings to each other and got their anger out, even by screaming, everyone would be cleared of their repressed feelings, and the schizophrenic would go off whistling down the street.

The free expression of feeling might have merit in some situations, like religious revival meetings, but in family therapy interviews it was a misfortune which could prevent changes in organization. The experiential therapist trained to bring out emotions in artificial groups had no theory of organization and so did not know how to reorganize a family. A family member could avoid an issue or disrupt an interview at any time by getting emotional, with the encouragement of the therapist. Everyone had a catharsis and did not have to follow a therapeutic plan or achieve any goal. The young person, whose job it was to prevent conflict developing between the parents, could become self-expressive and upset whenever necessary, and so prevent the resolution of any parental conflicts. Sessions based on making behavior conscious and bringing out feelings tended to be incoherent, disorganized, concerned with defense and proof of innocence, abrasive, and interminable. They also encouraged a "communication theory" of the families of schizophrenics, because such interviews generated peculiar communication.

The theory of repression did not lead to good outcome, was not simple, did not guide the therapist to action (but rather to reflection), and did not generate hope, because the causes were rooted in unchangeable childhood experience. It did not define failure or explain it when it occurred.

Systems Theory

The organic and psychodynamic theories were carried over from the past, while the social theories developed at mid-century. The idea of family systems was based upon cybernetic theory, which was developed in the late 1940s.[2] With this theory it was possible for the first time to conceive of

[2] See N. Wiener, *Cybernetics*, Wiley, New York, 1948. The systems idea was circulated from a variety of sources, one of the more important ones being the conferences supported by the Josiah Macy Jr. Foundation in the late 1940s and early 1950s.

human beings not as separate individuals but as an ongoing group responding to one another in homeostatic ways, and so behavior had *present* causes. The family system was said to be stabilized by self-corrective governing processes which were activated in response to an attempted change. The idea that a family, or any other ongoing group, was a system maintained by feedback processes brought a whole new dimension into the explanations of why human beings behave as they do. There was the awesome realization that people seemed to do what they did because of what other people did; the issue of free will came up in a new form. Family members were seen to be helplessly caught up in sequences which repeated and repeated, despite the wishes and attempts of the members to do differently. Therapists too were caught up in these repeating sequences, both in endless therapy and in endless conflicts with fellow staff members in agencies and hospitals.

The chief merit of a systems theory is that it makes certain happenings predictable. The chief demerit of the theory for therapeutic purposes is that it is not a theory of change but a theory of stability. Family therapy, the attempt to change families, developed within a theory of how a family remains the same. As interesting as this theory might be for explaining animal and human behavior, it was not a simple guide to what to do in therapy. It even handicapped the therapist by leading him to believe that an attempt to intervene activated resistance, because of governing processes to keep the family unchanged. This led to the kind of pessimism that ideas of resistance in psychodynamic theory had led to. This theory also suggested that if you caused a change in one part of a family, there was a response in another part. For some therapists, this activated the old myth about symptom substitution and caused them to hesitate to take action to bring about change.

Systems theory, as it was applied to families, tended to describe participants as equals, which made the theory difficult to use when planning the restructuring and reorganization of the family hierarchy. To consider the power of a grandmother, or to support parents as authorities over a child, was difficult within a theory which tended to equalize everyone as responsive units.

A primary problem for a therapist is the way systems theory takes away individual responsibility from the participants in a system. Each person is driven to do what he does because of what someone else does. Interesting as that theory may be for a philosopher concerned with free will, family therapists seem, in practice, to need to emphasize individual initiative. So within a theory that people cannot help doing what they are doing, the therapist is suggesting that family members act differently.

Family systems theory did not seem to lead to good outcome. It also was not a simple theory, as one found when attending theoretical discussions.

Often one did not understand what the speaker had said, though it sounded profound. The theory, because of the emphasis on high levels of abstraction, was even used to obscure the issue of whether anyone had really changed during therapy.

