(Fe)male: The Hidden Gender Dimension in Models of Family Therapy

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At a time when long-standing assumptions about families are being challenged throughout American society, gender has become one of the most controversial issues in the field of family therapy. Tremendous social changes over the past two decades have generated an upheaval in beliefs and practices concerning what it means to be male or female and what gender-linked rules govern interactions and expectations within the family and in the social world in which gender and family norms are embedded.

This chapter will examine the place of gender in family therapy theory and practice as it has been explicitly addressed, or merely implicit, in the literature relevant to the development of major approaches to family therapy. It presents an overview of the most influential approaches for comparison and contrast. We will consider the following questions in relation to each model:

1. **Family processes**: What are the assumptions about the role of gender in family functioning and in problem development and maintenance?

2. **Therapeutic change processes**: How is gender considered in the therapeutic objectives, intervention strategies and techniques, and in the therapist's use of self?

In contrast to some family therapists who maintain that feminist positions are incompatible with systems theory and practice, we argue that to ignore gender is, in fact, nonsystemic. Rather than suggesting that we abandon systemic therapies, here we attempt to advance theory and practice by suggesting ways to incorporate an awareness of gender in the various models of family therapy. Gender, until recently a hidden dimension in family therapy theory and practice (Goldsch, 1985), must become a visible and vital component in all models of family functioning and all approaches to change if our field is to develop.

Our review of family therapy models begins with the brief, problem-solving approaches, and in particular the strategic/systemic and structural models of family therapy. Next, we consider intergenerational growth-oriented approaches, and in particular the Bowen family systems model.

**Strategic/Systemic Approaches**

Strategic/systemic approaches to family therapy have been most strongly represented by the interactional view and brief therapy model developed at the and Research Institute in Palo Alto, the problem-solving approach of and Madanes, and the Milan systemic model.

**Interactional View/Brief Therapy Model**

The interactional view was launched by the Bateson group investigation of double-bind communication in the etiology of schizophrenia (Bateson, Jackson, Haley, & Weakland, 1956). On rereading the early papers we were struck by an apparent blind spot in conceptualization. Despite the paradigmatic shift from linear to circular causality, and from individual and dyadic units of analysis to the family as a system, there persisted a tendency in case examples to focus narrowly on mothers' pathogenic communication to their schizophrenic offspring. Parent was equated with mother and the influence was linear: Mother's behavior produced certain responses in her offspring. Only much later was this tendency corrected (Sluzki & Ranson, 1976).

Don Jackson and his M.R.I. colleagues established a language and conceptual foundation for the interactional paradigm. In two seminal papers, Jackson (1977a, 1977b) introduced the concepts of "the family as a rule-governed, homeostatic system" and "the marital quid pro quo." He also addressed explicitly the question of gender. In his description of "family rules" he contrasted this new concept to sociologist Talcott Parsons' widely accepted sex-role theory of marriage and family. Jackson's critique underscored the primacy of transactional phenomena, asserting that individual vocabulary was inappropriate to describe interaction. He introduced the novel idea of rules rather than roles as determinants of human behavior. However, in his fervor to refute the sex-role model and establish the interac-
tional paradigm, Jackson threw out the baby with the bath water. Jackson not only discarded sex-role theory as epistemologically ill-suited for the study of human interaction, but also, in focusing exclusively on communicational process, took an extreme position in which he negated the relevance of gender as a dimension in family theory. As one of the forefathers of the interactional view, Jackson's dismissal of gender differences initiated a taboo so strong that it is only now, 20 years later, being challenged.

Jackson (1977a) defined the concept of family rules as implicit or explicit norms which organize family interaction and function to maintain a stable system by prescribing and limiting members' behavior. He contrasted rules to roles and criticized sex-role theory on the following grounds:

1. The sex-role construct is an individual concept, while the concept of rules refers directly to the redundancies we can observe between individuals.

2. Sex-role theory was proposed as a normative theory in which it was not possible to separate the role concept from cultural preconceptions about "proper" sex roles. In this view men's and women's behavior was classified and measured against stereotypic ideals of masculinity and femininity, with no allowance made for the relationship which underlay and maintained this arrangement or for the possibility of a variety of ways of working out rules for a relationship.

3. Sex-role concepts are based on a priori categories rather than on observed phenomena. In Jackson's view, more important is the circularity in the evolution and maintenance of the differences.

Based on his concept of rules, Jackson (1977b) suggested a theory of marriage which emphasized the interactional and collaborative aspects of the marital relationship rather than individual gender-based roles. The marital quid pro quo refers to the rules about the exchanges between two partners: Each partner, as in a bargaining relationship, must receive something for what he/she gives; these exchanges consequently define the different rights and duties of the spouses. (See Walsh, Chapter 14 for a reappraisal of this theory.)

Considering that Jackson's ideas were developed during the early 1960s—a time when prevailing theories were monadic, normative, and a priori—his pioneering work elucidated a language for understanding interactional phenomena. In his critique of role theory he anticipated the recent feminist criticisms of Parsons' functionalist model of the family (Hare-Mustin, Chapter 4; Boss & Thorne, Chapter 5). Moreover, he offered a conceptual tool that advanced the field from the stereotypic and prescriptive theories in which normality was viewed as adaptation to a patriarchal model of the family.

Jackson's interactional view is consistent with feminism in that the concept of rules implies that relationships are not destined by our biology, but can instead be defined potentially in a variety of functional ways. Nevertheless, by focusing exclusively on the interior of the family, he decontextualized human interaction, as if interactional processes could be understood in a vacuum. He narrowly equated "system" with "family" rather than recognizing the reciprocal interplay between individual, family, and other social systems. His theory of the marital quid pro quo implied that each spouse enters the relationship as an equal partner and as a "blank slate," i.e., with freedom to define any rules. Actually, each spouse is already "rule-governed" by larger systems, especially by the family of origin and culture, which co-influence socialization processes in human development.

