

**B E T W E E N**

**GIVE & TAKE**



**A Clinical Guide to  
Contextual Therapy**

**IVAN BOSZORMENYI-NAGY  
& BARBARA R. KRASNER**

# Between Give and Take

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*By*

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# *Preface*

This book is addressed to therapists of all schools, modalities and convictions. It incorporates experience with both psychodynamic individual therapy and systemic-classical family therapy, but aims to transcend them. Summarizations and critical reviews of these approaches are helpful, introductory reading to the subject matter of contextual therapy.

The authors' long-term dialogue started with a common interest in Martin Buber's writings. It dates back to the time when the manuscript for *Invisible Loyalties* was completed (1971). This dialogue was the source of our book.

As the basic architect of the contextual approach it was Ivan Boszormenyi-Nagy's responsibility to designate its building stones and compose the first version of the manuscript. He was expected to define the design for an up-to-date textbook and clinical guide for the approach that reflects his current view of the premises of therapy rooted in the reality of human relationship. In this, the book represents the outcome of his 40 years of reflections on the essence of effective therapy and prevention. The actual writing of the book was dialogic.

As a codeveloper of the contextual approach, it was Barbara Krasner's task to contribute new formulations, fresh perspectives and extensive illustrations. She recast the new version of the writing and strove to make its complexities and language more accessible to the reader. In this, the book also represents an integration of her 20 years' involvement in social, political and religious concerns, her work with social agencies and her clinical experience.

This collaboration between Boszormenyi-Nagy and Krasner was based

on a 15-year cooperative effort at formulating a cohesive, convincing and communicable system of therapeutic approach. In the end both authors collaborated on a final, finished manuscript.

Our acknowledgments are due to numerous colleagues who have over the years contributed through the exchange of thought, and clinical experiences. Geraldine Spark was Ivan Boszormenyi-Nagy's co-author of *Invisible Loyalties*, the first major formulation of the approach. Special recognition is due to Margaret Cotroneo whose critical and creative thinking through discussion, teaching and co-authorship has helped to develop the contextual approach. Beneficial input was obtained through clinical, conceptual and social service exchanges with many colleagues, especially Judith Grunebaum, David Ulrich, J. Bruce Grisi and Suzanne Noble.

Ammy van Heusden (Amsterdam, Holland), Catherine Ducommun (Lausanne, Switzerland) and Siri Rinnyng (Vikersund, Norway), themselves teachers of the approach in Europe, have been generous readers and critics of the manuscript.

We are grateful to Doris Duncan and Shirley Medley for their steady readiness to type.

David Krasner lent himself to the lengthy writing process as sounding board, critic and source of courage. We are grateful to our families for providing us with experience, support, patience, and understanding without which this book could not have been written.

# *Prologue*

## **THE AUTHORS' PATHS TOWARD CONTEXTUAL THERAPY**

### **Ivan Boszormenyi-Nagy**

Contextual therapy, a preventive and healing mode of intervention that is both a method and a set of premises, was founded and initially developed by Ivan Boszormenyi-Nagy. As a set of premises, it informs both personal and professional relationships. As a method, it introduces a new, ethical dimension of relational leverages and determinants. Contextual therapy was an offshoot of dialectical intergenerational therapy (Boszormenyi-Nagy, 1972; Boszormenyi-Nagy & Spark, 1973) which itself evolved out of early attempts at intensive family therapy with schizophrenics (Boszormenyi-Nagy, 1960, 1962, 1965a).

Ivan Boszormenyi-Nagy was one of the originators of what became the family therapy "movement" in the United States. He was the founding director of what became the Department of Family Psychiatry of Eastern Pennsylvania Psychiatric Institute of Philadelphia (1957), one of the earliest and most active exploratory and training centers in family therapy. Many well known early family therapists developed through affiliation with the Department (Margaret Cotroneo, James L. Framo, Philip Friedman, Geraldine Lincoln-Grossman, Leon Robinson, David Rubinstein, Geraldine Spark, Oscar Weiner, Gerald H. Zuk, and others).

Unlike psychoanalysis, family therapy evolved from several conceptual frameworks. Boszormenyi-Nagy's interest centered on both the development of a broad-based family relational theory and a live exchange with

the leaders of other schools of thought. Some of the early nationwide conferences in family therapy (1964, 1967) were sponsored by the Department of Family Psychiatry. With Geraldine M. Spark and Alfred Friedman, Nagy initiated the Family Institute of Philadelphia in 1963, and with Gerald Berenson and Geraldine M. Spark the American Family Therapy Association in the late 1970s. Live contact with the development of the family therapy field was inseparable from the evolution of contextual therapy. Boszormenyi-Nagy and two of his associates (David Rubinstein and Gerald Zuk) had an early input into family therapy development in Europe through a three-month nationwide training program in Leyden (1967) which, along with the contributions of Ammy Van Heusden and others, launched the Netherlands as the first active country in family therapy outside the United States.

The late 1930s witnessed progress in the understanding of the biochemical basis of enzymatic function, the elements of cellular physiology. Intellectually, during the same period continental Europe witnessed the development of existential thought. As a psychiatric resident at the University of Budapest, Boszormenyi-Nagy decided to complete formal, chemical training at the University of Budapest (1944-1948). At the same time he was eager to learn about the existential and psychological dynamics of schizophrenia. In this endeavor Kalman Gyarfás was his initial guide. Later, in Chicago, Gyarfás became Virginia Satir's mentor (Jackson & Weakland, 1961).

However, the implications of his research at the University of Illinois on the enzymatic properties of the blood cells of psychotics convinced Boszormenyi-Nagy that the contemporary tools of enzyme biochemistry were no closer to the understanding of psychosis than previous efforts at neurohistology had been. Nor did the fascinating development of psychopharmacology in the mid 1950s appear to be capable of producing the answer.

Since 1955 Boszormenyi-Nagy has endeavored to focus on the exploration of the connections between depth psychology and close relationships. This was further facilitated by two new influences. One was Martin Buber's writings which pointed to a relationally-based existential understanding of human life. Another came through the writings of Ronald Fairbairn, the founder of the object relations school of psychoanalysis. It was his intention to apply these frameworks to the treatment of schizophrenics that caused Boszormenyi-Nagy to accept the offer of the Board of Eastern Pennsylvania Psychiatric Institute to set up a research-therapeutic department in 1957. The Department of Family Psychiatry continued its therapeutic training and research work until 1980 when the Pennsylvania Department of Welfare terminated the programs of this distinguished academic institute.

As director of the Department, Boszormenyi-Nagy was administratively free to design therapeutic strategy. During a period of concentration on intensive individual therapy with schizophrenics, he had ample opportunity for useful exchanges with leaders of Chestnut Lodge Sanatorium in Rockville, Maryland, perhaps the most significant of the centers for the therapy of psychosis. Over time, he became convinced of the crucial therapeutic role of trustworthiness, a conviction that was confirmed by the work and writings of Harold Searles, Otto Will, Donald Burnham, and others who worked in the outstanding tradition of Frieda Fromm-Reichman and Harry Stack Sullivan.

Another early methodological influence on Boszormenyi-Nagy came from Maxwell Jones' brief visit to the Family Psychiatry Department in 1958. It was then that Nagy was inspired to institute several procedures practiced at Jones' "therapeutic community" in London.

Yet only one of Jones' innovations had a lasting impact on the program of the Department of Family Psychiatry. That was a joint meeting of staff, patients and their relatives on a weekly basis. These meetings corroborated Nagy's and Kalman Gyarfás' earlier convictions about the importance of the patient-parent treatment context. It became increasingly evident that in the context of their families the otherwise withdrawn and bizarre psychotics were suddenly transformed into different people. Often taking leadership roles among their family members, they remained controversial but appeared to be authentic. By 1958, Nagy and his associates were seeing psychotic in-patients with their families. Before long the individual therapy sessions were discontinued. Within a few years Nagy extended the work from schizophrenics to all types of conditions and the inpatient program yielded to an outpatient one. During this period Nagy was also interested in the early work of Murray Bowen, Lyman Wynne, Nathan Ackerman, Carl Whitaker, and Don Jackson.