The Double Bind

Finally, there was the double-bind theory, published in 1956, which was not a theory of family therapy but became part of the enterprise. That theory included the idea of describing communication in terms of levels, with the possibility that those levels could conflict and generate a paradox, or bind, where no acceptable response was possible. The theory was an attempt to describe some of the processes in the learning situation of the schizophrenic. At first it was described as a bind imposed on a child by parents, and later as a reciprocal bind that people impose on each other. There was also a suggestion that a person could impose a "therapeutic bind" by so binding a person that he was forced to behave normally.[3]

As interesting as that theory was, and as valuable as the concept of levels was in describing behavior, I don't think the theory was helpful to therapists of families of schizophrenics. Not only was it a hypothesis about what happened, rather than a suggestion for how to change what was happening now, but it encouraged a description of a family in terms of a victim; helpful therapists found themselves siding with the victim against the parents. Since therapy is an art of coalitions, it is difficult to plan carefully how to be involved in factional family conflicts if one's theory biases one toward rescuing someone in the family. Just as the idea of a "scapegoat" was a misfortune for therapy, so was the idea of a "victim" of a double bind. From what we know today about the nature and importance of hierarchy, for an expert to side with a "victim" low in the hierarchy against someone higher can cause family distress rather than relieve it.[4]

[3] G. Bateson, D. D. Jackson, J. Haley, and J. H. Weakland, "Toward a Theory of Schizophrenia," *Behav. Sci.*, 1:251–264, 1956. For a history of the ideas of that project see J. Haley, "Development of a Theory: A History of a Research Project," in C. E. Sluzki and D. C. Ransom (eds.), *Double Bind*, Grune & Stratton, New York, 1976. The reader interested in the communication ideas of the Bateson project should read the writings of the project members, who were: Gregory Bateson, Jay Haley, John Weakland, and part-time consultants Don D. Jackson and William F. Fry. They published extensively from 1956, when they wrote the article on the double bind, to the end of the project in 1962. Their seventy papers and books are listed in "A Note on the Double Bind, 1962," in *Family Process*, 2:154–161, 1963. Bateson's basic ideas are presented in *Steps to an Ecology of the Mind*, Ballantine, New York, 1972, and *Mind and Nature*, Dutton, New York, 1979.

[4] For a description of hierarchy in these terms see J. Haley, *Problem Solving Therapy*, Jossey-Bass, San Francisco, 1976.

The view of the family implicit in a theory of victims was the negative view that people do bad things to each other. This orientation made it difficult for a therapist to organize his thinking in a positive way and gain the cooperation of the family to bring about change.

Whatever the problems of using the "double bind" in a family description, they were compounded when combined with the idea that change is caused by making interpretations to help people understand what they are doing. Family members were forced to listen to helpful therapists point out what dreadful double binds they imposed on each other. The response was defensive and angry behavior by the family members at being misunderstood. This was interpreted as resistance to the therapists, and so the therapists condemned the behavior they were evoking, which is rather like a double bind.

With the theory of the double bind and the concept of levels, the communication processes in the family became more interesting from a research viewpoint. Body movements, vocal intonations, and words with multiple meanings showed an astonishing intricacy. There were metaphors about metaphors about metaphors. A therapist who explored these meanings in interviews found himself unknowingly obscuring more basic issues. There were fascinating and endless discussions with a mother about how she wanted her child to do what she said spontaneously. It was pointed out to a father how he condemned his son for thinking as he himself did. The family seemed to prefer such discussions to taking any action toward change.