Jackson's cybernetic model accounts for neither the social and economic context in which the family is embedded nor power differentials between family members (James & McIntyre, 1983). The most problematic aspect of Jackson's work, however, is his contention that "sex roles" are not based on biological given but are actually the end result of the bargaining between two people trying to define rules of collaboration. He failed to see that roles and rules are reciprocally constructed. Moreover, since men and women are social beings constrained by their history, culture and social condition, they enter relationships with different kinds of knowledge and experience and different degrees of power. He asserted that most of the dilemmas in marriages are not due to sexual differences but instead result from difficulties in working out rules for collaboration. He concluded, "... it is possible that one could outline marriage as a totally nonsexual affair, nearly excluding all sexual differences, or at least minimizing the causal role usually assigned such differences" (1977b, p. 23).

Jackson came close to addressing today's gender issues in his assumption that our behavior cannot and should not be reduced to or explained in terms of biological differences. Yet, in order to avoid the pitfalls of the theories of his time, which viewed sex differences in a causal and deterministic way, he dismissed gender altogether. In doing so he unwittingly established a false dichotomy between the interactional point of view and the inclusion of gender as a self-evident concept in family theory.

In subsequent work at the M.R.I., therapists in the Brief Therapy project (Watzlawick, Weakland, & Fisch, 1974; Fisch, Weakland, & Segal, 1982) developed a strategic model for working with individuals, couples and families. Based on an integration of systemic/communicational ideas (Watzlawick, Beavin Bavelas, & Jackson, 1967), and on the work of Milton Erick-
ton, the brief therapy team evolved a problem-solving model focused on how problems come to be and how to resolve them:

"Problems begin from some ordinary life difficulty, of which there is never any shortage. This difficulty may stem from an unusual or fortuitous event. More often, though, the beginning is likely to be a common difficulty associated with one of the transitions regularly experienced in the course of life—marriage, the birth of a child, going to school, and so on. . . . But for a difficulty to turn into a problem, only two conditions need to be fulfilled: (1) the difficulty is mishandled, and (2) when the difficulty is not resolved, more of the same 'solution' is applied. Then the original difficulty will be escalated, by a vicious-circle process, into a problem whose eventual size and nature may have little apparent similarity to the original difficulty." (Fisch et al., 1982, p. 14)

The authors contend that individuals do what they do because of their beliefs and values (their "position") about what they think is the best way to approach a situation. The model was not proposed as a comprehensive theory about human nature or the family. Instead, it was intended as a map of interactional patterns that maintain or intensify problems and of interventions to intercept these dysfunctional processes.

Like Jackson, the brief therapy team is wary of normative theories. As a result, they attempt to maintain neutrality by offering a minimalist model limited to initiating changes that will get the individual or family "unstuck." They believe that each individual or family must define what is normal and healthy for itself and that it is not the function of therapy to direct how people live their lives. Although this is laudable as a theoretical principle, in being so parsimonious the brief therapy model is too incomplete a map for so large a territory. While the model is extremely helpful in focusing the therapist on the interactional sequences that maintain a problem, its exclusive attention to changing attempted solutions omits all else, including the context of the attempted solutions or the alternative "appropriate" solutions.

The M.R.I. therapists consider the patient's beliefs and values as essential in maintaining erroneous solutions, but they deal with the patient's position neither in terms of gender patterns nor in relation to social context. This omission is critical to the plight of women, especially in terms of the planned direction of therapy. The model posits that if the dysfunctional pattern is interrupted, alternative solutions will emerge. However, it is unclear how such solutions are generated and maintained. Even if only in indirect, paradoxical, or subtle ways, it seems unavoidable that, as long as we are in the business of being therapists, we will rely implicitly or explicitly on some notion of individual, family, and gender functioning. Our questions, our reframes, and our definitions of therapeutic goals are all value-laden. Even when working within a symptom-focused model, the omission of gender-based patterns can be limiting to the therapist in understanding the problems of women and the solutions available to them. Although a value-free model of therapy might be ideal, in actuality neutrality seems utopian and a poor fit with the complexity of the psychotherapeutic process.

Recent work by the brief therapy team (Fisch et al., 1982) reflects increasing attention to the individual. Recognition of the importance of the patient's "position," involving the operation of beliefs, values and attitudes in the maintenance of attempted solutions, can be a point of entry for integration of gender as a dimension in the model.

The M.R.I. brief therapy model has been developed exclusively by men and, in fact, team members have claimed that the model appeals more to male than to female therapists. This can be understood if we take into account recent work describing how, typically, men and women follow different paths in the process of acquiring knowledge (Belenky, Clinchey, Goldberger, & Tharule, 1986). The M.R.I. model was from the beginning advanced with rational, abstract, impersonal language and metaphors. Also, the model's instrumental nature and narrow focus, as well as its emphasis on behavior and cognition, omit important aspects of women's "connected" ways of learning and knowing, which utilize contextual understanding, intuition, and self-knowledge. In this vein it is important to mention Virginia Satir, who was the first director of training at the M.R.I. Although Satir's therapy approach was strongly influenced by the early M.R.I. development in mapping communication principles, her direction was diametrically opposed to the model that evolved out of the Brief Therapy Project. While the brief therapy model was presented in a logical and pragmatic style, with a narrow focus and emphasis on behavior, cognition, and problem-solving, Satir refused to be confined to the "black box" and instead tried to broaden the interactional view by integrating individual psychology and the importance of social systems (Satir, 1972). In sharp contrast to the brief therapists' cognitive style, Satir valued the intuitive and experiential modes of change and centered her approach on feelings and growth.

**Problem-Solving Approach**

The strategic model advanced by Jay Haley (1973, 1976) integrated the cybernetic/communicational orientation from his early work at the M.R.I. with assumptions derived from his observations of Milton Erickson and structural ideas formulated in collaboration with Salvador Minuchin. Like the M.R.I. group, Haley's major concern has been with developing a model of therapeutic change rather than a theory of the family. However, as he
shifted focus from communication to family structure, he added two key tenets about the family to the M.R.I.'s parsimonious model.