By the mid 1960s the Department had become a training facility, teaching hundreds of professionals annually and initiating the family therapy training programs of all five medical schools of Philadelphia. It established a family-day program based on multiple family treatment and it consulted with churches, schools, courts, city housing projects, community leaders of deprived neighborhoods, community mental health centers, mental hospitals, institutions for the mentally deficient, etc. This enabled the project to become one of the first known family therapy programs (Jackson & Weakland, 1961).

The family approach to schizophrenia at first and later to all forms of psychiatric problems enabled Nagy and his associates to see improved results in their work with the identified patient and now with the rest of the family. Instead of engendering therapist burn-out, workers at this state-supported research therapeutic program were able to share their en-

thusiasm with colleagues in the field. This led to organizing early nationwide conferences in 1964 and 1967 and to subsequent "integrative" publications (Boszormenyi-Nagy & Framo, 1965, Zuk & Boszormenyi-Nagy, 1967).

The early development of the contextual approach was inseparable from Nagy's concern about contributing to the field of family therapy. Conceptually, the initial emphasis on individually-based, existential-psychodynamic understanding yielded to systemic transactional formulations and, under the influence of Martin Buber's writings, to the focus on the ethical dimension.

### **Barbara R. Krasner**

Contextual therapy was in its second decade when Barbara Krasner first encountered it. Its focus on the justice dynamics of human relationships converged with her involvements in social justice movements, including civil rights, the peace movement, and the women's movement. Its linkages to the work of Martin Buber converged with her studies in religion and psychotherapy. Her work in Jewish-Christian relations and in Arab-Israeli relations was profoundly influenced by Buber's emphasis on "healing through meeting." This emphasis also provided her work with a bridge to therapeutic theory and practice.

Essentially a way of knowing and living, the notion of healing through meeting became a cornerstone of her emphasis in the contextual approach, i.e., healing occurs most fully when relating partners can bring themselves and their terms for relationship to each other for dialogue, mutual consideration, acknowledgment and negotiation. Through its unapologetic affirmation of the validity of many-sidedness (multilaterality), contextual therapy also embraced Buber's realm of "the Between." This realm is more familiarly known as the "meeting place of an 'I' and a 'Thou'."

Purely as a therapeutic modality, contextual therapy was developed by Boszormenyi-Nagy, and expanded by him and other clinicians. As a way, however, the contextual paradigm with its dynamics of loyalty, justice and trustworthiness are intrinsic to the philosophical anthropology of Martin Buber. They are also the basis of Jewish mysticism and the prophetic tradition. Krasner's (1975) Ph.D. dissertation was an attempt to integrate the wisdom of the therapeutic and religious communities. For her, the seed core of religious wisdom is transdenominational and consists of every generation's obligation to help its members find a balance between personal freedom and interpersonal responsibility.

Krasner was also influenced by people from the American religious community whose faith, stance and life work were essentially dialogic. Unabashedly rooted in the particularity of their own personal, ethnic, and communal legacies, they were graced with a capacity to be universally em-

pathic. Anchored in time-honored traditions of learning and wisdom, they retained a capacity for impassioned commitment and action. Among them were Lillian Miller, Howard Moody, Abraham Heschel, Maurice Friedman, Charlotte Meacham, Alexander Shapiro, Marjorie Penney, Paul Chapman, and Martin Luther King.

In 1970 Krasner began to train at the Department of Family Psychiatry, EPPI, where she was invited to join the staff. Later she became associate director for community outreach. In this capacity she began to use contextual methodologies in varied milieus, including social, legal, and religious agencies. Contextual therapy began to inform her intragroup and intergroup work. In many of these efforts and projects, she was joined by Margaret Cotroneo, and worked and wrote in close collegiality with her. Krasner currently directs the Center for Contextual Family Therapy and Allied Studies, whose emphases are clinical, social and spiritual.



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# I. PREMISES



# CHAPTER 1

## An Orientation to Contextual Therapy

Psychotherapy today is only one branch of a huge healing industry that seems to have an insatiable market. The public's search for help and guidance has grown to the point where countless schools of healing exist. Many of these schools and modalities are, of course, legitimate. Others are bereft of proven knowledge, reason and training. The public's press for human services occasionally gives rise to cultism and other ephemeral forms of change artistry that convey a promise of secular salvation.

It is easy to criticize the current state of affairs, but inherent difficulties exist in any attempt to critique the quality of the wares offered in a busy marketplace. The social and fiscal accountability of psychotherapy and the related healing arts themselves have come under increasingly close scrutiny and comment. To be sure, psychotherapy is derived from the field of medicine. The intuitive genius of Sigmund Freud, as well as the boundless input of many others, have produced truths that can be mutually validated among practitioners, and between practitioners and their clients. Even so, psychotherapy cannot claim a causally founded, scientific basis.

From the early nineteenth century on, *medicine* has depended on its practitioners' capacity to establish scientific causality. Here the patient typically functions as the monitor of the subjective signs of physical breakdown or illness. These signs function as indicators of the fact that a person's bodily integrity is under "objective" attack by bacteria, by tumor, by allergies, or by the processes of autoimmunity, among other possibilities. Beginning with the client's symptom or complaint, physicians proceed on the hypothesis that they can uncover the biological regulations that underlie and determine scientific truth. Scientific medicine may often

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fall short of its ideal goals but, at the very least, causality is intrinsic to its design.

By comparison, psychotherapy has never reached the stage of a truly causal science. From its beginnings, *classical psychotherapy* stressed its own truth. Emerging out of a biological background, psychotherapy acknowledged causality as well as it could. At base, however, Freud's focus was on the degree of consonance between a patient's "reality principle" and his or her neurotic denial of it. Had the patient failed to become master of his existential options and limitations? Freud wanted to make his patients accountable for the mature planning that leads to reasonable enjoyment of life's potential—and to do it essentially from the patient's own vantage point. This goal included scrutiny of the patient's capacity for relationships: that is, from his own unilateral perspective, how was he to secure benefits attached to mature relationships with people. In brief, a person's capacity to consider the implications of short-term pleasure and satisfactions for his or her long-term goals and life consequences constitutes the essence of Freud's principle of reality.

It is psychology rather than biology that became the medium of intervention for psychoanalysis. Nevertheless, traditional psychotherapy retained the medical model of contracting with one "patient." The patient's complaints or symptoms continued to be viewed as subjective indicators of *his* objective illness. By contrast, from the start, *classical family therapy* expanded its contract to include the interests of the patient's family members. Revolutionary in its impact and implications, in our view family therapy represented a shift to a multipersonal contract, rather than a change to a new method or new theory of pathology.

From its inception, family therapy was essentially unrelated to marriage counseling. Developing out of its own basis in the fifties, the *family movement* was chiefly the creation of therapists who treated psychotics: Theodore Lidz, Stephen Fleck, Alice Cornelison, Murray Bowen, Lyman Wynne, Don Jackson, Ivan Boszormenyi-Nagy, Virginia Satir, the latter two inspired by Kalman Gyarfás. Carl Whitaker and their associates had long evinced interest in psychotics and their development from within their families of origin. Though an outsider to the psychotherapy professions, Gregory Bateson, a scientist, was primarily interested in the familial roots of schizophrenia. Nathan Ackerman and Warren Brodey were among the few therapists who came from therapy with children and their families. So, too, it seems, was the case with John Bell.

It may be that the underlying common denominator unifying these early pioneers was the courage to struggle with challenges of *parent-child relating*, a realm of uniquely powerful characteristics, dynamics and motivations. The primary interests of these early family workers offered a sharp contrast to the central concerns of marriage counselors whose goals

were geared to peer relating. A focus on the peer relationships of mates is founded on symmetrical options for reworking skewed balances between them, and on options for terminating the relationship and finding replacements when required. No such options exist for parents and children whose relatedness holds global consequences for each other, regardless of the status of their current intimacy or estrangement. In sum, the newly emerging family field was reaching into the theoretical abyss of *multipersonal* and *intergenerational* relationships. Its practitioners had come to conclusions that forced them to expand the scope of their therapeutic contract. At the same time, they were being overwhelmed by the inherent incompatibility that exists between a unilateral, individual viewpoint, and the systemic-transactional realm of phenomena with its latent risk of depersonalizing the individual.

