# History of Family Psychiatry

## From the Social Reform Era to the Primate Social Organ System

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**KEYWORDS**

• Family • Family therapy • Family intervention • Family psychiatry
• Biological psychiatry • Comprehensive biological treatment
• Natural healing mechanisms • Primate Social Organ System • PSOS

**KEY POINTS**

- Child psychiatry and family psychiatry emerged in the context of the social reform movements of the early twentieth century.
- Child psychiatry and family psychiatry began in the child guidance clinics in the United States and Great Britain.
- In order of the first family publications, the founders of family psychiatry include Nathan Ackerman, Gregory Bateson, Carl Whitaker, Don Jackson, Lyman Wynne, Jay Haley, Virginia Satir, Ivan Boszormenyi-Nagy, Salvador Minuchin, Murray Bowen, and John Bowlby.
- With the emergence of family psychiatry (circa 1950), the relationship between child psychiatry and family psychiatry has evolved from estrangement, to impasse, to détente, and finally to synthesis.
- The primate brain evolved under selection pressure for social competence.
- The biopsychosocial family is the extended family social group.
- The sciences of interaction are (1) nonlinear brain dynamics, (2) gene-environment interaction, and (3) epigenetics, and these make obsolete current diagnostic and treatment frameworks in psychiatry.
- The organ system in psychiatry is the Primate Social Organ System (PSOS), consisting of all the brains typically in relationship to each other.

**OVERVIEW**

A lack of congruence in nomenclature regarding psychiatrists who treat families has existed for more than 6 decades. Almost universally, and definitely into the second half of the twentieth century, child psychiatrists had only so-called therapies to offer patients. Psychoanalytically derived treatments were available, as well as other

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**Abbreviations**

| | |
|---|---|
| AAP | American Academy of Pediatrics |
| AAPCC | American Association of Psychiatric Clinics for Children |
| ABPN | American Board of Psychiatry and Neurology |
| APA | American Psychiatric Association |
| NCMH | National Committee for Mental Hygiene |
| Ortho | The American Orthopsychiatric Association |
| PSOS | Primate Social Organ System |

therapies for children and adolescents related to conflicts; adaptations; defenses; parent-child relationships; social relationships; learning; and psychological, psychosocial, and psychosexual development.[1] Psychiatrists who treated children and adolescents using therapies called themselves child psychiatrists. Psychiatrists who treated families using therapies called themselves family therapists.

This distinction had, and continues to have, many determinants. Child psychiatry had reached a degree of maturity as a profession by the time psychiatrists and other mental health professionals started treating families, around or just before 1950.[2] Family psychiatry was in a stage of development analogous to Erikson's "identity versus role confusion." The family therapy field did not know whether its practitioners did interviews with whole families, (1) simply to gather information thoroughly and efficiently; (2) as a context within which to treat individuals or pairs of individuals (eg, the mother-child dyad); or (3) to treat an organism greater than the sum of its parts, the parts being all of the individuals and relationships in the family, and the whole being an emergent property of that complex organism.[3]

There were additional issues for the field to resolve, including (1) whether the term "family" described a therapy technique or a patient entity; (2) whether family therapy was a medical or a psychosocial therapy; and (3) whether a therapy other than one based on individual psychodynamics could be considered psychiatric.

Nomenclature issues can never be resolved until the entity being named is fully understood. This article reviews the history of the treatment of families in psychiatry, and concludes that the correct name of the field is *family psychiatry*. An interesting consideration in the age of biological psychiatry is whether family psychiatry just might be the only truly comprehensive biological psychiatry?[4–7]

## SOCIAL REFORM MOVEMENTS

Social reform movements, and the birth of organizations and institutions devoted to the mental health of children and families, in the first quarter of the twentieth century planted the seeds and fertilized the soil for the birth of child psychiatry and family psychiatry. The reform movements included the Settlement Movement, Mental Hygiene Movement, Child Guidance Movement, The Commonwealth Fund, Juvenile Courts, and American Orthopsychiatric Association. The vibrancy of these movements, led by a combination of citizen activists, middle-class and upper-class reformers, and concerned professionals, grew even during World War I, the Great Pandemic, Prohibition, Black Tuesday, the Great Depression, and the approaching World War II. There existed unstoppable concern for children, women, and families at all levels of society.