First, Haley stressed the importance of viewing the family and problem formation within a life cycle perspective (Haley, 1973). He stated that "families undergo a developmental process over time, and human distress and psychiatric symptoms appear when this process is disrupted" (p. 41). Secondly, he conceptualized the family as hierarchically organized (Haley, 1976). In doing so, Haley recognized that power differentials do exist among family members. However, continuing the taboo on gender, he paid exclusive attention to power differences across generations and did not address gender as a basic demarcation of family organization. In his writings, Haley made references to gender differences and the plight of women, but he looked at gender only as a secondary, extrafamilial social variable and ignored the power differential between men and women within the family. As a result of this omission, Haley's writings present a contradictory view of women's predicament. (See Goldner, Chapter 3, for a fuller discussion.)

On one hand, Haley presented a view of the life cycle which is culturally relativistic and contextual. He stated that the goal of therapy is "to free the person from the limitations and restrictions of a social network in difficulty" and that "a symptom cannot be cured without producing a basic change in the person's social situation, which frees him to grow and develop" (p. 44). It is in this light that Haley showed a sensitivity to women's dilemmas, considering their problems as deriving from an oppressive social situation. For example, in arguing against a view of therapy that would foster "adjusting" a person to his situation, he says: "Many wives, for example, discontented with the narrow pattern of suburban life, have been stabilized for years by intensive analysis. Instead of encouraging them to take action that would lead to a richer and more complex life, the therapy prevents that change by imposing the idea that the problem is within their psyche rather than in their situation" (p. 43).

On the other hand, as Haley described the stages of the life cycle more specifically, at several points he portrayed women's dilemmas with mixed sensibilities. Not only was his account tinted with a male bias, but he also did not address the dilemmas of gender within the family. For example, when describing the stage of childbirth and caring for young children he described how a special problem arises for women:

Having babies is something they [women] look forward to as a form of self-fulfillment. Yet caring for small babies can be a source of personal frustration. . . . The wife who finds herself confined largely to conversation with children can also feel denigrated with the label of "only" housewife and mother. A longing for more participation in the adult world for which she was prepared can lead her to feeling discontented and envious of her husband's activities. The marriage can begin to erode as the wife demands more child-rearing help from her husband and more adult activities, while he feels that he is being burdened by wife and children and hampered in his work. Sometimes a mother will attempt to exaggerate the importance of child rearing by encouraging a child to have an emotional problem, which she can then devote her attention to. The task of the therapist is to help the problem of the child by helping the mother disengage herself from him and find a more fulfilling life of her own. (1973, p. 55)

Haley began this formulation sensitive to the woman's experience as one of pleasure and frustration. However, to our surprise, he left the man and the couple's interaction out of the "problem" situation. He ended by placing sole responsibility for change on the woman, while the husband was portrayed as incidental and as simply reacting to his wife's problem—a rather linear view. Haley seemed to have recognized the oppressed nature of the woman's position on a societal level without recognizing it also as an interational and hierarchical problem within the family.

Haley's mixed views are also found in his discussion of the stage of middle marriage: "One of the inevitable human dilemmas is the fact that when a man reaches his middle years and has gained in status and position, he becomes more attractive to young females, while his wife, who is more dependent upon physical appearance, is feeling less attractive to males" (p. 58). By portraying this crisis as an "indefinite human dilemma" Haley did not recognize the sociocultural basis of the problem. He missed the point that the stress in these middle years can be the life cycle culmination of a patriarchal asymmetrical arrangement in which the wife, having taken an auxiliary role all along, is now faced with social powerlessness, while the husband may be collecting the benefits of the asymmetrical arrangement.

Haley (1976) postulated the necessity for clinicians to recognize that families are hierarchically organized. He introduced the idea of inequality of power among family members but then limited his attention to inequality of power across generations, stating that the most elementary hierarchy involves the generation line, i.e., between grandparents and parents, parents and children. He then posited that symptoms usually reflect a violation in the family's hierarchical arrangement, in which a member from one generation forms a coalition across the generational boundary. An organization is viewed as malfunctioning when a coalition across generations occurs repeatedly and the parents are not relating as peers in the executive capacity. By limiting his view of the husband and wife as equal peers in an executive team, Haley addressed hierarchical problems between the husband and wife not in a fundamental way but only as incidental to generation (Goldner,
Chapter 3). What he failed to recognize is that cross-generation coalitions are often secondary to the inherent power inequalities between the men and women within families, the pattern that prevails in our society. The best response to the problems in Haley's theory is Goldner's proposition that we transform our theory of the family to include gender at "ground zero" as a basic category of family structure. In other words, gender and generation should be understood as the two fundamental organizing principles of family life.

Cloe Madanes, a collaborator with Haley and a leading strategic therapist in her own right, deserves comment. While not explicitly addressing gender issues, Madanes (1984) has shown sensitivity to the unbearable situation of low-income single mothers. She has criticized traditional mental health services for their tendency to make things worse by admonishing overburdened single parents for neglecting their children and, in effect, blaming the victim. We agree with her assessment that efforts directed at increasing the mother's executive functioning by giving her more responsibilities generally fail and only make the mother feel all the more incompetent while neglecting her very real needs.

The Milan Approach

The Milan approach, developed by Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Giuliana Prata, was influenced initially by the work of the M.R.I. team. They adopted a strategic mode and elaborated their own methods of positive connotation and prescription of rituals. Rediscovering Bateson, the group edged away from the strategic approach, developing a new mode of interviewing that emphasized circular questioning, the formulation of systemic hypotheses, and the maintenance of neutrality (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980).

As Boscolo and Cecchin moved toward a non-instrumental/"esthetic" view of therapy, they increasingly adopted a position of neutrality and gave up the notion of directing and maneuvering people towards change. They have repeatedly distinguished therapy from education and have expressed a strong bias against "instructive interaction." Cecchin has stated:

As family therapists, we cannot invent a family. What we do best is bringing [sic] forth of patterns through interacting with a family. We cannot think of ourselves as teachers instructing families in better scripts for being families. Yet, because we do not know what specific script will be successful for a specific family, we are left to interact in a way that will perhaps perturb the system such as it finds its own new (or rewritten) script. (1987, p. 408)

The purpose of circular questioning, thus, is simply to generate new systems of meaning and to challenge the premises the family has had about their present situation, their relationships, and their problem. Like the M.R.I. group, they see change in behavior as closely intertwined with change in the basic premises individuals have about their problems. They utilize rituals as interventions to effect behavior directly. However, a distinctive aspect of their work has been their increasing attention to the meaning system—i.e., the premises, values, myths—as their primary focus (Boscolo, Cecchin, Hoffman, & Papp, 1987).

