Where did that come from?
Countertransference and the oedipal triangle in family therapy[1]

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Abstract

Family systems therapists are uncomfortable using psychoanalytic terms. This reluctance restricts discussion of therapeutic process. How does one describe, for example, the therapist's subjective experiences of the patient or family? Psychoanalysts call this countertransference yet there is no equivalent word commonly used in systemic practice. Therapists who avoid the word may also avoid the experience and thereby risk losing sight of fundamental clinical events.

Writing history backwards

"*Where does all this stuff come from?* How do we decide to say what we say when we work with families…?" asks Sigurd Reimers (2006, p. 230). His sources include no primary psychoanalytic ones at all. The earliest reference in his paper is to an observation by James Framo that "it is almost impossible not to get caught up in the drama of the family interaction" (Framo, 1965, p. 197) and a candid look at the "cases that touch on a feeling of 'madness' in us" (Reimers, 2006, p. 237). Reimers is thoughtful and observant but there is something parochial about a paper on the process of therapy that ignores the greatest body of work on the subject.

I did a small 'study' in a specialist psychotherapy bookshop. Looking at the references in a sample of systemic therapy books I found none before 1956, and rarely any to psychoanalytic texts after that. "As in the Russian revolution existing authorities were simply obliterated, as if they had never been. Even psychology was removed and replaced with philosophy and engineering" (Kraemer, 2002, p. 199). Though there are many honourable exceptions[2] the perception still prevails amongst systems therapists that psychoanalysts tell patients what they are thinking and that their interventions are focused primarily on past events; "The therapist's narrative

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1 A shorter version of this paper appears as 'Is there another word for it? Countertransference in family therapy' in Flaskas & Pocock, 2009, published here with permission, © Karnac.

2 The systems revolution is more evident in retrospect, but taking only a small selection of books and papers, more recent attempts at synthesis, belonging to what Lockyer (2007) describes as a 'subjugated narrative', are to be found in Skynner (1976), Stierlin (1977), Martin (1977), Holmes (1985), Byng-Hall (1986), Luepnitz (1988), Kraemer (1994), Flaskas & Perlesz (1996), McFadyen (1997), Speed (1997), Dare (1998), Larner (2000), Kraemer (2002), Donovan (2003), Johnsen, Sundet & Torsteinsen, (2004), Flaskas, Mason & Perlesz (2005) and Flaskas & Pocock (2009).

becomes the client's reality" (Gergen & Kaye, 1992, p. 172). A psychoanalyst who is disturbed or uncertain in the presence of a patient is rarely described. On both sides of the therapy fence there have been brave efforts to make authentic, nonphysical human contact through conversation with clients, but there is little fertilisation between them, leaving each open to accusations of mystification and omnipotence.

Systemic therapy is rightly regarded as a new paradigm in psychotherapy. In *The Structure of Scientific Revolutions* Thomas Kuhn (1962) showed how changes in our understanding of the world are not continuous or cumulative, as scientists are inclined to believe. On the contrary, there is a communal conservatism in scholarship and it is only from time to time that a new paradigm can emerge. This is not simply a matter of finding new data. "The transfer of allegiance from paradigm to paradigm is a conversion experience that cannot be forced" (Kuhn, 1962, p. 151). Kuhn noted how textbooks "have to be rewritten in the aftermath of each scientific revolution" (p. 137). "The temptation to write history backwards is both omnipresent and perennial" (p. 138). The terminology of the old paradigm is discarded, because it has no equivalents in the new. Something of this kind seemed to occur in the family therapy revolution where systemic concepts had no antecedent translations. Yet the new paradigm did not supersede the old. Psychoanalysis continued, and developed its own systemic ideas independently. Family therapy barely registered in the psychoanalytical world.