### *Mental Hygiene Movement*

Founded in New York City in 1909, the National Committee for Mental Hygiene (NCMH) worked, "to humanize the public attitude towards those afflicted with mental

disease."[8] The organizers of the NCMH included Adolph Meyer, William James, and Clifford W. Beers, a Yale-educated, upper-class man who was hospitalized several times for mental illness. Beers' book about experiences in psychiatric facilities, *A Mind That Found Itself,* published in 1908, helped catalyze the formation of the Committee, and aided in solicitation of funds from other well-to-do families and Ivy League friends.[9]

Additional financial support for the NCMH was provided by The Commonwealth Fund. The latter was established in 1918 by Anna M. Harkness "to do something for the welfare of mankind." The Fund developed a Five Year Program for the Prevention of Delinquency (1921), devoted to severe difficulties of "personality and behavior" in children predisposed to delinquency.[10] The establishment of the Five Year Program recognized the approach among professionals caring for children fragmented the child.

> *In planning the work of the division it was early recognized that in spite of the progress made in various phases of child health and child welfare, these activities to date were uncoordinated, that each group was only taking a fractional interest in the child and treating him either as a mind to be educated, a physical organism to be safeguarded or an offender to be disciplined.*[8]

### *Child Guidance Movement*

The idea leading to the first child guidance clinic came from reform-minded citizens in Chicago. They were associated with Hull House, a "settlement house," founded by Jane Addams. It was one of more than 400 such communities in the United States working to alleviate difficulties associated with poverty. The settlement houses provided education, daycare, medical care, and other services in a communal living arrangement of low-income residents and middle-class volunteers.

Similar to the spark provided by Clifford Beers in 1908 leading to the formation of the NCMH, Mrs Ethel Dummer of Chicago in 1909 became the catalyst for the child guidance movement. She was a volunteer at Hull House, a member of the Board of the Juvenile Protective Association, and a frequent visitor to Cook County Juvenile Court, which was led by the reformist judge, Merritt W. Pinckney. Her donation funded the study and treatment of delinquency for 5 years.[11]

Mrs Dummer's philanthropy led to the founding of the Juvenile Psychopathic Institute (1909), subsequently renamed the Psychopathic Clinic of the Juvenile Court (1914), Illinois Juvenile Psychopathic Institute (1917), Illinois Institute for Juvenile Research, and eventually the Institute for Juvenile Research (1920), later known simply as IJR. The Juvenile Psychopathic Institute was the first child guidance clinic and the model for all subsequent child guidance clinics.

### *The First Child and Adolescent Psychiatrist*

Dr William Healy outlined the plan for this new institute, and thus for the child guidance movement. The plan included "a careful physical examination, special school reports from teachers, interviews with parents and relatives to ascertain 'heredity, developmental personality peculiarities, family relationships, and much else.'"[11] Dr Healy was a British-born neurologist practicing at the Chicago Polyclinic before becoming Medical Director of the Juvenile Psychopathic Institute.