The rationale of *group therapy* is unable to cover the essentials of parent-child relationships. Still, the assumptions of group therapy constituted at least a partial prototype for the systemic-structural thinking that became the mainstay of classical family therapy. Classical family therapy shifted its focus from the unique realities of the differentiating individual to the systemic realities whose constituent elements could be identified in any group. These included the here-and-now interactions and communications that took place in the therapy room, transactional patterns that were embedded in the family group, family structures, interpersonal boundaries, role assignments, and power alliances among other factors. Nonetheless, the early family movement did not establish links with group therapy or organizational association with marriage counseling. Instead, it developed its special emphasis on a systems point of view, typically emphasizing parent-child relationships.

## CONTEXTUAL THERAPY AS AN INTEGRATIVE STANCE

An outgrowth of both individual and classical family therapy, contextual therapy takes an *integrative stance*. It argues that a truly comprehensive grasp of human existence is inevitably composed of both individual and relational realities. It also contends that, as usually applied, systems theory tends to surrender personal depth and scope to address the complexities of parent-child relations. These have more to do with equity of responsibility than with family structure and transactional patterns. At base, contextual therapy means to reintroduce the truth of personal uniqueness into systemic therapy, and to bridge with individual therapy through relational linkages and balances.

In this approach, *relational reality* may be viewed as a large container that surrounds and includes the fundamental dimensions of individual

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uniqueness or personhood. These dimensions are fourfold, involving biology, psychology, transactional patterns, and responsibility. That is, biologically determined, each person as a self is responsible for facing his or her own life options. These options occur and must be identified in a milieu that is burdened with transactional patternings that ricochet from person to person, and from generation to generation. In the process specific *consequences* evolve and, in their flow from one life to another, impinge on the futures of people who are still unborn. In its design, the *contextual approach* may be defined as more than a therapeutic modality, given the organismic base of biology, psychology, transactional patterns, and responsibility, and how they intertwine. Its basic stance is inseparable from the primary prevention that must be implied whenever adults take responsibility for the welfare and well-being of posterity.

### CONSEQUENCES: A KEY TO THE CONTEXT

The fundamental design for contextual interventions is based on two convictions: 1) That the *consequences* of one person's decisions and actions can affect the lives of all the people who are significantly related to him, and 2) that *satisfactory relating* for one person is inseparable from the responsible consideration of consequences for all of the people to whom he or she is in significant relationship. As we use the term, context implies consequences that flow from person to person, from generation to generation, and from one system to its successive system. The term "context," then, is used by the authors to convey a highly specific meaning: the dynamic and ethical interconnectedness—past, present and future—that exists among people whose very being has significance for each other.

In our view the consequential nature of relationships is ontological, based on the very fact of *being*. Family relationships are empowered by the fact that the members *are* connected to each other by birth. They are empowered only secondarily by what family members *do* for each other. Simply put, relationships draw their significance from *being* itself. Unrivaled in its closeness, the relationship between a mother and her fetus best demonstrates our point. The weightiness of their connections is rooted in begetting, in becoming, in being, and in deserving. Despite what they may eventually do to and for each other, in the first instance the significance they hold for each other is invested in their being. Communications and transactions will inevitably contribute to the quality of their lives together. However, it is the connectedness *per se* that proves to be the factor of greatest consequence. The unwavering assumption that connectedness continues to exist, even among those close relatives who may cut themselves off from contact and communication, is a therapeutic resource by itself.

Given the pull of close attachments, the younger the person is, the more dependent he will be on the integrity of his adult world. The more dependent, the more likely he will be to suffer from the destructive consequences of exploitative adult behavior whose input may engender lasting negative character traits. Obviously, then, infants and children are highly vulnerable to destructive consequences.

In any case, individual, e.g., psychological and transactional characteristics, tend to be derived from the consequences of past relationships, and hold consequences for future relationships. It should be noted here that the process of transmission is an open-ended one whose *forward thrust* offers new options for healing and growth. In our experience, the consequences of successive generations never form a closed feedback system. Consequences of the past are decisively influential, perhaps even irreversible, but not rigidly *predetermining*, circular, or homeostatic.

As we use it then, the term "context" implies a given "order of being." It implies the inescapability of intergenerational consequences. It implies that no one is exempt from the good or bad consequences of relationship. It also implies that there are intrinsic opportunities in significant relationships for transforming existing consequences—through discovering new options for relating, and making fresh inputs into stagnant relationships. Context is shaped by the openness of people's realities and by the malleability of people's fates.

An enabling whole, context recognizes the limiting aspects of thinking in terms of family "pathology." Instead, it emphasizes the existence of *resources* in significant relationships that, once actualized, can rechannel hatred into closeness, felt injustice into balances of fairness, and mistrust into trust. In this sense context is inductively defined by the process and flow of relational consequences. Contextual interventions are never solely defined by a set of premises about the causes of the family members' pathology nor by a set of methodologies on how to rework pathology. In the first instance, contextual therapists respond to empirical evidence that suggests that, at any time, partners have options for responsibly acting on the relational consequences affecting themselves and each other.

In part, there is an overlap between *context* and *system*. The difference between them is substantial, however, and chiefly has to do with their logical processes. As already indicated, context implies a realm of relationship defined and characterized by the dynamics inherent in the prospect of vital give and take between significantly interconnected partners. Its methodologies are linked to people's responsible readiness to investigate the consequences to every partner to these relationships, and how to alter them for the purposes of healing. On the other hand, system implies a descriptive realm of relationship that is held together by certain functional rules. The system is encompassed within specific deductive criteria, i.e., accepted conclusions drawn from a set of premises, whose

truth is based only on the formal or functional unison of the constituents. Systemic conclusions are defined by categorical descriptions like role definitions, coalitions, networks, recursive or homeostatic sequences of behavior, social organization, and subsystems among others.

Systemic epistemology organizes family relationships into behavioral categories. It then posits that pathology can be righted by therapeutic interventions that focus on enmeshment, rigid coalitions, generational boundaries, or role reversals, for example. By contrast, context implies an existential openness that belongs to the totality of the consequences and influences that impinge on the welfare of relating parties now and later. Thus, any behavioral, structural description of relationship is not viewed as inherently "good" or "bad" for the family. Instead, structural descriptions of relationship are seen as additional sources of consequences, whether helpful or detrimental. Relational *consequences* have widespread implications for all relating partners, for future generations, and for posterity as a whole. Inevitably these consequences will affect a conflicted young couple and their prospective children alike—whatever the systemic characteristics. To consider the isolated therapy of a parental couple as a subsystem, unrelated to the fate of their young children, is noncontextual.

In summary, context is an ontological realm. It consists of pre-ethical reality, i.e., the fact of personal accountability for relational consequences. Its criteria for validity rest on an ethical choice: assuming or refusing to assume responsibility for the consequences of current relationships that are bound to affect others. The *willingness to care* about consequences is not synonymous with predictive knowledge about all future prospects of past and present behaviors. This, of course, would be a humanly impossible task.

A young adult may suffer from painful and disturbing shortcomings in his daily life without realizing that his problems hinge on stagnation in his formative relationships. The shadow of abandoned relationship with members of one's family of origin can fall on a person's most important peer relationships. The linkage between the two relationships is often completely obscured by avoidance, forgetting or a genuine lack of awareness. *Contextual therapy aims at interventions based on the understanding of the fundamental connections between formative and all later relationships.* The most important therapeutic resources stem from facing the responsibility for these consequential linkages.

A young woman has given up seeking closeness with her allegedly distant and coldly rejecting parents. She has had years of marital difficulties. Her moods and evasion of a frustrating sexual life have discouraged her husband and filled her with feelings of guilt. It

seems that resentment and disappointment have blocked any moves toward her parents.

The contextual therapist's repeated efforts to prod this woman to reconnect with her parents were met with evasiveness and arguments on the uselessness of all attempts. She argued that her parents were rigid and unchangeable. The therapist recognized that the woman was entitled to attention focused on her own suffering, and so offered a moratorium: He would initially attend to her marital and mothering concerns and only periodically return to the theme of how her "cutoff" from her parents was functioning as a festering wound.