Countertransference
Countertransference was first thought to be an obstacle to psychoanalysis. Sigmund Freud had said in 1910 "we have become aware of the 'counter-transference', which arises in [the physician] as a result of the patient's influence on his unconscious feelings..." (Freud, 1910, p. 144, 145). Countertransference later became more useful. Amnon Issacharoff explains why it had at first been so troublesome: "It is almost as if [Freud] shied away from public comments on the matter. After all, psychoanalysis was not part of the 'establishment' at that time. It was still sensitive and highly vulnerable to its numerous detractors" (Issacharoff, 1979, p. 28). This vulnerability is the risk of exposing the private and personal feelings that analysts have about their patients. Yet, these are precisely what they learn to notice and take seriously, and from which new understanding arises.

The Second World War changed psychotherapy. The damage done by loss, death and migration shifted the focus of dynamic psychology from individuals towards relationships. "Psychology and psychopathology have focussed attention on the individual often to the exclusion of the social field of which he is a part" (Bion & Rickman, 1943, p. 681). At the same time, sophisticated electronic engineering in guided missiles, and in other equipment using self-correcting feedback, contributed to the creation of cybernetics. Using systems theory, some psychologists and psychiatrists

discarded the prevailing paradigm of individual drives and devised new models of family interaction: "the conceptual shift from energy to information" (Watzlawick, Beavin & Jackson, 1967, p. 29). Meanwhile psychoanalysts, privileging the need for relationship over other drives, began to see countertransference as a source of information, communicated not in words but by the transfer of states of mind or feeling from one to another. Their innovations were evolutionary rather than revolutionary. Paula Heimann wrote: "In my view Freud's demand that the analyst must 'recognize and master' his counter-transference does not lead to the conclusion that the counter-transference is a disturbing factor and that the analyst should become unfeeling and detached, but that he must use his emotional response as a key to the patient's unconscious" (Heimann, 1950, p. 83). Margaret Little grasped its elusiveness: "...to try to observe and interpret something unconscious in oneself is rather like trying to see the back of one's own head - it is a lot easier to see the back of someone else's" (Little, 1951, p. 33). Countertransference, she said, "is a special kind of identification of the analyst with the patient" (Little, 1951, p. 33). Psychoanalysts became less censorious of their own mental states. Using different terms, these pioneers were describing patient and analyst as a system[3].

One of the few psychoanalysts to acknowledge systems theory was Harold Searles (b. 1918). For many years he worked analytically with schizophrenic patients. He was impressed by the double bind theory and contributed a chapter in an early collection of papers on family therapy (Searles, 1965). His work is noted with approval in the classic text of Milan systemic therapy, *Paradox and Counterparadox* (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978, p. 175). Searles' candour in writing about his own states of mind at work is startling:

> "In my several-years-long work with a woman who showed a borderline personality organisation at the outset, I found that she recurrently held over my head, mockingly, year after year, the threat that she would become frankly and chronically schizophrenic. ... In many of the sessions during those years, I felt a strong impulse to tell her ironically that I had felt for years, and still did, that she could become chronically schizophrenic if she would just try a little harder. Essentially I was wanting at such times somehow to convey to her that this was a *choice* she had. ... In order for the analyst to help the patient to become able to choose, the former must be able not only to experience, indeed, a passionately tenacious devotion to helping the latter to become free from psychosis, but also to be

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3 "There is no such thing as a baby". This famous statement, never published in these precise words, was first uttered by Donald Winnicott at the British Psychoanalytical Society in 1940. He was perhaps the first to note the essentially systemic nature of the baby and mother couple.

able to tolerate, to clearly envision, the alternative "choice" - namely that of psychosis for the remainder of the patient's life" (Searles, 1986, p. 217).

"[In] my work with patients who have been involved in chronically troubled marital situations wherein there is a chronic, suspense-laden threat of divorce hanging over the marriage ... it has appeared to me no coincidence that, concurrent with especially stressful phases of the analytic work, my own marriage has felt uncharacteristically in jeopardy" (Searles, 1986, p. 222).