In 1915, Dr Healy published, *The Individual Delinquent,* his analysis of more than 800 case studies completed at the Juvenile Psychopathic Clinic.[12] Levy places *The Individual Delinquent* and Healy's work in historical context: "The book had an

amazing influence on legal procedures, on the fields of sociology, anthropology, psychology, and especially psychiatry. The fact that the child guidance movement started in the field of delinquency made necessary the utilization of a team—psychologist, psychiatrist, and social worker."[11]

Was William Healy the first child and adolescent psychiatrist? Julius B. Richmond, pediatrician, Project Head Start originator, and Surgeon General, implies as much: "A Chicago physician, Dr William Healy, in 1909 organized the first child guidance clinic in the world… establishment of this clinic under medical auspices served as a stimulus for the development of child psychiatry as a discipline."[13]

### *American Orthopsychiatric Association*

The American Orthopsychiatric Association (Ortho) was founded in 1923 by 9 psychiatrists, including Herman Adler, V. V. Anderson, Bernard Glueck, William Healy, Arnold Jacoby, David Levy, Lawson Lowery, Karl Menninger, and George Stevenson. Many of the psychiatrists, physicians, and other professionals who were active in the child guidance movement, were active in Ortho (an organization not restricted to physicians), paralleling the team approach practiced in child guidance clinics. The *American Journal of Orthopsychiatry* began publication in 1930.

## ORIGIN OF FAMILY PSYCHIATRY

The primary loci for treatment of children for approximately 50 years were the child guidance clinics. Psychiatrists, pediatricians, and neurologists, working in teams with psychologists and social workers, applied the formula devised by William Healy in 1908. The system of child guidance clinics was totally decentralized for almost 4 decades. The individual child guidance clinics had working relationships with juvenile courts and social service agencies in their communities.

There were relationships among the professionals with the NCMH, The Commonwealth Fund, and Ortho, and relationships among the physicians with the American Psychiatric Association (APA) and the American Academy of Pediatrics (AAP). The literature hints at some uncertainty as to the primary specialty (psychiatry or pediatrics) with which such a physician, addressing the mental health needs of children and adolescents, might be identified. The totally decentralized system of child guidance clinics became more centralized in 1948 when 54 clinics affiliated with the new American Association of Psychiatric Clinics for Children (AAPCC), 39 years after the Juvenile Psychopathic Institute opened its doors.

### *Early Landscape of Family Psychiatry*

Movements begin and proliferate when an idea makes so much sense in a culture that it has multiple originations. Family probably was on the minds of physicians when house calls, and giving birth at home, were common. With the heightened interest in children and adolescents early in the twentieth century, it is reasonable that parents might have come to the minds of professionals, which they did because the first, and all subsequent, child guidance clinics included parents in their diagnostic and treatment efforts.

The intellectual and scientific climate coincident with the emergence of family psychiatry was exciting, especially studies of behavior and the development of hypotheses applicable to *Homo sapiens*. **Table 1** lists important intellectual events coincident with the origins of family psychiatry.

**Table 1**
**Intellectual landscape: 1946 to 1953**

| Date | Science | Authors | Publication, Film, or Event |
|---|---|---|---|
| 1946 | Cybernetics | Warren McCulloch | First Josiah Macy Cybernetics Conference[14] |
| 1946 | Psychiatry | William Menninger | Group for the Advancement of Psychiatry[15] |
| 1949 | Ecology | Aldo Leopold | *A Sand County Almanac*[16] |
| 1951 | Ethology | Niko Tinbergen | *The Study of Instinct*[17] |
| 1951 | Communication | Jurgen Ruesch & Gregory Bateson | *Communication: The Social Matrix of Psychiatry*[18] |
| 1953 | Attachment | John Bowlby & James Robertson | *A Two-Year Old Goes to the Hospital*[19] |
| 1953 | Psychotherapy | Carl A. Whitaker & Thomas P. Malone | *The Roots of Psychotherapy*[20] |

### *Family Psychiatry Movement*

My own understanding of family therapy, which I always understood to be family psychiatry, because it seemed mostly practiced by psychiatrists, began in 1975, my first year of psychiatry residency. My teachers and supervisors included Carl Whitaker, MD,[21] David Keith, MD,[22] Jack Westman, MD,[23] Augustus Napier, PhD,[24] Richard Anderson, MD,[25] and Jack P. Hailman, PhD.[26] My understanding of the history of family psychiatry is unavoidably influenced by my relationships and experience.