Researchers and Clinicians

I have summarized a few of the theoretical and research ideas of the past, but there was another assumption that seems strange today. It was taken for granted that a therapist and a researcher were of the same species (although the therapist had a more second-class status). It was even thought that research training was a way to train a therapist, and many young people spent years in graduate school doing research as a way of getting a degree to do therapy. Today, it seems more apparent that the research stance and the posture of the therapist are quite the opposite of each other. The researcher must keep distant from his data, be objective, and not intrude on or influence what he is studying. He must also explore and explain all the complex variables of every issue, since he is a seeker after truth. The therapist's stance is quite different. He must be personally involved and human, not distant and objective. He must intrude actively on the data to influence people, so that what has been going on will change. He must also use simple ideas that will accomplish his goals and

not be distracted by explorations into interesting aspects of life and the human mind.

It seems evident that the creation of a researcher and the creation of a therapist are different enterprises. Yet in the past these enterprises were confused. When looking at an interview, one could not tell whether a person was doing research on a family or setting out to change them.

FAMILY THERAPY FROM THESE IDEOLOGIES

Given these theories, what therapy with the family of a schizophrenic logically followed? A family would be brought in, and the parents would expect to be blamed for driving their offspring crazy. Otherwise, the therapist would only have done therapy with the offspring. The parents would typically behave in distant and defensive ways because of the accusatory context. Sometimes they would ask, "Do you think it is our fault our son is crazy?" The therapist was likely to reply that the cause was complex. If the parents said, "We did not drive our child crazy," the therapist would say, "Oh?" with just enough of an inflection to let them know they were at fault. The scene was like a Kafka trial, where parents began to defend themselves against charges which had not been made. Since the approach was psychodynamic and nondirective, the therapist did not take charge and organize what was to happen. He did nothing and waited for the family to initiate action. The family did not know what they were supposed to do and so waited for the expert to do something. There were long, significant silences. Sometimes the therapist would say, "Isn't it interesting what a silent family this is?" or, "How does it feel to be so silent?" To fill the silences without revealing signs of guilt, a father would try to talk about other things, like the cold in Antarctica. The therapist would point out to him that he was being tangential and avoiding the real issues. If the father asked the expert, "What are the real issues?" the therapist would reply, "What do you feel they are?" When the family began to be upset or angry, the therapist would ask, "Have you noticed that you are upset and angry?" This would make the family angrier, which pleased the therapist, since he had the idea that being emotional would help them unrepress their emotions. If the parents got too upset, the schizophrenic child would do his job by being rude or acting delusional, to make it clear that he was the problem, not the parents. With relief, parents and therapist would talk about the patient's irrational ideas. Sometimes, if the therapist could not think of anything else to do, he would interpret the family members' body movement to them and point out its real significance. Soon the family members did not know how to sit to avoid the therapist's making comments about their underlying negative impulses.

The task of the therapist was to keep the family coming to the interviews and getting them to talk, in the hope that something would change. The task of the family was to find out what they were supposed to say and do in the interviews and why they were there. The therapist could not tell the family to do anything because that would be manipulative, which was against the rules of therapy in the 1950s. He could not ask the parents to take charge of the child and make him or her behave, thereby structuring a hierarchy, because the therapist operated from a theory that the parents were a noxious influence; they had harmed the child in the past and should not be in charge in the present. Another reason the therapist could not put anyone in charge was that he could not take charge himself. He could only respond as a consultant to the family, with the idea that they somehow should help themselves; his task was only to make them aware and hope for the best. His only therapy technique was an interpretation; a comment on the meaning of something, no matter how trivial. If the family gave up trying to find out what to do and merely sat, the therapist helped them understand how resistant they were to facing their resistance to dealing with their family system.

Typically, the therapist communicated an underlying apathy, despite a forced cheerfulness, because his theory said that the patient was really a biological and genetic problem, or fragile from infantile traumas caused by the parents, from which he would never recover.

If the patient turned normal and the family began to reorganize, the therapist was often surprised by a colleague stoning the patient with medication or hospitalizing him because he had become troublesome. Then the therapist had to start over, waiting for the family to initiate something so he could respond with an interpretation, and hoping that somehow everyone would get "better," whatever that was.