Searles shows how he is disturbed by his patients. He writes about feelings of romantic love, of intense amusement and, most powerfully, of alterations in his sense of identity, much more profound than mere changes in feeling. Psychoanalytic therapists are trained to attend to their most private fantasies. They learn this in their own analysis and in one-to-one supervision, where candid reflection on their mental and bodily states when with a patient is encouraged. Family therapy is less intimate, and fleeting subjective experiences can easily slip through the net. Yet these are often the events that make a difference in therapy. This is related to the question of training analysis. The requirement to have one's own therapy is an essential condition for any psychoanalytic training, but not for systems therapy[4]. Many of the first and second generation family therapists had a psychodynamic training, including personal therapy, before they became family therapists. Though there are individual exceptions this is no longer the case. Lying on a couch with an analyst behind you makes you more familiar with inner states, including some that are not spoken of. The increasing absence of this tradition among systemic practitioners has fundamentally altered the craft, training and scholarship of family therapy.

Where do you get your therapeutic ideas from? Gregory Bateson said "The probe we stick into human material always has another end which sticks into us" (Haley, 1972, p. 26).

Interviewing a 16 year old boy who had taken a suicidal overdose the previous day, together with his mother, I ask him a question and there is a long pause before he answers. He speaks deliberately and intelligently so I hang on his every word, as I sense does his mother. I wait, and feel tormented by this young man, who looks quite distressed but he also flashes an enigmatic smile at me from time to time. I said that he seemed a tortured person but that he also tortures others. Mother nods.

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4 The family therapy training at Bristol University requires trainees to attend three therapeutic consultations with their families, friends or colleagues (Woodcock & Rivett, 2007).

The sense of torment I experienced while waiting for words led me to make this comment. Moments like this happen every day in therapy. Psychoanalysts would regard this vignette as entirely unremarkable. For the rest of us "Where does this stuff come from?" is a question we still have to answer[5]. The client+therapist system includes bodies as well as minds. One source of data, not so available to analysts, is visual. In its purest form, psychoanalysis does not involve face-to-face communication during the session. Family therapy is mobile and active, with elements of spectacle. While listening and talking we are also looking, sometimes only subliminally noticing what we see. The family therapist Carl Whitaker (1912-1995) though quite theatrical and mischievous, was unusual in that he never abandoned his psychoanalytical roots. He would speak freely of his own reactions: "The way you glared at me just then gave me a prickly feeling in the back of my neck" (Whitaker & Keith, 1982, p. 343). In the 1970s I witnessed the psychoanalyst and psychiatrist Henri Rey in open clinical presentations at the Maudsley Hospital. He was interviewing a man with a very strange face. Others had spoken with him about everything except his face. Rey simply asked "What do you see when you look in the mirror?"

Looking at faces is what mothers and babies do, the prototype of all intimate human contact. Colwyn Trevarthen compares these interchanges to theatre, demonstrating the "neonates' extraordinary capacities for reactive and evocative imitation" (Trevarthen & Aitken, 2001, p. 3). Therapy with families exploits these qualities yet prevailing theory in systemic therapy does not refer to them. For example, the thesis of Harlene Anderson and Harry Goolishian's iconic paper 'Human Systems as Linguistic Systems' is that "Therapy is a linguistic event" (Anderson & Goolishian, 1988, p. 371). They wanted to forge a new paradigm by taking social science out of therapy. Citing the philosophers Ludwig Wittgenstein and Richard Rorty, they show how conversation creates, rather than discovers, meaning. "Language does not mirror nature; language creates the nature we know" (p. 377). "By 'being in language' we refer to the process of the social creation of the intersubjective realities that we temporarily share with each other" (p. 376). But they neglect the fact that language as it is learned in infancy is not simply social. It is aesthetic, a distillation of the communications that begin as sensuous, musical and dramatic qualities, contact with skin, solids, liquids and gases, and the apprehension of smells, noises, facial expressions and movements. Anderson and Goolishian disembodied the process to produce an omni-competent philosopher-therapist: "a master conversational artist, an architect of dialogue" (p. 383). The discredited psychoanalytic psychotherapist who knows best is replaced by one with acrobatic mental skills. "The therapist entertains multiple and contradictory ideas simultaneously" (p. 381). "It is in our questions that we display the skill of 'worldmaking'"(p. 382). "The therapist maintains a dialogical conversation