Over the months, however, attention was repeatedly directed at the prospect of how her parents might respond to her, or what her own reaction might be if she tried to approach them. The therapist suggested that some of the family members' detached behavior might itself amount to them "screaming out" to each other. Eventually the young woman recalled an occasion at which she literally screamed out to her mother while she was in the house by herself. This recollection helped convince her that she too had a deep need to connect with them and soon she was able to go to lunch with her mother. Their conversation was promising and new excitement and interest entered into all of the aspects of this young woman's life.

### **The Role of Responsibility**

Responsibility for consequences as a relational reality is a demanding notion that is sometimes viewed as retrogressive and even countercultural. It seems to fly in the face of the ordinary wisdom of life that offers more expedient routes, e.g., the readiness to appease people's self-oriented claims and alleged rights, provided that no one seems to get hurt. "Please people and make no enemies!" is an appealing position if it can be done. But it is rarely possible. Moreover, such a position is essentially unrealistic and unethical; it entices people into the false hope that they can live their lives free of the need to be responsible for the consequences of relating.

*It is easy to overlook the fact that children are obliged to pay the price of adult freedom from responsibility.* It is children who will inherit the costs of poor parenting, indifferent education, hypocritical values, vindictive intergroup traditions, alienation, and a lack of trustworthiness and stability in failing nuclear families and their alternatives—to say nothing of the costs for our children of issues like air and water pollution, and the terrifying specter of the ultimate radioactive contamination of the environment. In our view, few caring parents would deliberately ignore the consequences of overt behavior like eating all of the food in the house while their children went hungry. Sadly, in terms of less overt or immediate forms of responsibility, it seems less costly for adults to take what they can get, and let their children fend for themselves.

One of the fundamental guiding principles of contextual therapy is based on its recognition that children are captive legatees of past and present behavior. Given this reality, contextual work, like other therapies, is geared to helping people first find short-term, immediate interventions to their problems and their pain. Its work is also geared towards helping adults incorporate responsibility for the *consequences* for posterity. Moreover, contextual workers argue that there is ample evidence to prove that a person's responsible investment in posterity *ipso facto* constitutes therapeutic intervention. A divorcing parent may want her freedom. By providing her child with continuity of parenting from both her ex-husband and herself, she is likely to win her freedom as well as incremental degrees of healing.

To put it in other terms, the contextual approach asks its therapists to help clients order their life's priorities. The task of ordering personal and interpersonal priorities is, of course, a demanding one, for it occurs in the midst of relationships between family members that are both intensely ambivalent and irrevocably interdependent. Nonetheless, *contextual priorities* are inseparable from responsibility for prospective consequences, especially for posterity.

## RESOURCES AND RELATIONAL REALITY

The contextual approach's fundamental value bias is a universal one—that it is costly for a person to deny the basic existential realities of his or her own life: "Where do I come from? Who am I? And where am I going?" The therapist is no exception to this rule. He cannot be oblivious to the task of pursuing his own point of view on life's major relational priorities. By exploring his own key relationships from other people's sides, a therapist gains a multilateral perspective on the consequences of relationships. A multilateral dialogue helps a person assert his own claims and consider the due claims of others. A person learns to discern her own identity or self through this dialogue. She also validates the worth of this self through due care for the other. Without a multilateral perspective, a therapist cannot guide clients toward viable relating that is based on the trustworthiness of fair give-and-take.

Given the complexity and intensity of the interpersonal field that he or she is about to enter, the beginning therapist may well be struggling with his own insecurities and defensiveness. On the other hand, if he has done contextual work with his own family and friends, he is likely to be buoyed by a direct knowledge of resources that can continue to exist even among seriously warring family members.

The contextual approach offers new options for discovering the residual

*resources* in close relationships, regardless of their state of disrepair. Its concepts and experience guide people towards untapped, sometimes previously unidentified, reservoirs of trustworthiness, often at exactly those times when long periods of mistrust persist and seem to belie the worth of any new effort on the part of a family member. Contextual therapists operate out of an empirically derived conviction that there is a universally valid reality in the order of existence.

Obviously, it is in the just order of things for adults to care for their helpless infants. It is also in the just order of things to earn the rewards that are dynamically linked to offering due care. The most fundamental of these rewards is the enhanced personal freedom that derives from what we have termed *entitlement*. Entitlement, earned through offering due care, flows from the resolve to accept active and personal responsibility for the consequences of relational reality. It is not to be confused with the "shoulds" or "oughts" of idealism and moralism. Contextual ethical priorities are based in universal human reality, not in value priorities of particular groups or cultures. The reality, for example, that the future is more vulnerable to consequences than the past is a universally valid fact rather than a value.

Contextual therapists are guided by operating principles that begin with their capacity to integrate a family's own definition of its problems into a therapeutic plan. The therapist has to have the eyes to see and the ears to hear family members *on their own terms*. Conveyed through behavior and words, people define their interpersonal conflicts and describe the existential and psychological sources of their pain. In the process, they require a measure of acknowledgment from their listener, a legitimization of the validity of their past and present suffering.

From her side, the therapist is bound to be respectful of what is proffered, a task more easily said than done. A therapist's capacities to be respectful are often jarred, especially by people's universal urge to blame. Prudence and convenience dictate that people urge each other to correct their faults and change their ways; it is considerably more difficult to begin therapy with the kinds of disclosures that are self-incriminating.

A therapist's capacity for eliciting multilateral acknowledgement of people's suffering is to be sharply differentiated from "strategically" *joining or colluding with one family member against another*. Not only is such collusion a hopeless position from the perspective of the deep loyalties that bind family members to each other and keep strangers and therapists out; it is also countertherapeutic. Sometimes the temptations can be overwhelming, for example, in cases of child abuse in which there seems to be little question of who is victimizing and who is victimized. But who is to say whether the victimizer was once victimized and, if so, what is to be done about it? Are there still avenues through which he might ac-

quire redress or, at least, fair acknowledgment of his wounds? From a contextual perspective, a therapist can ill afford to join family members in disqualifying each other through the manipulative mechanism of assigning blame.

The leverages of contextual therapy emerge from the polar opposite of mutual blame: a mutuality of commitment and reciprocal accountability on the part of the family members. "Now that you and I are in this mess, what if anything, can each of us do to turn it around?" Here the basic hypothesis is no longer one of simply trying to please someone. In all probability that route has already been tried. What is at work instead is a fresh option for freeing one's self from jointly held despair. "I may not think you merit my goodwill, given all you've done to me, but unless I take some action, whether you do or not, my situation will get worse."

Contextual therapy aims to support attitudes and behaviors that actively contribute to the well-being of all relating parties, whether or not they are present in the therapy room. It operates out of a contract that offers *therapeutic accountability* that family members can offer each other. Accountability to the other requires that one define and assert one's own side too. The martyr does not really contribute anything to the person who is held on a string of guilt. On the other hand, reciprocal giving and benefiting between partners form the ethical basis of relationship viewed as *dialogue*.

In every family, diffuse and nameless "pathologies" exist in and among individuals who often function as each other's antagonists. In addition, beyond specific symptoms and frequently in place of them, family members suffer from other shortcomings: family disintegration, estrangement and alienation, fear of the future, fear of competition, fear of the community, an inability to commit themselves or apply themselves usefully, an overly materialistic grasp of life, and escalating degradation through mutually dehumanizing processes and mechanisms.

A family's renewed concern for a *redistribution of burdens and benefits* among its members may be comprehended as "change," or as restoration of viable continuity of relationship, a major resource from a contextual perspective. Self-sustaining continuity of relationship is a more valid and specific goal of therapeutic intervention than is the simpler goal of change. In the first instance, the process of restoring viable relationships in the midst of injustices and mistrust requires a measure of intergenerational integrity. The ability to define one's own fundamental truths and entitlements is the beginning of such integrity. It is also tantamount to improving the quality of life itself. Moving from a random struggle for the survival of the fittest is one step towards attaining a gain in the quality of human life. Another step has to do with the willingness to disclose one's terms of relationship. Such active self-disclosure is in itself an offer of care that can enhance the giver's personal freedom and enable interpersonal justice.