NEW DEVELOPMENTS

How did therapists recover from these theories? One could not merely put aside past theories and adopt a new one, because there was not a new one that was satisfactory. Every therapist faced the difficult task of choosing which ideas to discard and which to retain.

I have experienced a transition in my own thinking which parallels the change apparent in the work of many therapists. Dealing with mad young people over the decades, it has become more evident that madness is an expression of a malfunctioning organization. What became clearer to me was that all learning animals organize and cannot avoid doing so. The organizations are hierarchical in form, some members having more authority and status than others. This obvious fact was slow to be appreci-

ated in the family field. Families were described as groups of individuals, as a coalition system, or as a communication system, but only slowly was it acknowledged that they were organizations with a hierarchy deserving of respect. A therapist who ignored a powerful grandmother or joined a child against parents was simply naïve. His theory did not include the fact that levels of power in an organization must be recognized by an outsider entering the organization. Sometimes therapists were quite concerned about status and power in their clinics and hospitals but ignored such issues when dealing with patients and their family organizations. In an interview, a child would be encouraged to bring out his hostility by attacking his parents, without concern for the effect on an organization when an expert called in by parents encourages a problem child to attack them.

Over the years, as more families were observed, it became increasingly evident that, both in the hospital and at home, a mad young person was responding to a particular kind of organization. The hierarchy was not the usual one of parents in charge, with executive authority over their children, and with the grandparents advising the parents. Cross-generational coalitions were occurring, in that one parent sided with a child against the other parent, or a grandmother was joining a child against parents, or the expert joined one faction of a family against another. There was confusion in these families and also in mental hospitals, where it was not clear whether the doctor had authority over the whole ward, or the nurse, or an aide. Similarly, the powers of a hospital social worker or psychologist over other staff members or a patient remained undefined.

When it became clearer that psychopathology was the result of a malfunctioning organization, it became self-evident that the task of a therapist was to change the organization. It was also evident that some past theories made that task difficult if not impossible. For example, to encourage free association in an interview among all family members was a way of introducing randomness rather than a way of restructuring an organization.

The steps in my own thinking and in the thinking of many other therapists were as follows: In the 1940s it was believed that a mad individual suffered from confused thought processes which *caused* him to communicate strangely and to establish deviant relationships. The therapy task was to correct the person's disordered thoughts and misperceptions of reality on the assumption that, as his thoughts were corrected, he would communicate differently and organize different relationships. In the 1950s the families of mad young people were observed, and it was noticed that the intimate relatives communicated in deviant ways. It began to be assumed that a young person had deviant and disordered thoughts because he lived in a communication system where such thoughts were appropriate. If a mother communicated to a child that he should spontaneously obey her, that multilevel paradoxical communication was thought to be causal in the child's disordered thinking. The therapy task was to focus on changing the communication system by educative and other interventions, and then the young person's mad thoughts would change.

Finally, in the 1960s, came the realization that people communicated in deviant ways if they were organized in a way that required such communication. The disordered thought process was therefore a product of disordered communication produced by a malfunctioning organization. For example, if a mother communicated to a child that he should spontaneously obey her, the mother was in an organization where she did not have sufficient executive authority over the child to *require* him to obey her. Some other adult at her level, such as the father, was joining the child against her and giving the child more power than she had. Or an authority at another level, such as a grandmother or an expert professional, was in coalition with the child against her. Therefore the mother did not take charge of the offspring because the organization was of such a nature that the child had more power than she did, and there would be organizational consequences if she exerted authority. When an organization was thus confused, the therapeutic task was to reorganize its structure so that the adults, particularly the mother and father jointly, had executive authority in the family. When the family was reorganized, the communication system would change, and so would the thought processes of the mad offspring.

As this way of thinking spread, it became evident that other theories made the therapeutic task difficult and would certainly fail to change the mad young person. For example, if the therapist viewed the offspring as a victim of parents who had been a noxious influence, the therapist would attempt to save this "scapegoat." That approach would mean joining the child against the parents, increasing the malfunctioning nature of the organization and thus further confusing the hierarchy rather than restructuring it.