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[5] Reimers (2006) presents an honest and subtle view of family therapists' habitual modes of working and is clearly aware of the processes I am describing here, yet he does not grasp the countertransference nettle.

with himself or herself" (p. 382). They ask this paper's key question "How does a therapist choose what to respond to and in what way?" (p. 381) and in answer acknowledge the irreducible fact of a personal viewpoint in every therapist:

> "As therapists, we all have opinions about people and about how all of us should or should not conduct our lives. … We cannot be blank screens. We think of these prejudgements as opportunities. That is, they are the energy to spark curiosity and the drive to explore other ideas. … In this process the therapist changes. …the only person the therapist changes in the therapy consultation is himself or herself" (p. 384).

These words had a powerful impact on family systemic theory. Aiming for a shift in the therapist rather than the patient is indeed a radical idea[6]. Yet analysts had already, for decades, been struggling to restrain the urge to change patients: "..the capacity to forget, the ability to eschew desire and understanding, must be regarded as an essential discipline for the psycho-analyst" (Bion, 1970, p. 51). As early as 1929, C. G. Jung wrote "…the doctor must change himself if he is to become capable of changing his patient ..." (Jung, 1954, p. 73) and described this transformation as traumatic:

> " ... a good half of every treatment that probes at all deeply consists in the doctor's examining himself, for only what he can put right in himself can he hope to put right in the patient. It is no loss, either, if he feels that the patient is hitting him, or even scoring off him: it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician[7]" (Jung, 1954, p. 116).

Although Anderson and Goolishian emphasise the risks that the dialogic therapist must take, what is missing from their account is how much anxiety is generated trying to keep an open mind under therapeutic pressure. They are describing 'cool reflection' (Lockyer, 2007, p. 41) rather than sweaty personal engagement. Resistance to change is a fact of life, not altered by philosophy. In most social encounters we are negotiating with others, often

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[6] Change in the therapist that precedes change in the client was also mentioned in passing by Luigi Boscolo and colleagues just a year earlier: "While [positive connotation] is often taken to be similar to the strategy of positive reframing ... actually it is much closer to a restructuring of the therapist's consciousness" (Boscolo, Cecchin, Hoffman, & Penn, 1987, p. 7). An even briefer - perhaps the first – note of this process in systemic work appears in a bold paper on positive connotation by O'Brian and Bruggen (1985): "Then the mental state did change" (p. 9).

[7] A rather uncanny parallel to this view comes from solution-focussed therapy. Steve de Shazer, no friend of analysis, demonstrates a similar exchange of anxieties in a simple diagram (de Shazer, 1982, p. 50). Like a shaman the therapist temporarily takes over the patient's troubles.

covertly trying to change them rather than ourselves. This is precisely why there is such sustained effort on the part of systemic therapists to avoid doing so. In order not to impinge too much on their clients many have had to control, even censor, themselves quite carefully. In his work with a patient who had been sexually abused John Burnham courageously writes "my desire to be respectful had led me to be reluctant to take any risks in the relationship…" (Burnham, 2005, p. 17). Jim Wilson sometimes presses colleagues in systemic therapy workshops to tell of an episode that 'worked' but which they had "kept to themselves because it would be greeted by colleagues' raised eyebrows as an unusual thing to do" (Wilson, 2007, p. 148). In earlier times it was not only analysts who recognised the negative countertransference. Though I can find no published reference to this, the Milan group were famous for the 'orgy of linear thinking' they would indulge in behind the screen before coming up with a positive connotation. Their leader Mara Selvini Palazzoli (1916-1999) could be a cruel mimic of the most irritating members of a family in session.