## Loyalty and Its Implications for Fairness

One of the main concepts of familial dynamics, loyalty, was introduced into therapeutic literature as a contrast to psychodynamic considerations (Boszormenyi-Nagy, 1972). In this sense loyalty is almost synonymous with the essential irrefutability of family ties. No matter how successfully a person displaces or transfers his or her filial attachment to therapist, boss or partner, the primary commitment basis of family loyalty remains untouched. On what is this commitment based?

Loyalty in contextual therapy is not based on a "sense" of loyalty or on the psychology of attachment or attraction. Nor is it based on power-inspired dependence or submission of the weaker person, as in feudal loyalty to king or high nobility. Loyalty in our sense is a preferential commitment to a relationship, based on indebtedness born of earned merit. Parents beget offspring and become obligated to their survival and nurturance. Parents also earn their child's commitment in return for mother's and father's unique, unrepayable contribution. Spouses commit their lifetime and life options to a common venture; to that extent, they merit loyal commitment from each other.

Still another function of the justice criteria of the human context has to do with the phenomenon of unresolved *loyalty conflicts*. A person's commitments to his family of origin on the one hand and his peer commitments on the other hand often collide and conflict in terms of priority. Thus, loyalty conflicts seem to be ubiquitous causes of marital and partnership incompatibilities. Of central interest to contextual therapists, loyalty conflicts can be a major deterrent to individual freedom and interpersonal fairness among peers.

This dynamic is especially important to explore in situations where avoidance clouds people's ambivalence towards their parents. Adolescents and adults often profess a high priority for working on their peer relationships and shun concern about parent-child relating. In clinical experience, however, it is precisely those people who "protest too much" who are often unable to commit themselves to peers or individuate in any age-appropriate way. Paradoxically, rather than being a source of persistent bondage under parental authority, due consideration of parental needs is a liberating resource.

Even very small children are sensitive barometers; they *know* when their parents are overburdened with anxiety, guilt and mistrust. Moreover, they want to do something about it. Clinical observation of families gives ample indications of how enormously giving and caring very young offspring want to be toward their massively needy parents. It is precisely this reality that lies at the core of later, adult-age loyalty conflict: "By what right can I enjoy other relationships if my parents are always suffering?"

It is easy to confuse filial loyalty and its implicit conflicts with fixated

dependency needs that persist from childhood. Loyalty conflict also lies in the parents' needy condition, not just in the child's needs. It is more legitimate, therefore, to identify just how significant children are as relational resources to their parents.

Contextual therapy resists the tendency to regard children merely as the end products of adult pathology. Dealing with relational reality requires a multilateral concern about every relating member's merits, credits, benefits and burdens. It becomes increasingly evident to contextual practitioners just how often the "royal road" to self-mastery weaves through the complex maze of a person's indirectly self-victimizing, invisible loyalties to his or her family of origin. Liberation from loyalty conflict through direct rather than invisible loyalty contributions leads to the freedom to enjoy commitment to peers, partners or spouse.

How can *therapists help family members* reclaim new degrees of wholeness and satisfaction in the midst of dissatisfying and fragmented existences? At some point clients try to turn towards directions that can lead them to something "better", something "more." How can therapists help people learn that,

- Strong family members can gain from concerning themselves with weak, helpless and handicapped family members;
- Individual freedom is most effectively won through a consideration of balances of fairness between the self and all of the significant others with whom the self is in relationship.
- Grown-ups will find a more peaceful resolve in their own lives if they can claim their own just due at the same time that they are actively involved and invested in caring for posterity.

In sum, how can therapeutic effectiveness be grounded in the resources that rely on the foundations and consequences of the truths of relational reality?

### **A Clinical Illustration of the Resource Orientation**

The following situation is meant to illustrate the *relational* truths that are linked to a presenting symptom or complaint, in this case a marital crisis. The reader will note, however, that neither marriage nor the disappointments attached to it begin to define all of the significant and long-festering sources of the young couple's struggle and pain:

Jessie, 25, is a lively, outspoken young woman, and Kevin, 24, a shy, somewhat sad-looking young man. They had lived together, unmarried, for over two years. At first they had gotten along well; sex, they said, was great. They liked each other and felt that their styles of

life meshed. It also appeared that they were allies against their respective families of origin. Before they met, Kevin drank heavily. After they started living together, he gradually reduced his drinking to a few beers a night. Jessie occasionally smoked marijuana. Kevin started to work at a steady job and made it possible for Jessie to work part time.

Neither of them minded when Jessie got pregnant. In fact, the idea of a family seemed appealing to them. It was then that they decided to get married. They went to City Hall where they had a "no ceremony" wedding. Kevin was able to share the news of his marriage and expected baby with his mother. He had long ago lost track of his father who had been an alcoholic.

As the pregnancy progressed, tensions between the couple began to grow. Their sexual relations diminished and became almost non-existent. On the evening that Jessie experienced her first labor pains, Kevin walked out. He stayed away, drinking at a bar all night long. Jessie was brokenhearted; her disappointments built up to near murderous rage. She felt she had been abandoned at precisely the point in life when she most needed to be loved. It was hard to believe that this was happening to her. She concluded that Kevin was callously indifferent to both her and his own unborn child.

Jessie had to go to the hospital alone. On the taxi ride there, she decided that there was no one in this world to rely on but herself and her child to be. She presumed that she would have to raise the baby without benefit of father just as her mother had had to do with her. She felt sad at the prospect but also reassured. In her fantasy she saw the baby-child as a strong grownup man. Unlike other men, he would be deeply devoted to Jessie, his mother.

In the meantime Kevin felt enormously guilty and worthless. He felt that he did not deserve to be a parent, nor was he ready for all it implied. He felt a sudden flow of warmth for his father who had never wrenched free from a sense of failure. Did his dad use alcohol to help him handle his self-deprecation? Kevin's thoughts went from his father to Ellen, a woman with whom he worked. From the time he started at the store, she had shown an interest in him. Ellen was divorced and raising a four-year-old by herself. She relied heavily on help from her mother, who was outspoken and tough. Ellen was having a hard time just like Kevin.\* He had never realized how scary life could be. He suddenly realized how lost he felt in a frightening world. If that's how it really is, he thought, there seemed to be little purpose to struggling.

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\*Kevin's thoughts of Ellen were typical of an attempt to escape from relational accountability. A loving partner, of course, is more than a caring neighbor. For his part, in the presence of unfaced responsibility for parental obligations, Kevin was tempted to take an all too familiar escape from the difficulty of a known relationship to an unknown one.

Representative of a large segment of human experience in current society, Jessie's and Kevin's situation evokes fundamental therapeutic questions: What is the symptom and whose is the pathology? Is pathology confined to the hidden realms of one person's unconscious? It hardly seems to lie in the rigidity of any dominating, recalcitrant family system, as alleged by some advocates of classical family therapy. Or might pathology also lie in the failure of these young people to mobilize and actualize resources that are *already there* for them in their families of origin?

Who is to be identified here as the object in need of help? Does Jessie need therapy so she can rid herself of an immature, unreliable man? Is it Kevin who requires help, given his proclivity towards a heavy use of alcohol? In his present state, he may even be a candidate for suicide. From the beginning, Kevin's and Jessie's parents mistrusted the marriage and competed with their child-in-law. Should therapy be offered to them? The tiny baby who arrived on the day that his parents split up stands a high chance of being maltreated. A symbol of his parents' pain, he may eventually have reason to wreak retribution on a world which views him as a low priority. Is it the newborn baby for whose sake intervention should be made, and how should that occur? Or are there ways to help all of the members of this context, this inherently related set, learn how to help one another as well as help themselves? Still more, what are the sources of this help?

A caring neighbor, an attentive bartender or beautician, a family physician or lawyer can all offer empathic listening and good common-sense advice. A show of any kind of friendly interest undoubtedly helps. Why then professional intervention? And at what point? What is the role of therapeutic training and skill? What options and leverages are specific to therapy? And what kind of therapeutic intervention makes sense? Countless books have been published to guide confused consumers in learning how to distinguish the characteristics of the wide range of available choices, among them individual psychotherapy, client-centered therapy, group dynamics, encounters, network therapy, gestalt therapy, systems therapy, and restructuring or strategic intervention to name just a few.