From this view, past theories can be examined in terms of how they handicap the therapist.

Organic Theory

The trouble with the biological or genetic theory of schizophrenia is not only that there is no evidence to support it but that the mad young person's problem is defined as being in the medical rather than the parental domain, and so the therapist has no leverage to restructure the family hierarchy. He can only commiserate with the parents for having an incurable child. The problems became so severe that I largely discarded the term "schizophrenia." A therapist becomes incapacitated by that term and can-

not approach the problem with hope, particularly if he or she is a psychiatric resident. I was reluctant to give up the term, but it proved impossible to keep the focus on therapy when "schizophrenia" was used. The focus could never be shifted from diagnostic issues, and from endless discussions about which medication to use, to therapy technique. If the Food and Drug Administration bans psychiatric medications because they have dangerous side effects and cause irreversible neurological damage, this generation of psychiatrists is likely to be mute in case discussions.

The main reason I dropped the term "schizophrenia" was that it so handicapped the teaching of therapy. I found it almost impossible to persuade psychiatric residents—or social workers, since they follow the lead of psychiatrists—to expect a "schizophrenic" to become normal. They would hesitate when they should have pushed for normal behavior, and the family would hesitate because the expert did so. Soon everyone was treating the "patient" like a defective person, and therapy failed.

I have never understood why some therapists escaped from the biological view and others could not. I was greatly influenced by Don D. Jackson in my therapy with these families. He believed that there was nothing wrong with a person diagnosed as schizophrenic. It was inspiring to watch him work with a family with a mad offspring who was an expert at failing. I recall one who would not speak. She would sit pulling at her hair like an idiot. Yet Jackson treated her as if she were perfectly capable of normality, given a change in her family and treatment situation. The family was forced to accept her normality, partly because of Jackson's certainty.

When teaching therapy, I tried different ways of dealing with this problem. With some students, I found it effective to say that the person was misdiagnosed as schizophrenic, despite the hallucinations and delusions. The therapist could then treat the person like a human being, because he was not really schizophrenic.

In desperation, I also created a new diagnostic category to solve the problem. I said the person was a "pseudoschizophrenic;" that is, a person who has all the symptons of schizophrenia but is not really schizophrenic. That effort was defeated too, and finally I simply dropped the category "schizophrenia." I tried to avoid calling anyone that and searched for other terms: "mad," "crazy," "eccentric," and "problem people."

Some psychiatrists can escape this problem by staying within the politics of medicine while using more of the advances of modern medicine. The idea that schizophrenia is genetic or irreversibly biological is nineteenth-century medical ideology. In this century, medicine is more flexible in diagnosis, more concerned with stages of an illness, more doubtful about the irreversibility of any ailment, and more innovative in the temporary use of drugs.

Psychodynamic Theory

Psychodynamic theory is based on the idea that the psyche of the individual is the problem, not the situation in which he lives. It is therefore difficult, if not impossible, to use that theory effectively to change an organization. The psychodynamic therapist focuses on the person's misperception of the organization. Essentially, that theory guides a therapist to encourage a mad young person to express himself and guides authorities to be permissive and allow that expression. From that posture, it is almost impossible for a therapist to require parents to assume executive authority and to expect respect from the offspring. To restructure an organization, conversation must be directed and organized by a therapist rather than being free-flowing and expressive. The permissive, passive therapist and the correction of hierarchy are not compatible.