It is neither possible nor desirable to abandon all therapeutic prejudices, but it is necessary to keep monitoring and questioning them. "Injunctions to take up a position of 'not-knowing' are designed to move our cherished notions aside to make room for the patient's, not to empty our minds entirely" (Kraemer, 2006, p. 243). It is significant that, from the very beginning, systemic therapists relied on philosophers for intellectual inspiration. None of these men were therapists and some such as Bertrand Russell (whose theory of logical types has a central role in the double-bind hypothesis) and Ludwig Wittgenstein found in philosophy a refuge from their own personal suffering. The fact that Wittgenstein, Bateson and Rorty (1986) all acknowledged, with inevitable reservations, the power and depth of Freud's thinking is not noted in systemic texts. Speaking in 1940 a few months after Freud's death Bateson said "in spite of all the muddled thinking that Freud started, psychoanalysis remains as *the* outstanding contribution, almost the only contribution to our understanding of the family – a monument to the importance and value of loose thinking" (Bateson, 1973, p. 58). "Here, finally, is a psychologist who has something to say" said Wittgenstein of *The Interpretation of Dreams* (Mancia, 2002, p. 169, 170).

Theory and practice do not match here. In contrast to their published statements Anderson's and Goolishian's observed clinical work is intimate and embodied. "Instead of a therapist operating on the reality of a person or family from the outside, you had something closer to therapists putting themselves almost bodily into a family's or person's private world[8]" (Hoffman, 2002, p. 138). What were they feeling and thinking as they

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[8] One of their most ardent followers, and an admired innovator in his own right, was the Norwegian psychiatrist Dr Tom Andersen. His practice, including many years of work with physiotherapists, was clearly 'embodied', yet his texts retain the fluidity of postmodern writing, in which judgements about others must always be suspect. "My concern is that a philosophy of ontology will be placed above a philosophy of ethics" (Andersen, 2001, p. 79).

worked like this? How, in their own words, do prejudgements spark curiosity? There is an opacity in their text as if, like the early psychoanalysts, they did not want to expose their personal reactions to public view.

A theory of suffering
As was their intention these authors steered systemic therapy away from any lingering preoccupations with pathology, either in client or therapist. A guiding star of the family systems revolution was 'the end of blaming', a worthy goal in that it helped us to support patients rather than humiliate them. Yet it is based on a logical error; that because psychoanalysts identify psychopathology in their patients they are therefore also blaming them for it. Searles (above) described the fine line that an analyst must tread between challenging and attacking. Even when the analyst has not crossed the line some patients experience challenges as blaming, but Searles' conclusion is that analysis is only possible where the patient has a choice. One can pay attention – own up – to what one is doing, or not. To get away from making judgements about their clients systems therapists believed they had of necessity to get away from observing what was wrong with them, too. The urgent ambition to end blaming led to the abolition of pathology. In spite of the liberating methods of postmodern, narrative and related therapies (e.g. WHITE, 1995) the intellectual cost of this was a detachment of theory from practice, of mind from body.

Many of the early family therapists were doctors[9]. The experience of careful clinical contact with the bodies of others - and seeing what diseases can do - stays with a practitioner for life, whatever path one then follows. "The ego is first and foremost a bodily ego" (Freud, 1923, p. 26). It may be significant that the greatest iconoclast, Jay Haley (1923-2007) was not medically trained[10]. His criticisms of psychoanalysis were relentless. Anderson and Goolishian's work can be seen as a more recent manifestation of the movement to bury Dr Freud.

The absence of a "theory of suffering" (Hoffman, 2002, p. 110) left the scholarship of family systems therapy too dependent on philosophy and mathematics rather than on clinical knowledge of people in mental pain or

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[9] Apart from Bateson and Weakland, who were both anthropologists with no clinical background, most of the male pioneers were medically trained: Ackerman, Boszormenyi–Nagy, Jackson, Minuchin, Fisch, Whitaker, Bowen, Wynne. Some were psychologists, Framo, Zuk, Watzlawick. Haley had university training in theatre arts, library science and communication. His clinical experience came from later collaboration with clinicians and social scientists. In contrast the majority of the leading women - Virginia Satir, Betty Carter, Lynne Hoffman, Marianne Walters, Peggy Papp and Olga Silverstein - were social workers at the start of their therapeutic careers. In the generation that followed it is noteworthy that all the Milan associates were doctors and also had psychoanalytic training.