Contextual work utilizes all of the resources at hand, including the effective "techniques" of all reliable therapeutic modalities. Even more significantly, it is geared toward using all of the available resources of the family network. Almost needless to say, any comparative generalization of one family member's problems over and against others would be useless. On the other hand, it is a steadfast rule of contextual theory and practice that therapists regard and treat family members as prospective sources of reserve relational energy, even those whose behavior warrants a designation as unruly "monster." Successful parenting, a family's major ethical task, requires stable relating among adults who are capable of identify-

ing their own resources as well as their problems. These resources may be among the family members themselves or in the extended family.

Contextual therapy tries to help people discover and construct multilaterally responsible solutions in the very situations in which their impulses drive them in opposite directions. Akin to classical Greek drama, a victory based on disregard for significant people in an individual's life weaves tragic consequences into the fabric of the future. Conversely, therapeutic help that considers the consequences of one person's reality on another person (centrifugal), as well as the legitimacy of self-concern and regard (centripetal), is of benefit to all.

The methodological resources of contextual therapy are composed of the fundamental assets and truths of each family member's being and relating. Such truths inevitably have negative as well as positive characteristics and consequences. The *negative* aspects of relating include exploitativeness, symbiotic possessiveness, narcissistic self-confinement and blame, and refused responsibility for consequences, among others. The *positive* characteristics and consequences of relationship include fair availability, need-complementarity, trustworthiness, well-founded loyalty, exoneration, and the autonomy that is gained through the process of earning merit or entitlement.

At issue here is not whether parents and children, among other significantly relating parties, have done each other harm. Injuries and pain are inescapable aspects of all relating and are ever likely to be so. For us the central question has to do with whether, in a misplaced longing to avoid further "hurt," people settle for too little, too late. To what extent are family members caught in a negative definition of life's characteristics and consequences to the unintended exclusion of any positive side? To what degree does a consistently negative definition of being and relating induce families to a failure to identify, mobilize and utilize the relational resources that underlie their subjective experiences of injustice and mistrust?

The therapeutic methods of contextual therapy are chiefly based on eliciting an active, assertive and responsible position-taking on every family member's part. The therapist turns to every member with the expectation that each will state his or her side. The purpose is to evoke not a therapist-client dialogue but eventually an intermember dialogue of genuine spontaneity and "self-delineation" (Boszormenyi-Nagy, 1962, 1966). In that dialogue, based on responsibility and a capacity to respond, every participant is reinvesting new trust. The therapist can help them rework interpersonal patterns distorted by repetitious reliance on any one person's internal relating pattern. Its elicitory rather than prescriptive or structuring methodological approach makes contextual therapy an *activating* rather than a merely *active* procedure.

Trust in the therapist-client relationship leads to a helpful spontaneity in the client's work. Only through trusting can the client bring the genuine, nondefensive manifestations of his behavior and his relationships to the therapist for exploration. Trust enables the client not only to reveal the true reality of his life manifestations but also to follow the therapist's guidance with genuine spontaneity. Initially people's feelings of trust can follow the fulfillment of emotional satisfaction. Here, however, the importance of emotional resonance is secondary to more solid bases for trust that include people's due concern for each other. A mutually responsible relationship benefits the self at the same time that it benefits the other. Contextual therapy is based on the healing evoked through due concern, a refinement of "healing through meeting."

In sum, contextual therapy is concerned with the comprehension of causal factors in human behavior. Causal factors as sources of relational consequences and their therapeutic ramifications, in our view, can best be grasped through an integrative effort. Therapeutic intervention can be most effective if it can penetrate the crucial existential criteria in every person's world. This possibility is most likely to occur through a consideration of a rightful synthesis of facts, individual motives, transactional systems and a dialectical perspective of fair relating.

## CHAPTER 2

# The Challenge of the Therapy of Psychotics: Background of the Contextual Approach

### ORIGINS OF CONTEXTUAL THERAPY

Like its predecessor, classical family therapy, contextual therapy has grown out of a desire to overcome the limitations of classical individual psychotherapy. Although there have been attempts at modifying Freudian psychoanalysis to fit the requirements of the treatment of more severely disturbed patients, much remains to be accomplished. Having spent considerable time and energy on searching for biochemical clues in the mid 1950s, Boszormenyi-Nagy's interest soon focused on the behavioral and psychological phenomena of schizophrenia. What therapeutic options have remained unutilized after pooling all available knowledge about serious mental conditions? How can the knowledge of human relationships contribute to a more effective therapeutic design?

Throughout history, efforts have been made to uncover causal clues to the problem of *psychosis*. Striking unreason in human behavior has always called for an explanation. Many approaches have been taken toward the challenge of explaining and curing madness: Religion, magic, exorcism, have been employed for ages. More recently, early environmental conditioning, neuropathology, inherited brain damage, and disordered biochemistry have been advanced among other explanations but have resulted in no conclusive causative clues.

The hardest test of therapeutic endeavors has been presented by psychosis and what has been diagnosed as personality disorders of severe types. Many therapists have tended to avoid the continuing and unyield-

ing existence of hard, recalcitrant symptomatologies. Paranoia, psychosis and psychopathic character traits, among other like manifestations, have traditionally been described as inaccessible to ordinary, corrective logic. People afflicted with these conditions seem to maintain an enduring commitment to a rigidly-held inner, distorted logic. Consequently, the "patient" repetitiously falls into the same conflictual social situation. For all of his great charisma and competence in solving fundamental puzzles of "psychopathology," Freud resigned himself to the unanalyzability of these recalcitrant, ego-deformed patients. Basically, he joined Kraepelin and perhaps the majority of humanity in a pessimistic despair over the curability of insane forms of irrational, antisocial behavior.

If human beings tend towards a despair over their possibilities, they are also reluctant to accept real limits of their reasoning power. Attempts at healing irrationality have been as obdurate as the conditions they were intended to remedy. In the past, efforts were made to literally shake desperately insane people out of their social or even physical contexts. Regarded as obsessed by witches or the devil, they were frequently threatened with inhuman torture or with execution. At other times they were exposed to the shock of cold water, rotation, and, more recently, to insulin, metrazol or electrical shocks. For a while, hypnotic-suggestive approaches gained credence. In the middle of the twentieth century, tranquilizing medication was added to these efforts. And currently, behavioral restructuring and paradoxical "unsettling" of family relationships are on the ascendency.

Part of the difficulty may lie with the fact that it is difficult to generalize when it comes to psychotics. One potentially universal trait may have to do with their massive failure to process social behavior. This failure seems to occur to such a blatant extreme that even—or perhaps particularly—the closest family relationships seem to overburden the psychotic's adaptational capacities.

If it is true that family situations require a lower degree of adaptational skills than other, less familiar social situations, what dooms psychotics to failure in their own family relationships? Is there a massive "pathology" that underwrites their failure? What are the *latent factors* that initially predispose certain people to becoming psychotic? And why does it typically occur in their late teens or early adulthood? What necessitates the suspicious withdrawals and the "paranoid" misinterpretations of people's motivations that estrange psychotics from others? Why the enormity of rhapsodic mood swings in which near murderous rage can be evoked by apparently trivial disagreement or conflict? What causes their oscillation between the extremes of dependent love and vindictive rage? What underlies a mode of thinking that is so distorted and constricted that it leads to a delusional misinterpretation of reality?

Answers to these questions have been sought in a variety of directions, including genetic causation, ethology, unconscious motivation, object relations theory, and psychosocial developmental stages. Each of these factors is likely to be a partial ingredient in the blend of pathogenic determinants and each deserves at least passing reference here.

### **Genetic Causation**

In our view, there is no reason to question the role of genetic causation. It is logical to assume that in all life situations, inborn, *gene-dependent* regulations are co-determinant in their effect with *environmental* influences. These two sets of factors consistently combine to shape a person's behavioral patterns. Genetic preprogramming is obviously an element of psychotic development. So, too, is personality formation. No reasonable argument seems to exist that would preclude the significance of both developmental structuring and personal experience in the formation of human personality. To this point, however, our accrued information on the long range "mechanisms" of human environmental influences on the growing child is rudimentary. It is to be hoped that, over time, therapeutic knowledge will evolve that can offer guidelines for preventive interventions.