The Milan approach is a method of practice rather than a theory about the family. They refer to families only in abstract and cybernetic terms, in doing so they do not address gender explicitly as a dimension of family functioning. They acknowledge that families can have premises regarding gender, but they seem to accept those premises rather than question them. In a discussion of their ideas and practice (Boscolo et al., 1987), Peggy Penn asked how premises are learned. Boscolo replied, "From their present relationships, from their history, and also from the general culture. You can have very powerful religious premises which are handed down by the culture in which a family lives. Or you can have premises regarding gender: what a woman is supposed to do, what a man is supposed to do" (p. 149). Cecchin then shifted the discussion away from gender, but Lynn Hoffman returned to the topic to raise the question of neutrality in cases of physical and sexual abuse:

Hoffman: "...It is hard to see a therapist take such a hands-off stance with behavior that is not only morally repugnant but defined as criminal. Could you state in more detail what you mean by neutrality?"

Boscolo: "Neutrality is the result, over time, of the interaction between the therapist and the family. If you ask the family 'What does the therapist think you should do?' or 'Whose side is the therapist on?' and if the family cannot answer these questions, the therapist has achieved neutrality. They might say he's 'tough' or 'warm,' but if they cannot state his position about what they should do, then he has achieved neutrality." (p. 149)

As a (non)reply to Hoffman's question, Boscolo's apparent indifference to issues of abuse is rather alarming. Reminiscent of psychoanalysis, the achievement of neutrality seemingly overrides all other concerns, implying that the therapist should strive not to let a family think that he or she has any position on what they should do about abuse. However, revealing no position can communicate indifference or even support of the abuse. The ethical implications of such neutrality demand more serious consideration.
Although there is brief mention that gender-based premises may be part of the problem, this point is not specifically elaborated. It is left to the particular sensibilities of the therapist to determine whether or how to focus circular questions on gender-based premises and myths. We see this as an important direction to pursue for clinicians working with the Milan approach. Rigid, normative assumptions about wives' and husbands' roles, rights, or obligations can and must be questioned if other possibilities are to be imagined. For example, one might ask family members their views on how it was decided that mother, who like father has a full-time job, is to be in charge of all household duties. Noticing and questioning differences between male and female experiences and perceptions can facilitate the appreciation of other positions and perspectives. What is called for is more explicit attention to gender in the circular questions that are asked, in systemic hypotheses that are posited, and in the stance of neutrality. Evan Imber-Black's utilization of rituals and attention to larger social systems (Chapters 17 and 22) are valuable models in addressing gender within a systemic approach to intervention.

**Structural Model**

The structural model of family therapy emphasizes the importance of family organization for the functioning of the family unit and the well-being of its members. Minuchin (1974) proposed a conceptual schema of family functioning to guide therapy. He viewed the family structure as an open social system in transformation, operating within a particular cultural context. Accordingly, the family progresses through successive stages of development, each transition requiring restructuring. The family must also adapt to changed environmental circumstances in ways that allow members to maintain continuity and to further their psychosocial growth. Individual dysfunction is viewed as symptomatic of a family's difficulty in restructuring in response to a developmental or environmental challenge. At this theoretical level, the structural model is quite congenial with feminist values in its attention to context and in the normalizing of problems as adaptational dilemmas.

Family structure is defined as the invisible set of functional demands that organizes family interaction. Transactional patterns defining relationships and regulating behavior are thought to be maintained by two constraints: (1) universal rules governing family organization, especially the power hierarchy, and (2) mutual expectations in particular families—explicit or implicit contracts that persist out of habit, mutual accommodation, and functional effectiveness. Each system maintains itself according to preferred patterns, resisting change beyond a certain accustomed range. This conceptualization is similar to Jackson's constructs of family rules and marital quid pro quo. To this, Minuchin added the rules that govern family organization, especially the power hierarchy. However, like Haley, Minuchin did not apply these principles to gender. Yet one can readily consider their specific application to gender-based transactional patterns that define relationships and regulate behavior. Gender patterns are likewise constrained by societal rules governing the power hierarchy, as well as by mutual expectations, or contracts, in particular families.

The structural model offers the conceptual framework and the vocabulary for addressing organizational patterns, boundaries, and subsystems. But it has yet to apply the framework to the dimension of gender—either to the gender-based arrangements in the construction of marital/parenal subsystems (Scheinker, 1988), or to the gendered coalitions across generations and among sisters or brothers. In the collaboration of Haley and Minuchin, it's curious that the generational distinction is a major focus of attention without notice taken of the distinction between genders. Husbands and wives have been conceptualized as a marital or parental unit, with the most salient distinguishing feature between them ignored, perhaps to avoid falling back into an individualistic view in noting sex differences. In fact, structural family therapy diagrams, until recently, made no gender distinctions: There was one symbol for parent and for child, as if individuals were interchangeable and unisex. That ignores the fact that there are fundamental distinctions between wives and husbands, or sons and daughters, just as there are distinctions between children and parents in families. Gender is a structural relationship variable, not simply an individual characteristic (Goldner, Chapter 3).

Minuchin has been keenly aware of the impact of socioeconomic and cultural environment on family and individual functioning. Nevertheless, in practice, when it comes to the position of women in the family, the frame of observation and intervention has tended to focus on the interior of the family. The diagram constructed for planning the phases of intervention is typically restricted to the nuclear family unit or household structure, with the occasional addition of a few key extended family members. Since the model posits the interconnection of family and its sociocultural context, structural family therapists could readily include the linkage of each family with other systems operating significantly in their lives, especially their work systems. Evan Imber-Black (1986, Chapter 17) makes such connections an integral part of her systemic assessment and treatment approach.