[10] Like Freud, Haley began his therapeutic career using hypnotism. Having rejected Freud he chose another doctor-hypnotist to be his mentor, the charismatic Milton Erickson, whose work and influence he celebrated in *Uncommon Therapy: The Psychiatric Techniques of Milton H Erickson M.D.* (Haley, 1973).

terror, or in helpless states such as childbirth, infancy, and terminal illness. Having begun in revolution, family therapy remains in flight from its disavowed ancestors. "We tended to ascribe our effectiveness to the fact that we were using a new theory" (Beels, 2002, p. 69). Even its own pioneers, such as Salvador Minuchin (b. 1921) and Haley, who had developed the most powerful and dramatic methods of engagement with families, are routinely discredited. But at the beginning of this story is an emptiness where psychoanalysis should be.

Working with a translator I am interviewing a teenage girl, T, and her father. Her mother is in their country of origin and has a serious mental illness. We discuss the mother's condition and the girl, who speaks English fluently, says that neither she nor her father misses her, but she wished she had a different mother to help her now. T is taking dangerous risks with boys and is out of her father's control. He wants me to give her psychiatric treatment to cure that. His voice becomes more shrill and intimidating. I am irritated and frustrated by this man, and say through the translator that I cannot see what the psychiatric problem is. T is insolent and provokes her father with tantalising grimaces and evasions. I am disturbed by her coquettishness with him.

The meeting is not going well. The translator gets into lengthy discussions of which he gives me only brief summaries. Everyone seems to be talking at once. I am looking at T and say to her "Can you imagine having an argument with your father in English?" She laughs, with a hint of embarrassment or even mockery, but the father says, almost triumphantly while raising a fist, and before the question has been translated for him, "Yes!"

Where did that come from? From two- to three-person systems
I came across Gregory Bateson (1904-1980) and John Bowlby (1907-1990) at around the same time, as a psychiatric trainee in the 1970s. They were almost contemporaries and both saw human interaction in ethological and systemic terms, yet neither seems to have acknowledged the other in his published work[11]. While my therapeutic skill comes from training and personal experience - including analysis - these two polymaths provided me with a scientific basis for a theory of suffering. Bowlby was a psychoanalyst, but saw a limitation in the classical view of the child's tie to the mother. Bringing ethology into the picture he showed that attachment is universal in mammals. An immature[12] individual seeks to be looked after as much as it needs to be fed. 'Looking after', as these simple English words imply, means

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[13] Bowlby knew of Bateson's work, however. In 1958, while they were both working at the Tavistock Clinic, John Bowlby introduced Ronald Laing to the double bind theory of schizophrenia. [Daniel Burston, 'A brief biography of R D Laing'. http://www.decaelo.com/rdlaing/bio.htm]

12 Attachment is also activated by fear, pain, darkness, tiredness, weakness, and any form of helplessness. It is lifelong.

following the infant's state, trying to make sense of his or her experiences. The human baby, the most helpless of all newborn mammals, is programmed to engage with a caregiver immediately. The identification of attachment as a separate need was as revolutionary as the discovery of gravity. Once its universality was pointed out it was both blindingly simple to observe yet complex, even mysterious, in its workings. The unfolding of an attachment relationship is an intimate and formative process, all the more interesting because the couple cannot always understand one another. Small errors are inevitable and it is these breaks and the repairs that follow that promote the growth of mind and brain. "Reparation, its experience and extent, is the social interactive mechanism that affects the infant's development" (Tronick, 2007, p. 342).

At around the same time as Bowlby had first formulated his theory (Bowlby, 1958) Bateson and his colleagues were studying attachments gone badly wrong, in families with a schizophrenic member. They conceived the double bind, a graphic term to describe the torturous entanglement of parent (typically mother) and schizophrenic child (typically son). Systematic misunderstanding between the two is overwhelming, and there is no reparation. The theory explains how the subject of lifelong contradictions "would not know what kind of message a message is" (Bateson et al, 1956/1973, p. 182)

> "Given this inability to judge accurately what a person really means and an excessive concern with what is really meant, an individual might defend himself [by assuming] that behind every statement there is a concealed meaning which is detrimental to his welfare. He would then be excessively concerned with hidden meanings and determined to demonstrate that he could not be deceived – as he has been all his life." (Bateson et al, 1956/1973, p. 182).