Often clinicians with a psychodynamic view criticize more active therapy and object to the use of any force. This view is hypocritical in that such clinicians often avoid treating crazy people, and so they criticize without offering an alternative. More important, they tend to hire other people to use the force. I can recall permissive and benevolent therapists doing psychodynamic therapy in mental hospitals, particularly private ones. They would say the therapist should only be kind and encourage self-expression, and they would object to any therapist asking parents to restrain their offspring physically if he or she got violent. Yet these same therapists worked in a setting where hired employees handled the violence, while therapists pretended they did not. Muscular aides taught patients how to behave on the wards with force and violence, while the psychodynamic therapist chatted with the patient in his office and called the aide if there was trouble. The institution also used shock treatment, medications, tubs, packs, and isolation rooms, so that the psychodynamic therapist would have a compliant patient to be kind and permissive with. Ignoring the social situation and focusing on the psyche allowed a therapist to avoid thinking about the social system of which he was part.

A final important aspect of psychodynamic theory is its assumption that what people do is based on aggression, hostility, and self-defense. Such a view is the opposite of that offered in this work. It is best for a therapist to assume that what people do, no matter how seemingly destructive, is basically protective. It is the benevolence of people that poses problems. If a wife has a sudden onset of anxiety attacks that make great demands on her husband, it is best to assume that she is protecting him by that problem. Whether anxious or angry, a spouse should be assumed to be motivated by a benevolent concern for the other spouse. Similarly, it is best to assume that a mad young person is not defending himself or being hostile to his

family by his troubled and violent behavior. The question is, what would happen to his family if he did not behave that way? For therapeutic purposes it should be assumed that mad young people are sacrificing themselves to stabilize their families. Stability in a system is the motivating force that drives the members. If he has that view, a therapist tends to be more positive in his approach to everyone involved in misfortune.

If one wishes to do effective therapy with mad people, it is best simply to abandon psychodynamic theory. The therapist who attempts to be broad-minded, trying to bring together psychodynamic theory and an approach based on restructuring a family, will be the most handicapped.

Systems Theory

Systems theory is a more difficult problem because it has many merits as well as demerits. I found it necessary to deemphasize the issues of homeostasis and stability and to focus more on the aspects of change. Thinking in terms of systems, one can plan a therapy in which a crisis is induced in a family, and the family must reorganize to deal with it. Alternatively, one can begin a small change and persistently amplify it until the system adapting to it must reorganize.[5]

The chief merit of systems theory is that it allows the therapist to recognize repeating sequences and so make predictions. He can then plan his therapy in anticipation of what will happen. There remain the problems of how to simplify the sequences so they become recognizable and useful, and how to use the concepts of hierarchy and sequences in a system. The past tendency to equalize the elements in a system makes all family members equally powerful, and conceptualizing differing statuses and powers in a hierarchy is correspondingly difficult.

The Double Bind

I largely discarded the term "double bind" and returned to Gregory Bateson's original term "paradox." I found I did not know what a double bind was anymore, because so many people used it in so many different ways. Paradox is a clearer and more precise term for describing conflicting levels of communication. The term "paradoxical intervention" also has a less negative connotation than "double binding" a client.

The communication ideas which came out of the Bateson project are a valuable way of describing human beings dealing with one another. The idea that a message at one level conflicts paradoxically with a message at

[5] M. Maruyama, "The Second Cybernetics: Deviation-Amplifying Mutual Causal Processes," in W. Buckley (ed.), *Modern Systems Research for the Behavioral Scientist*, Aldine, Chicago, 1968.

another can be carried into a description of organizations. After all, an organization is merely a system of repeating sequences of communication. As people communicate with each other in systematic ways, that communication becomes the organization. When one person tells another what to do, and the other does it, a hierarchy is being defined by that process. When one person tells another to "disobey me," the communication is paradoxical, and the organization is likely to be a malfunctioning one.

Out of the struggles with difficult young people and their families have come a number of ideas. Something valuable has been developed from systems and communication theories, while at the same time a new view of organizational power has been developing. Out of failure, as well as out of success, has come the view that youthful madness is best understood as a product of a family life-stage where reorganization is taking place, and that the youth's behavior is adaptive to that social context. Only with a change in the social context can normal behavior become appropriate. Changing a social organization to which they belong is the task of family therapists, and theories that guide them to induce that change are necessary for effective therapy.