For instance, structural family therapy frequently focuses on restructuring dysfunctional triangles with an overinvolved mother and child and a peripheral father. Minuchin (Simon, 1984) has stated:
In this circumstance I tend to use the father to separate the mother from the children. It is an intervention I find useful because it expands the father's function, shifts the woman's concentration on the maternal, and creates new possibilities for her to function as a more complex, adult woman, and it introduces perturbation in the parental field. (p. 67)

In response to feminist critics, Minuchin acknowledged that this is a skewed way of entering the system that supports male cultural stereotypes. Yet he asserts that this operation "doesn't represent either a coalition of males or a political statement" (p. 67). However, the failure to notice the culturally based hierarchical imbalance within the marital/parental subsystem leaves the husband's relatively greater power and authority and the woman's subordinate position unaddressed in the therapy. Nor does it consider how a woman, socialized primarily for a maternal role, can spontaneously develop meaningful alternatives in a society in which her options are limited. The social pressures and constraints on a husband's position are also not dealt with adequately. For instance, a sense of powerlessness and failure in meeting standards for job success and financial provision to his family may contribute to a father's unavailability and frustration, which may be expressed in neglect or abuse of his wife or children.

As the model was developed to meet the challenges confronting multi-problem inner-city families, structural family therapists have been more sensitive than others to the plight of low-income single parents. With single mothers, the structural therapist actively promotes the authority and competence of the mother, while also normalizing and addressing her unmet needs for adult support and companionship. The therapist is cautious not to "fill in" as the missing father. However, the therapist does need to avoid suggesting to the mother that she—or the family—is incomplete without a husband, or that what she needs is a new man to rescue her, as in the classic case, "Family with a Little Fire," in which the therapist, Braulio Montalvo, ends the therapy by using the metaphor of "setting mother on fire" to attract a new man (Minuchin, 1974, and videotape, Philadelphia Child Guidance Clinic).

The particular style of the therapist and misapplication of the model have at times been problematic. For instance, the forceful manner of a powerful male therapist may be confused as a requisite of the model and viewed as a necessary therapeutic stance for the approach to be effective. Therapists need to be sensitive to the therapy experience of a wife or mother who has been in a subordinate position to the men in her work and family life. Despite her apparent compliance, she is likely to feel intimidated or patronized by an overpowering male therapist. In practice, therapists can promote structural changes by using themselves in a variety of ways that are respectful to all family members.

Structural family therapists need to become more aware of the impact of metacommunication in the therapy context that reinforces gender stereotypes and dysfunction. Fishman (1988) describes his efforts to promote a sense of competence in a 19-year-old girl in a family session at her hospital discharge:

DR. FISHMAN  Congratulations—do you want your lovely grown-up daughter to be at home?
MOTHER  She can't leave. She can't do important things.
INGRID  She's right.
DR. FISHMAN  I don't understand. You know a foreign language but you can't boil an egg—you can't cook at all? (p. 214)

Whether intended or not, the therapist conveys the message that domestic activities are the competencies that matter for a young woman.

In another family case, Fishman identifies a skewed marital pattern—in which the husband was always up and the wife was always down and feeling devalued—as maintaining the wife's severe anorectic symptoms and child-like functioning. While he defines the therapeutic objective as correcting this structural imbalance in order to promote more competent functioning by the wife, his interventions actually reinforce her one-down position. At a meta-level, the structure of the therapy is isomorphic to the dysfunctional skewed pattern. The therapist repeatedly interrupts and challenges the wife, relates with the husband's position, and talks to the husband about her; at no time (in the transcripts presented, pp. 261-275) does he interrupt the husband, acknowledge or support the wife's position, or talk to her about her husband.

As the wife attempts to describe her experience of marriage and her distress, the therapist (like the husband) at no point shows sensitivity to her feelings or validates her position. For example:

HERB  Anybody that has gone through all this crap would have left you long ago (he laughs).
DOROTHY  But maybe there's nothing there anymore. Maybe you're going to stay, but maybe there won't be anything left of us anymore. Of course you will stay. It's too convenient to leave. Who else is going to be as good a cook? And who else is going to iron all those shirts real nice, and make sure the collars are starched? You come home at 7:00, you go to sleep at 9:00. But I never tell you anything about it. You say, "Do you mind if I close my eyes?" No, I don't mind if you close your eyes. At
Once I told you I was going to drink too much because then at least I would go to sleep. I couldn't even do that. Because that was doing something. I can only deprive myself.

**DR. FISHERMAN** I see Herb as very committed to this relationship.

**DOROTHY** He really is.

**DR. FISHERMAN** Don't speak for him—because it's not fair. He needs to speak for himself. (To Herb:) I see you as very committed to Dorothy. But somehow Dorothy doesn't hear it. So what can you do to help? Do you feel committed to her?

**HERB** Yes, very much so. I think she knows that. We wouldn't be here if . . .

**DR. FISHERMAN** Herb, she doesn't know that. Because she just said she doesn't. Tell her.

Although the therapist defines the structural imbalance as a fixed complementary pattern—Dorothy being sick and Herb responding, he notes only her contribution, implying that she is to blame for the problem:

**DR. FISHERMAN** Now you are putting yourself down. You are inviting your husband to disrespect you.

**DOROTHY** Why do I do that?

**DR. FISHERMAN** I don't know why. After you are better you can find out why.

An even greater skew is promoted by the value-laden objectives the therapist injects for the distant husband's more active involvement. In his case commentary, Fishman observes that the husband's focus on his wife's disorder has kept him from fulfilling "his parental function, which is to pluck the adolescents away from her." (p. 256). Fishman puts the husband in charge of the family, advising him to become the "captain of the ship." Fishman comments:

I engage Herb directly, trying to increase his participation by using an image of leadership that has been painfully missing. One would think that Dorothy wants this, but instead she activates to interfere and to try to arrest the participation. I resist the intrusion and pull him out (p. 258). . . . To end the session I intensify the message to the father that he must take control and challenge the mother to change (p. 260).

As clinicians address structural imbalances in families, they need to become more aware of the gender implications of the positions they take and the objectives they set for therapy.