In addition – which is what makes the bind double - the subject ".. cannot, without considerable help, discuss the messages of others. Without being able to do that, the human being is like any self-correcting system which has lost its governor; it spirals into never-ending, but always systematic, distortions" (p. 183). This description, while referring to concepts from engineering (and elsewhere in the paper to philosophy), does not evade the agony of the poor patient. The injunction on both partners not to notice what is going on is what makes it tragic. Not only are they bound in a torturous relationship, they are also gagged from commenting on it.

In an introductory footnote to the double bind paper Haley and Weakland are credited with having noted "the formal analogies between hypnosis and schizophrenia" (Bateson et al, 1956/1973, p. 173). Without apparently knowing of this work, the British psychoanalyst Harold Stewart a few years later described the collusive relationship between hypnotist and patient. The trance is undermined, or even broken, if negative thoughts about the

hypnotist are entertained (Stewart, 1961). Likewise the 'secondary injunction' of the double bind "is communicated to the child by non verbal means" (Bateson et al, 1956/1973, p 178). It forbids the child to doubt that his threatening parent really loves him[13].

Bateson and Bowlby showed how from the very beginning the human being is intensely preoccupied by *where he or she stands in relation to others*. Infants have many ways of communicating but no ability to care for themselves. They are therefore always attentive to the state of the people who do this for them, on whom their lives depend. This works well enough when the adults can take the lead, but if caregiving is undermined by fear, pain, anxiety or depression the infant has to regulate himself. Tronick's still face experiments show this most painfully (Tronick, 2007, p. 268). The mother, while sitting facing her baby, is asked to keep a still face for a few minutes. The child immediately becomes distressed, struggling to engage mother, looking away and withdrawing when he fails to do so. If this kind of mismatch is prolonged, for example when the mother is depressed, the infant has to adapt. He cannot give up entirely because he needs to be cared for. One option is to try and look after mother, a reversal of roles in which the child becomes parentified (Macfie, McElwain, Houts, & Cox, 2005). Searles had noted that "..innate among the human being's emotional potentialities, present in the earliest months of postnatal life, is an essentially psychotherapeutic striving" (Searles, 1979, p. 459). Though not taboo, the infant's efforts are not usually appreciated by either partner, in effect a futile and invisible exercise.

The reinvention of the Oedipal triangle
Initial enmeshment of caregiver and infant may obscure the presence of others in the family drama, but there is always a third party. Recent systematic studies have shown what child psychotherapists have frequently observed, how within a few weeks of birth infants also begin to monitor the relationships *between the adults* around them (Fivaz-Depeursinge & Favez, 2006). Regulating ones place in three person systems is a basic skill, and lasts a lifetime.

'Two against one' has an ancient pedigree, being a familiar feature of primate social systems (Harcourt & de Waal, 1992). As humans evolved from apes, gossip - two individuals together discussing the condition of a third - brought language into the frame (Dunbar, 1996). By historical times the triangle had became the staple of tragedy, of passion, murder, and suicide: the rivalry of Cain and Abel, the incest of Oedipus, the jealousy of Othello. Freud saw Oedipus' desire in the mind of every child, who "… notices that his father stands in his way with his mother" (Freud, 1920, p. 105). He has to learn that babies can't make babies (Kraemer, 2005, p. 114). Overcoming this

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[13] This is close to the much more recent notion of disorganised attachment (Solomon & George, 1999). Minuchin's term for an entangled cross generational relationship, especially in psychosomatic families, was 'enmeshment'.

disappointment will in time expand his consciousness so that he becomes capable of "being a participant in a relationship and observed by a third person as well as being an observer of a relationship between two people" (Britton, 1989, p. 86).