### **Ethology**

This is one such attempt to increase our knowledge of the roots of human behavior. The scientific study of animal and human development is a relatively new field. One of its most compelling concepts has to do with the irreversible processes of early conditioning, i.e., with "imprinting." Independent of external reinforcement, imprinting requires a suitable, critical period of susceptibility that occurs over a specific and specifiable length of time. Its manifestations in animals are typically long-delayed.

It is clear that ethology's study of the inborn and learned roots of animal behavior (Lorenz, 1981) holds obvious implications for human beings. But there is a higher degree of complexity in human ethology. It is decisively more difficult to study causal factors and their impact on human social environments. To date human ethology is still relatively virgin territory. Its theories are intriguing but await solid data.

Nevertheless, ethology's basic concerns have to be linked to contextual concerns over relational consequences. The family therapy setting may provide an arena in which to study if and how ethological and contextual data and premises converge and combine. Hopefully and inevitably, our knowledge of the developmental input of adult relationships will increase. Whatever its promise for the future understanding of character formation, ethology remains a recent development whose implications are still untested.

### **Unconscious Motivation**

The Freudian perspective of unconscious motivation, on the other hand, is by now an almost universally accepted element in contemporary thought about the roots of human behavior. In fact, it is difficult to estimate the degree of the impact that the concept of unconscious determinants has had on Western culture. In this view, lasting character traits are inevitably influenced and shaped by unconscious motives as well as by consciously realistic goals. Here, inherited and imprinted components in an individual converge with still another component of human programming: the conscious and unconscious requirements of personal satisfaction. Certain environmental circumstances, for example, can condition sadistic, destructive patterns of satisfaction in a person. These patterns eventually become a habitual outlet through which to channel the natural human need to relate.

The formation of individual identity involves the entire spectrum of psychic development. Psychoanalysis has introduced concepts that describe how identifications evolve out of a state of undifferentiation. Parental interactions provide the background to identification even while primary identifications are still embedded in psychic fusion.

In defining his concept of "reality testing," Freud emphasized the fact that a person's healthy life interests are served by her efforts to extricate herself from pet distortions of this nature. His argument was based on an implicit relational premise for therapy. Thus, the patient's best prospect for reworking her faulty personality formation lies in a useful therapeutic regression and a struggle with resistances to relinquishing "neurotic" patterns of inner attachments. In turn, these inner attachments lead to a transferred dependence on the therapist and, finally, to the relinquishment of that dependence both on the therapist and on the pattern.

In point of fact, success in systematic elimination of pathology has always been secondary to psychotherapy's efforts to help people mobilize their resources. Freud's discovery of unconscious motivations, for example, lent itself to a therapeutic process that relied on the degree to which a person could mobilize his ego strength. It was not simply a function of the therapist's surfacing secrets unknown even to the patient himself, and then curing him through conscious, insightful explanations. Freud's methods were not recommended in cases of psychoses or certain character disorders. In these situations, people tended to lack the resources that the ego requires to endure the process of therapy. The transference, set in motion by the impact of the therapeutic relationship, obviously imposes huge demands. Chief among them is a person's capacity to live with the therapeutic resurgence of old hatreds, fears, suspicions, pains, shame, and cravings.

Contextual therapy also requires its clients to endure the trauma of fac-

ing old injuries and reworking hateful and painful realities. Here, however, transference is additionally viewed as an indication of potential ethical disengagement. A complete reliance on the notion of transference-based cure is predicated on an implicit, relative undervaluation of actual family relationships. Contextual therapy is concerned about the prospective disloyalty connotations of therapeutic alliances and of transference. (Boszormenyi-Nagy, 1972). The intensity of contextual therapy is thus linked less to the relationship between therapist and client and more to every individual's capacity to work through the ongoing relational context of his just or unjust human order. All of this is helped by the therapist's expert elicitation of relational resources.

Over time, therapeutic thinking has gradually begun to shift from an individual to a *relational understanding* of human behavior. Hypotheses about the pathogenic nature of parental behavior began to emerge out of this shift, all of them unidirectional. It was assumed that the child, when he suffered, did so because of his mother's shortcomings. For example, the concept of the "schizophrenogenic mother" emerged. Here the parent's vicarious need gratification through her child was described as an unconscious, implicitly exploitative parental attitude (Johnson & Szurek, 1952).

### **Object Relations Theory**

Defined by Fairbairn (1952, 1954) and later Guntrip (1961), object relations theory made important contributions to the development of new therapeutic methods. It was assumed that, from its beginnings, the mind's dynamics are essentially rooted in structurally implicit dialogue between the self (ego) and the other (internal object). This assumption provides a helpful explanation of the human tendency to misperceive relationships: The patterns that program distortions in interpersonal relationships are themselves relational. The basic need for both good and bad internal others (objects) colors our use of significant relationships (projective identification). Conversely, a person may adapt his own inclinations to oblige his relating partner's needs for a "bad" counterpart. Consideration of relational phenomena like these is crucial for an understanding of concepts like projection, displacement, and therapeutic transference.

Freud's insistence on the individual's need for (object) relationships retained its obvious validity. By itself, however, it stopped short of a concern for the relational benefits and burdens for the "object." Simply put, it failed to examine the "centrifugal," other-directed consequences of a person's concern and needs for his partner. As such, it lent itself to relational implications that could prospectively become exploitative and trust-diminishing. The phenomenon of transference implies that relationships, apparently operating out of interpersonal and reciprocal criteria, are also

patterned in part by each relating partner's inner mental set. Thus, each person in a relationship relies on a generalized internal relational formula whose roots may be inborn, imprinted, or simply reinforced.

From this perspective, particular, current "real" interactions between people are used to compete with, substitute for, or document the existence of each person's internally valid mental formula or set. This set is presumably guided by a gyroscope of subjective and unconscious agendas, as in: "Why aren't you acting as I wish my father would have acted? Haven't I extended you the privilege of getting closer to me than my father ever was?" In other words, "I want you to behave in ways that can address my earlier inner needs, without consideration of what you want or need to do." From the vantage point of contextual therapy, one can even be indirectly loyal to one's parents via blaming current relationships.

Unfortunately, as a relationship gets more intense and involved, the need for making one's partner fit the internal relational format can intensify. At the same time, the balance of the relationship becomes unfair and exploitative. The dialogue takes on an I-It format instead of the mutually responsible I-Thou pattern described by Buber in his seminal work (1958). It is this fateful internal drive toward passionately possessing the other as a recreated replica of the "internal object" rather than a mere instrumental "use" of the other that represents the greatest source of unfairness in close relationships.

Object relations theory describes a ubiquitous human tendency that deserves serious consideration. Fairbairn, for example, went so far as to define the human mind as a relationally constructed entity from its outset. For him, primary, psychological need-configurations presuppose matching ego and internal object components. To us, his psychological view of individual depth dynamics seems to be analogous to and compatible with Buber's existential-ethical view of dialogue as the foundation of human being and becoming. Both perspectives can help therapists better understand the *relativistic basis* of the human mind as well as of human relatedness. The parallel between the two frameworks served as an early foundation for contextual therapy (Boszormenyi-Nagy, 1965a).

The integration of the Fairbairn-Guntrip view of internal object relations theory with Buber's notion of genuine dialogue can powerfully characterize the futility of many "close" relationships. We usually pick relationships on the basis of their emotional meaningfulness to us. Freud observed that a man may seek to find a woman whom he can squeeze into the image of his maternal introject. Yet this is only partially true. In part, the man is also reacting to his attraction to the "real" characteristics of a particular woman. In the sense of Fairbairn and Guntrip there is a rivalry between the requirements of the internal and the external or inter-

personal relationship. Contextually, the more one squeezes the partner into an internally desirable image, the more one is likely to be unfair and exploitative.

### **Psychosocial Development Stages**

Fairbairn's (1952) object relations constructs about the basic dynamics of the mind might be linked to and aligned with Erikson's (1959) foundation of psychosocial (instead of simply psychological) notions of development. Basic trust versus mistrust characterizes Erikson's first stage of psychosocial development; however, it also remains that lasting foundation for all of a person's later stages. In this regard, Erikson's optimism is matched by Kohut's (1977) hopes for "empathic" therapeutic parenting. In Kohut's view, the young child who fails to receive the empathic parenting that he needs (deserves?) turns out to be a narcissistic person who suffers from an injured "self-psychology."