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**Hidden Gender Dimension in Models of Family Therapy**

**Multigenerational Approaches**

**Psychodynamic/Intergenerational Approaches**

A number of family therapists, such as Framo (1970), Meissner (1978), and the Pauls (Paul & Paul, 1987), have attempted to bridge psychodynamic, object relations, and family systems views of family functioning and approaches to intervention. Gender has not been addressed explicitly in these formulations; however, a number of implications are embedded in both theory and practice.

Although intergenerational family therapy models attend to relationship systems, some basic premises in the psychodynamic model have persisted in ways that negatively regard and influence women in families. Traditional assumptions about the focus and source of problems, as well as views of normality and health, are worth noting in order to place our critique of family systems therapies in sociohistorical context.

First, the psychoanalytic model places the focus of problems within the individual, personalizing human distress as individual psychopathology. Women, who have been the predominant consumers of psychotherapy, have disproportionately been pathologized and blamed for their problems by the assumption that their complaints are a symptom of their own inadequacy. Insufficient attention has been given to the context of their distress.

Second, the source of problems was located in the distant past, in the earliest relationship between patient and mother. The mother, as primary caretaker, was held ultimately responsible for all problems in life evidenced by offspring. Thus, pathology identified within clients, both male and female, was viewed as caused by "bad mothering" or maternal character deficiencies. There was a failure to view women and mothers contextually, to expand the frame of inquiry and intervention beyond the mother-child dyad, and to consider reciprocal influences within the broader network of relationships.

Third, the psychoanalytic tradition, wedded to the medical model, was concerned with the diagnosis of psychopathology. Treatment was aimed at reduction of conflicts and deficits. Women as consumers and as mothers tended, therefore, to be overpathologized. Strengths and resources tended to be unnoticed or misconstrued as pathogenic. Treatment was regarded as successful if a (woman) patient came to accept her own limitations and came to terms with (i.e., accepted) her mother's deficiencies.

Fourth, diagnosis and treatment goals were strongly, yet subtly, influenced by gender role expectations consonant with cultural ideals. Although the stance of the therapist was to maintain a value-free neutrality, implicit assumptions and beliefs about proper roles and attributes for males and females operated in unacknowledged and powerful ways. Normative female
characteristics (how women should be), such as emotional expressiveness, passivity, and dependency, were labeled as pathology, as in the oversued diagnosis of hysterical personality. Yet, standards of health fit male models, and a woman adopting those standards was criticized for being unfeminine. Moreover, a double standard operated when the same behaviors in men and women were labeled and counted as health for men but pathology for women. A strong man in relation to his wife was praised for being dominant (as men should be), whereas a woman stronger than her husband was condemned for being "domineering" or "castrating."

Intergenerational family therapy approaches, like other systemic therapies, have assumed a gender-free position, examining relationship dynamics and transactional processes as if spouses were interchangeable genderless units and as if they have equal influence on one another and on the system as a whole. Gender differences in socialization require closer scrutiny as they relate to marital and family dynamics (Feldman, 1984). For instance, men and women have quite different experiences and problems around loss issues, with men constrained in the expression of grief and women expected to carry the socioemotional and physical caretaking tasks for the entire family. At the same time, because women are more central in families and are responsible for maintaining extended family connections and traditions, there is a tendency in practice to focus disproportionately on wives and mothers and on the maternal line in families of origin. Our experience as family therapy trainers suggests that fathers tend to offer less information about themselves and to claim that their own family experience was simply "normal" or unnoteworthy. Therapists are less likely to press husbands for more information, and husbands tend to be less forthcoming with their feelings and concerns, so that family assessment and intervention can become skewed toward problems in the wife's family of origin. Moreover, in family-of-origin inquiry, relationships with mothers loom large because of mothers' centrality in families and fathers' shadowy presence. As a consequence, women and their relationships in families remain the predominant focus of therapy. Therapists need more actively to encourage husbands to express their feelings and address their family of origin issues.

Intergenerational approaches have corrected the traditional narrow, linear causal focus on early mother-child dyadic relationships, instead attending to ongoing, circular transactional processes in the family as a system. Yet, when family history is gathered, there persists a tendency to focus more on past relationships and ignore current stresses affecting the family. Moreover, as the source of current relationship problems is located within each spouse's family of origin, problems become pathologized within a particular family in unresolved past relationship conflicts and losses. The historical and ongoing influences of other social systems, particularly economic and cultural imperatives, are outside the frame, hidden from view. Thus, the impact of poverty, work discrimination, or inadequate day care options for a single parent is likely to receive scant attention, and very real culturally determined problems may be interpreted as symptoms of unfinished work with her family of origin. Intergenerational therapists need to attend as fully to social context as to intrafamilial context.

The emphasis on psychopathology has persisted. Despite a systems orientation, intergenerational therapists risk retaining an "individualistic" perspective when they simply shift focus from looking within the individual person to looking within the individual family. In spite of a basic premise of circular causality, family therapists unwittingly revert to a reductionistic, linear explanation of behaviors when they ignore extratraditional influences and regard symptoms necessarily as evidence of underlying pathology in the marriage or of unresolved conflicts from the family of origin.

Intergenerational approaches are growth-oriented, with therapy aimed at comparatively vague goals that are often utopian ideals of healthy functioning (Walsh, 1982). Although therapists attempt to maintain a neutral stance in order to avoid imposing their own values, the unclarity of goals leaves a good deal of room for the influence of culturally based and idiosyncratic notions about healthy families. Therapists need to examine their own beliefs and values about gender and the models they have had in their lives.