> "A third position then comes into existence from which object relationships can be observed ... This provides us with a capacity for seeing ourselves in interaction with others and … for reflecting on ourselves whilst being ourselves" (Britton, 1989, p. 87).

The three players are never quite comfortable, however. "Essentially, the task for the mother, father and infant involves tolerating the link between two people they desire and which excludes them. This situation cannot be harmonious" (Marks, 2002, p. 95). As in musical chairs someone is always being left out. In the most disturbed families the game is stalled with one parent repeatedly excluded but - as the double bind explains - no one must comment on this. We can then no longer see ourselves in interaction with others.

The double bind was originally a feature of a two-person relationship but, within a few years, Haley had extended its remit beyond psychosis, and added a third person. His identification of the 'perverse triangle' (Haley, 1967) was described by Hoffman as "Haley's leap from a fascination with communication to a fascination with structures" (Hoffman, 1981, p. 112). This was a paradigm shift that brought the Oedipus complex into the heart of systems theory[14]. While consistently scornful of psychoanalysis, Haley described how the child has a special relationship with one parent, which excludes the other.

> "The term *coalition* means a process of joint action *against* a third person … the problem is most severe when the coalition across generations is denied or concealed … when this becomes a way of life the family organisation is in trouble" (Haley, 1976, p. 109).

Though they worked in different ways both Haley and his colleague Minuchin (1974) framed the presenting problem in a young person as a challenge to the power arrangements between the parents. The child is out of control but the couple cannot act together to contain him, because one of them is in a covert coalition with the child[15]. Crediting Haley's influence, the Milan associates fearlessly brought this out into the open by asking in therapy

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[14] In an intricate psychoanalytic paper Aaltonen and Räkköläinen (1987) identify a double bind in the Oedipus complex.

15 The failing couple can be mother and father or any other pair, such as mother and grandmother, mother and stepfather, a parent and an older sibling or, in larger systems, a school and a parent, a manager and a clinician, and so on (Haley,1976, p. 116/7).

sessions "where is the marriage in this family?". Their technique of circular questioning (Selvini-Palazzoli et all, 1980) exposed family members' constant monitoring of others' relationships, which usually goes on beyond awareness.

The systems revolution had reinvented the Oedipal triangle but in a form that was no longer recognisable. There is a common thread of cover up here. The injunction to turn a blind eye to a coalition between parent and child was first described by Sophocles. Jocasta (Stewart, 1961) and Oedipus (Steiner, 1985) were not innocent victims of fate. They had knowledge of their own parts in the tragedy but concealed it from themselves, and from each other. The rewritten history of systems therapy brushed out our bond with psychoanalysis.

In the clinical example above, there was no mother to intervene in a dangerous escalation between father and daughter. I felt like a boxing referee who has to pull the contestants apart, to get them into a healthier relationship; something an effective mother - the one that T wished for - could have done. In retrospect I see how anxiety about the sexual tension between father and daughter prompted me to take mother's place, to propose another form of intercourse for them that is not secret or perverse, but can instead be celebrated.

Conclusion
The absence of clinical theory has left systemic therapists reliant more on wisdom and intuition and less on reflection of their own mental and physical states. Without an explicit account of ones own viewpoint there is a risk of idealising or mystifying our sources, as Lynn Hoffman (Hoffman, 2002) tends to do, using poetic metaphors such as the 'deep well' to describe where her therapeutic ideas come from. "Inner movements" (Shotter & Katz, 2007, p. 29) and similar descriptions refer to the effects on us of our patients and clients. These are less mysterious if seen as the necessary work of a therapist trying to make sense of what he experiences, according to his own ideas.

Because systems therapy saw no use for transference it was thrown out, but countertransference - which is still needed - went with it. The successive flowering of systemic therapies made possible clinical interventions that could not have taken place in other models: medical, behavioural, cognitive or psychoanalytic. This was a revolution, after all. My purpose is not to reverse it, but to understand what we actually do and to contribute to a more honest history of psychotherapy.

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