From a Freudian perspective, Erikson's emphasis on basic trust versus mistrust and Kohut's emphasis on empathic parenting can be viewed as pointing to a large-scale, global "fixation." This kind of fixation afflicts people who appear compelled, at least symbolically, to return to early patterns of relating, and to desperately test whether basic trust or empathy can belatedly be found in the world.

On the other hand, from a contextual perspective, Kohut's rationale of "restoration of self" represents a welcome stance, but one that requires still further integration. For no individually-oriented model is sufficient to grasp the interpersonal balances of the relational context. What is called for here is an *integration of individual models* of psychic restoration with a *supra-individual regulatory force*, that is, what Buber termed the "justice of the human order."

In our terms, this supra-individual regulatory force may also be called "the context of residual trustworthiness," a realm that plays a vital role in enabling self-sustaining trust. That is to say that self-sustaining trust is regulated by the degree of justice that a person has met in his own human order: Being injured can give rise to widely varying degrees of feeling injured, hurt, deprived, ripped off. There is a tragic truth to the fact that an individual's deep desire and willingness to test what residual trust still exists in his human order is inseparable from historically justified negative input into here-and-now relationships. Past injustices, unilaterally perceived, typically result in a currently vindictive input. As a person continues to press for his historically justified, unrequited "rights," he is likely to become even more alienated from the resources and possibilities of his present living context. Under the circumstances, he is likely to appear increasingly incorrigible, inappropriate and insane.

It was Martin Buber who first formulated the principles of therapy on the level of caring and just interhuman relationships (1948, 1957). He made a decisive distinction between healing through efforts at integrity in relationship and technical, often implicitly dehumanizing attempts at symptom change. In all likelihood, he contributed more to building the foundations of accountable human relating than any other thinker of our time. He sensitively defined the profound human issues of relationship and interpersonal suffering and witnessed to the proposition that, in the spirit of a responsible I-Thou dialogue, the self can gain merited reward. History will probably recognize Buber as a giant of twentieth-century thought. He was not a psychotherapist but a philosophical anthropologist. His contributions may be more fully acknowledged in philosophy, religion and disciplines linked to issues of community than in the field of psychotherapy. But Buber seems to have addressed people and society by references to therapy as well as through his other concerns. For us, his passion for realized justice in the human order has direct and immediate implications for a world in danger of abandoning its children.

The early, contextual realization that trust as a foundation of personality development and as a relational resource is different from trust as an experience led to the recognition of trustworthiness as a crucial requirement for viable, close relationships. The psychological criteria of the need for trust interlock with the ethical criteria of trustworthy relationship. It is at this juncture that Martin Buber's concept of genuine dialogue presents a unique opportunity for integration between the clinical foundations of individual and relational theory. The dialogic notion of responsible responding was an important underpinning of the first formulation of the intergenerational dialectic (Boszormenyi-Nagy & Spark, 1973).

Buber's concern for the "realm of the between" seemed to provide a conceptual approach that incorporated and extended Freud's theory of individual object need. His focus on the equitable validity of words that bridge (*dialogue*) offered a helpful guideline for trustworthy therapeutic interventions. It rightly implied that a genuinely trustworthy relationship requires relating partners to consider the validity of each other's interests, rights and needs as well as of their own. It also rightly implied that therapeutic interventions geared towards building merited trust required methodologies founded on *simultaneous consideration* of two or more relating partners. Since neurotic "distortion" of any kind diminishes the person's trustable relating capacity, successful individual therapy may or may not result in increased trustworthiness.

## **PERSPECTIVES ON CHANGE: FAMILY THERAPY**

From the very beginnings of family therapy, there were warning signs that cautioned its practitioners against the lure of assuming easy or auto-

matically lasting change. Anyone involved in the demanding attempts to help psychotics was put to an early test. Bateson et al. (1956) came to important conclusions about how double-binding communications contribute to the onset and development of schizophrenia. Significantly, however, most family therapists eventually abandoned their work with schizophrenics. The tedious process of helping people learn how to trust again seemed to become too trying. One way or another, the efforts of these early family therapists were likely to give them pause: Enlightened practitioners had to come face-to-face with implicit difficulties that—beyond psychosis—attend all human interchange. Short-term and long-term relational interventions could and would be conceived, tested and promulgated over the ensuing years. How many of them would lead to enduring individual and relational improvement was another issue.

With the advent of classical family therapy, motivational explanations were joined by the concept of inadvertently collusive, relational dynamics. Now the fluctuations of the identified patient's role and the "homeostatic" phenomena (Jackson, 1957) of family behavior required explanation. It seemed reasonable to assume that certain behavioral functions were regulated on a systemic level that transcended the individual. It was the system that was characterized by health or pathology rather than its members. Thus, the system was personified at the risk of depersonalizing people.

The newfound knowledge forced many initially individually-oriented therapists to reconsider how the relational understructure of life interfaces with personal motivations, rewards and benefits. On the other hand, the tendency of some therapists toward an impersonal, systemic "supraindividualism" led to a new kind of professional magic and, in our view, became a major impediment to the conceptual growth and development of the "family therapy movement." At the same time, however, Bowen's (1965) stress on undifferentiation in adults and even in entire families has significantly contributed to a more balanced systemic perspective. His therapy is aimed at the formation of differentiated selves for the identified patient and, eventually, for his or her family members as well.

In contextual therapy, it is abundantly clear that each individual's efforts to survive and thrive constitute the driving force of relationship. Surely nobody gains from a therapeutic dismissal of the resources implicit in knowledge about individual motivations. *Mutually interlocking individuation* is one definition of a relationship system.

By and large, to date, most family therapists have followed the path of *transactionally* anchored concepts and interventions, for very apparent reasons: 1) All relating partners collectively go through a "dance" of transactional sequences regardless of what other discrete criteria inform and shape their lives, and 2) transactional patterning is the most easily observable of any relational criteria. One might conjecture that even a Martian therapist, recently arrived atop the Empire State Building, could pick up

formally valid patterns of human behavior by looking down during the morning and evening rush hours. He could describe which cars go in which direction and on what streets. Seeing the congestion, he might diagnose the problem and suggest an appropriate intervention. It would obviously be helpful to break up and restructure the "rigid," compulsive rules that keep humanoids in such a chronic jam. Yet the Martian does not know that it is not the direction or the congestion nor the flow that motivates the person desperately in search of a cab to get to his first appointment with an important prospective customer. He couldn't care less about whether the taxi that gets him to work in time fits a pattern of cars going north or south on a given street.

No understanding of the transactional pattern is complete without regard for coexisting multipersonal criteria. To deny the existence of the individual is a self-deceptive parsimony. Ignorance of the self-other or I-You dialectic tends to weaken rather than strengthen the therapist's spectrum of options.

Attempts to establish a *bridge between individual and relational motivational regulations* have been relatively rare: Traditional psychotherapies have based their rationales on the individual's motivations to be free of symptoms and complaints and to attain a successful life. A client is helped to move toward these goals through a variety of measures that include insight, an ability to express real emotion, recognizing transference attitudes, working through, internalizing, and a capacity to rework defenses. A person is hindered in these projects by the inertia of his former habits and by the limits imposed by his dynamically unconscious resistance. Throughout the struggle, it is the improvement of his own condition *per se* that is presumed to motivate and ultimately reward the patient for his efforts to heal.

From its inception, family therapy grasped the fact that some conditions that were disabling to people lay in relationship configurations. So did many resistances to change, as well as the capacity to improve. It has typically been assumed that effective individual reorganization in one or several family members can result from "changing" these debilitating behavioral configurations. This assumption was reinforced by the observation that one family member can induce and sustain self-damaging behaviors in another family member.

Proceeding on these hypotheses, family practitioners designed techniques to affect individual behavior through *changing transactional patterns*. What were the guidelines for change? At times a rationale was offered to justify why certain patterns needed to be altered and show how new patterns could be more efficacious. Sometimes change was defined in terms of needing to produce new patterns that would better correspond to cultural values than did old patterns. Other times, the need for change was defined in social science terms, e.g., power coalitions, boundaries,