Bowen Model

The Bowen family system model, in common with psychodynamic approaches, is growth-oriented, with a therapeutic mandate for exploration and change beyond symptom reduction. Both emphasize the gathering of information about family-of-origin relationship patterns and unresolved conflicts or losses, with the objective of changing one's perspectives and current relationships with key family members. These methods and goals are consistent with feminist values, especially when they assist both male and female clients to gain an evolutionary and contextual perspective on women's experience. Harriet Goldhor Lerner has observed,

Through both Bowen work and feminism, a woman's sense of isolation about her so-called pathology is replaced by an empathic understanding of the continuity of women's struggles through the generations and the ways in which she is both similar to and different from those who came before her. (1986, p. 37)

Yet, in locating the source of individual or marital problems, Bowen (1978) placed particular emphasis on the importance of the maternal line in the transmission of pathogenic multigenerational influences. As Luepnitz
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(in press) has noted, a consistent theme in Bowen’s work is the contention that mothers “overinvest” in their children because they could not separate from their own mothers, who in turn were unable to separate from their mothers. He has therefore focused disproportionately on the maternal line in family-of-origin inquiry and change. Although Bowen has asserted the importance of the father’s role, there is scant mention of fathers in the clinical material in his major volumes (Bowen, 1978; Kerr & Bowen, 1988). This bias has been corrected by feminist therapists working with a Bowen orientation, notably Elizabeth Carter and Monica McGoldrick (1976; 1988) and Harriet Goldhor Lerner (1986). The development and application of the genogram (McGoldrick & Gerson, 1985), introduced by Bowen, have been of particular value in enlarging the lens from the narrow focus on mothers to the broader network of relationships.

While psychodynamic approaches promote the sharing of feelings among members in sessions, which is closer to what we regard as “feminine” in our culture, the Bowen approach is closer to the “masculine” model. The therapist assumes the role of coach, takes a highly cognitive stance, and encourages the control of one’s emotional reactivity in contact with family members outside sessions. Unlike the psychodynamic and experiential approaches, there is little value placed on direct communication of pent up emotions, especially long-standing and previously unexpressed feelings of disappointment or anger. Rather, communicating with family members is a very thoughtful, enterprise in which feelings are well modulated. This can be a highly effective way to work. At the same time, we need to be careful not to communicate to clients that strong feelings must be kept under control or that they are necessarily reactive and dangerous.

Bowen has presented mixed messages regarding the healthy balance of intellectual and emotional functioning and between differentiation and togetherness (Luepnitz, 1988). While he has repeatedly emphasized the importance of balance, there is little elaboration on these attributes in his work, other than his Scale of Differentiation of Self (1978). Under healthy functioning are the following attributes: “autonomous,” “being-for-self,” “intellectual,” and “goal-directed.” The poorly differentiated person is described as: valuing “relatedness,” “seeking love and approval,” and “being-for-others.” From this scale, it appears that a “feminine” relationship orientation is devalued and pathologized, while male norms for autonomy and achievement are the criteria for health, with little balance evident on the scale.

However, it is not a relationship orientation, but rather a fused, reactive emotional position, that is regarded as dysfunctional by Bowen. Those low on the scale of differentiation of self are dominated by their emotions, which override thoughtful, intellectual modes of thought. Their overdepen-

dence on others in relationships impedes their ability to pursue independent interests and achievements.

Because the Bowen method focuses on differentiation of self, some critics have misunderstood Bowen to be concerned only with achieving separateness and autonomous functioning. To the contrary, differentiation is promoted in order to achieve the goal of a deeper and richer relationship, which is not possible when members are either too closely fused or reactively distanced, or cut off. The central objective in Bowen therapy is the differentiation of self in relation to others. It involves being separate and connected.

Nevertheless, in the Bowen method therapists don’t directly promote togetherness. Bowen has assumed that, if clinicians encourage differentiation from families of origin, clients will be able to engage more fully in their current relationships. In other words, togetherness will take care of itself. However, we cannot take that for granted when efforts have been directed toward separateness. Clients, men in particular, because of their socialization experience, are likely to need assistance in developing more intimate relationships.

There are many commonalities between the Bowen coaching method and women’s assertiveness training, especially in efforts toward differentiation of self, as in assuming more responsibility for changing oneself in relationships. Taking an “I” position—without attacking, defending, or withdrawing—is close to the notion of asserting one’s own position in transactions with others. Gender differences in the typical reactive stance of men and women should be noticed by clinicians: Attacking and defending are more likely to be male responses in an uncomfortable interaction, while women tend to back down and defer to the positions of others. Moreover, men are reinforced positively for expressing their own ideas and opinions strongly; women doing the same tend to be viewed as “bitchy” and “too aggressive.”

While Bowen can be criticized for tilting the balance of intellect and emotions a bit too much in favor of the cognitive control of emotions, it should be kept in mind that Bowen has valued the importance of maintaining connectedness and repairing cutoff relationships in families. Working with the Bowen model, clinicians need to strive for a balance that neither pathologizes emotions and closeness nor overvalues an autonomous self at the expense of connectedness, as we have done in our culture. Clinicians need to be careful not to confuse the concept of differentiation with pseudounautonomy, which is seen when extreme self-reliance and emotional or geographic distance that must be maintained from one’s family in order to feel separate. Rather, a healthy differentiation involves the ongoing maintenance of self in relation to one’s family.

In application of the Bowen model, we have to keep in mind that when we
are coaching women to change themselves in relation to others, they are most likely starting from a one-down position vis-à-vis their husbands. It is much harder to change oneself in relation to another when that other holds considerable power over your life. That must be taken into account in setting goals and planning effective intervention strategies. Too often, a woman who attempts to change herself in relation to her partner finds the task impossible from a one-down position, in part because the nature and conditions of the hierarchy have not been fully considered. She may then direct all her energies toward her children or career development, either shutting down in the marriage or experiencing increasing disparity between herself outside the home and inside the marriage. She is then likely to see leaving the relationship as the only viable alternative. A woman may have to take the first steps in changing a marital relationship, but eventually the husband must make reciprocal changes for the marriage to work. Unless he takes an active part in changing himself in relation to her as well, we replicate society’s charge to women—that they must bear sole responsibility for change in the family.

Furthermore, the construct “self-in-relation-to-other” must be considered in the broader context. Both husband and wife will likely have to change their respective positions in relation to their work systems if a rebalance in their marital relationship is a goal of therapy. Here, too, it is a formidable task for men as well as women to alter their positions in work systems that hold such power over their lives in terms of economic security, job advancement, time allocation, and expectations for success. Clinicians can be helpful by applying Bowen techniques for change in relation to work systems. For instance, the genogram and coaching method can be used to assess clients’ own work systems, noting triangles involving competing demands of work and family, and to alter their position in that system in relation to family life. A clinician might coach an overburdened single mother with the aim of strengthening her job position or joining effectively with coworkers to achieve day care benefits in a firm in which she feels exploited and powerless. One might also coach a father who is constrained by job performance expectations from active participation in parenting to restructure an inflexible work schedule.

In sum, we see many advantages in the Bowen method of therapy in addressing gender issues. We urge that information gathering, genogram construction and coaching techniques be directed to work systems and other contextual influences, in addition to the usual focus on multigenerational patterns. Clinicians need to help men and women in families to achieve a fuller valuing and balance of intellectual with emotional functioning and of differentiation with relatedness.

Hidden Gender Dimension in Models of Family Therapy

Discussion and Recommendations

By and large, the major models of family therapy have not by design promulgated sexist beliefs or practices. However, the architects of our models of family functioning and family intervention have been blind to gender as a fundamental organizing principle in human systems and have not taken into account the differential in power and status between men and women in the larger social systems in which families are embedded (Hare-Mustin, 1978; Goldner, 1985; Taggart, 1985). As a consequence, with the exception of recent feminist critiques, gender has remained a hidden dimension in models of the family and change. The limited focus on current, intrafamilial process to the neglect of historical and socio-political contexts contributed to the gender blindness. The emphasis on circular causality and the maintenance of neutrality fostered a reluctance to confront gender issues in clinical practice.

The cybernetic perspective brought to our attention the circularity of influences in ongoing interactions. However, as family therapists began to reify this model and to regard as important only the transactional sequences and loops between individuals within families, relationships were depersonalized and de-contextualized. In employing the cybernetic metaphor, we began to think of the family as if it were actually a machine (James & McIntyre, 1983), and like machines, genderless. What we failed to see were the gendered patterns both within and beyond that frame, regularities in the interactions between males and females in families and throughout our culture. Since it was very much a “man’s world” at the time of the development of systems models, women were “other,” defined (by men) by their positions as wife and mother, and their experience was rendered invisible. As Bateson (1979) noted, the ways in which we punctuate human experience determine what we see and how we define that experience. If we are to apply the cybernetic model to families, we need to incorporate gender as a basic element in human systems.

Also, in the early development of the field of family therapy, we were pushing away from the influence of the psychoanalytic tradition. Any attention to “content” issues or history was considered linear, deterministic, and irrelevant to change. However, we must not lose sight of the very process and content issues that distress family members. If we are not attending to gender as a distinguishing feature in families, we may fail to notice a woman’s subordinate position or to hear her pain. To understand her experience, we must expand our attention to the historical and socio-political contexts of gendered relationships.

Family therapy pioneers mainly developed theories about change and steered away from formulations about the family that could unwittingly be
taken as prescriptive. This cautious attitude derived from the constructivist view that all notions about "normality" are merely subjective and that therapists should not meddle with a family's value orientation. Yet, shared beliefs and assumptions about gender are core variables in all families and their contribution to problem development, maintenance, and change must be more carefully examined.

In order to address gender issues, models of change need to be accompanied by models of family functioning, relative to varying economic and cultural contexts and fitting particular developmental tasks and environmental demands (Walsh, in press). We must also be more cognizant that patterns that are functional at one system level may not be functional at another. Traditional roles, rules, and interactional patterns that may have enabled men to fit with societal standards for success have nevertheless been dysfunctional for the family. Families have been organized to support that success, to the detriment of overburdened and undervalued contributions of wives and mothers and to the limited participation of husbands in family life. Now that most women are active members of the workforce and men are seeking greater involvement in parenting, traditional assumptions are being called into question by families we treat, either explicitly or through symptoms of distress. We must neither assume nor tacitly reinforce gender status quo.

Family therapy training should assume greater responsibility for helping therapists to gain more explicit awareness of the values and beliefs about gender that are embedded in practice models and in our own cultural and family experiences. The provision of supervised experience interviewing non-clinical families can also be important in broadening the perspective of clinicians (Walsh, 1987). Our intervention approaches must be more responsive to the diversity of family forms and the unprecedented dilemmas confronting women and men in contemporary families.

The most curious feature in the development of the field was the negation of power as a valid or useful construct. There persists an attitude that it is not "systemic" or consistent with circular causality to talk about power in families. Haley and Minuchin did attend to the power differential in the hierarchy between generations as a universal feature in family systems and focused intervention on structural rebalancing as a chief objective of family therapy. However, the hierarchical imbalance between husband and wife has yet to be addressed in practice models. Given the differential of power and status between men and women in the society that frames all family interaction, it is a fallacy to assume that a power balance is maintained in family systems, with each member having equal influence. The insistence on therapeutic neutrality has left some difficult questions unaddressed. Fundamentally, is it possible to intervene and influence a system and yet remain neutral?

Is it ethical even to attempt neutrality when systemic patterns maintain abuse?

We have to construct power on our interactional map if we are to chart the family's territory. We must pay attention to the overt and covert rules that regulate the expression and balance of power between males and females in society and in families (Walsh, Chapter 14). We need to examine what blocks us, as family therapists, from addressing this issue. Discussions about power have tended to focus on hierarchical relations between males of one generation and males of the next, perhaps because that is where the culturally defined action has been. If power is equated with success and success is defined in male terms, then the extrafamilial male arena would be the significant arena of focus and the power differential between men and women would not be, following Bateson's reasoning, "a difference that makes a difference" to men.

Our society is changing and new generations of family therapists are bringing a greater awareness of gender to family therapy theory and practice. It was not possible here to review all models and developments. Noteworthy contributions to the analysis of gender issues in Behavioral approaches to marriage and family therapy have been made by Jacobson, (1981; 1983); Gurman and Klein (1984), and Margolin, Tsalovic, Fernandez, & Onorato (1983). Avis (1985) and Warburton and colleagues (Chapter 9) have examined gender in the Functional Family Therapy model and the differential experiences and impact of male and female therapists with male and female family members. The formidable challenge of integrating gender awareness in the conceptual frameworks, training, and practice of family therapy still lies ahead.

REFERENCES


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