### *Origins of the Idea: Nathan W. Ackerman (1908–1971)*

After a rotating internship and an assistant residency in neurology at Montefiore Hospital (1933–1935), Ackerman did a neuropsychiatry residency at Menninger Clinic and Sanitarium (1935–1936). He joined the staff of Menninger Clinic in 1936, becoming Assistant Medical Director of Southard School (1936–1937), probably the Menninger Child Guidance Clinic.[27] He returned to New York City in 1937 where he founded the Family Institute in 1960 (renamed The Ackerman Institute for the Family following his death in 1971), and cofounded the journal *Family Process* with Jay Haley (1961).

The family psychiatry movement had multiple loci of origination and multiple parents, speaking multiple languages, with much of the history never recorded. Just as with child psychiatry, the child guidance clinics were prominent in the early conceptions of family psychiatry. However, there was not a single father or mother, a William Healy, of family psychiatry. If there were one, he would be Nathan Ackerman. In a 1970 presentation, published posthumously in 1972, Ackerman referred to the idea of family psychiatry as "my primary interest in the psychiatry of the whole family."[28]

Based on his own writing, including his insistence on developing a theory of family therapy before attempting to treat a family, he almost certainly was not the first psychiatrist to treat whole families. However, his ability to define the goal of family diagnoses and family group treatment at professional meetings and in print,[2,29] and his openness regarding the difficulties in transitioning from individual to family group psychodynamics, were a vital contribution to family psychiatry.

In his first publication on the treatment of families (1950), Ackerman and Sobel[2] highlight the family oriented approach in child guidance clinics. They seem to say that nowhere were whole families being treated.

> *Accordingly, we believe that the treatment of the young child should begin with the treatment of the family group. However, we find ourselves confronted with the fact that, up to the present time, no adequate criteria for family disturbances, as group disturbances, have been found. Until such criteria are formulated so that we may describe (and later classify) such family disturbances, we have no frame of reference for the treatment of families as groups, despite the claims of many child guidance clinics to the contrary. Although the trends in child guidance are toward family orientation, the child and the mother, but not the family, are treated. We do not know whether it is possible to treat families as groups. Perhaps it is not possible.*[2]

In Ackerman's final statement about the field, he reiterates his career-long goal of developing a system of family diagnosis, and the "responsibility of conceptualizing and categorizing family types." He spoke of, "a natural behavioral phenomenon, family healing… a range of self-healing processes which occur spontaneously in family life."[28]

### *Origins of the Idea: Carl A. Whitaker (1912–1995)*

Whitaker did his internship (1936–1937) and 1 year of residency in obstetrics and gynecology (1937–1938) at City Hospital (Bellevue) in New York City. Following psychiatry residency at Syracuse University Psychopathic Hospital (1938–1940), he trained in child psychiatry at the University of Louisville Bingham Child Guidance Clinic (1940–1941), his fellowship funded by The Commonwealth Fund. From 1941 to 1944, Whitaker was the treatment psychiatrist at Ormsby Village in Anchorage, Kentucky. Ormsby was an unfenced, cottage type, coeducational facility for approximately 300 children and adolescents committed to the Louisville and Jefferson County Children's Home.[30]

In their book, *The Roots of Psychotherapy* (1953), Whitaker and Malone[18] advocate, "the importance of treating the whole family when one member of the family undertakes psychiatric treatment." Whitaker and Malone,[20] like Ackerman and Sobel,[2] saw family treatment as facilitating both better treatment of the individual patient and the relational context in which the individual patient lived. Referring to "a fundamental principle of modern ecology," the longer version of the Whitaker and Malone principle states:

> *Not only are the parts of an organism so interrelated that the whole is more than the sum of its parts, but the relationships among different organisms in the bionomical field are such that the whole is more than the sum of the organisms involved. The principle has led to the recognition of the importance of treating the whole family when one member of the family undertakes psychiatric treatment. We have all seen dramatic changes occur in children, both physically and psychologically, when they are moved from one environment to another. The most striking example of the sensitive interdependence among members of a family is that seen in the case of a patient who undergoes psychiatric treatment successfully. The new-found capabilities in one member of the family upsets the total economy of the family so that the other members are precipitated into a different type of pathology or therapy, or both.*[20]

From 1944 to 1946, beginning their 50-year collaboration, Whitaker and Malone used nontraditional methods of psychotherapy at Oak Ridge, Tennessee.[31] The city was established by the US Army to work on the Manhattan Project. Whitaker was Director of Psychiatry. He recruited Malone to the staff. One technique they developed, multiple therapy,[32] later became known as cotherapy, and would become a core technique in the training and practice of family psychiatry. According to Malone's son, "I think they were already seeing families at Oak Ridge and continued to do so at Emory" (Patrick T. Malone, MD, personal communication, July 13, 2014). Dr Whitaker

was Chair, Emory University Department of Psychiatry (1946–1955). Fig. 1 shows Whitaker, Malone and Richard Felder, three of the original founders of the Atlanta Psychiatric Clinic, in 1987.

**Fig. 1.** Carl Whitaker, Tom Malone, and Richard Felder at a reception in Malone's home following a public presentation by Whitaker titled "Symbolic Experiential Family Therapy," at the Academy of Medicine, Atlanta, Georgia, June 12, 1987. They were attempting to pantomime, "See No Evil, Hear No Evil, Speak No Evil." (*Courtesy of* D. Kramer, MD, MS, Middleton, WI.)

### *Origins of the Idea: Gregory Bateson (1904–1980)*

It is impossible to summarize Bateson's scholarly endeavors. Numerous books have been written describing his work, the best being the biography by David Lipset.[33] With an MA from Cambridge University in Natural Sciences and Anthropology, and 5 years as a Fellow of St John's College, he influenced during his lifetime at least 7 major areas of science, including social and cultural anthropology, evolution, ethology, communication, cybernetics, marine biology, and psychiatry. An excellent introduction to his work is *Steps to an Ecology of Mind*.[34] His best book is *Mind and Nature: A Necessary Unity*.[35] Fig. 2 shows Gregory Bateson at a weekend seminar for a small group of psychiatry residents, including the author, in 1978.

Bateson and his colleague, social psychiatrist Jurgen Ruesch, wrote an approach to psychiatry in 1951 based on analyzing social and family relations. The preface to the 1968 edition of *Communication: The Social Matrix of Psychiatry* summarizes their formulation:

> *Notably in human systems the circuit which must be studied usually includes at least two persons… The description of a theory of communication, adapted to the human situation, and particularly to the needs of psychiatry, was the end to which this book was originally written… The convergence of physiology, ecology, and ethology–fields that study the organism's transactions with his physical and social environment–have resulted in the emergence of general systems theories of the biological sciences… Communication thus has become the social matrix of modern life.*[36]

In the first sentence of the above quotation, Ruesch and Bateson[36] establish the difference between psychiatry (and medicine) as it had always been understood, and what they brought to the discussion. Human systems involve communication (and

relationship), and thus require more than 1 person; 1 person being an arbitrary distinction used in most other transactions in modern medicine.

Mental health professionals have criticized Bateson as the coauthor of the double-bind theory of schizophrenia.[37,38] The theory was seen as blaming families for schizophrenia. The theory was controversial. Bateson[39] agreed: "I am forced to agree that double bind 'theory' has contributed its share to the sufferings of those who are called (and sometimes call themselves) 'schizophrenics.'"

In reading the original 1956 publication, it is understandable that families and others felt blamed. Bateson and colleagues[37] describe patterns of relating in a manner that an anthropologist might do, operationalized those observations into 6 criteria, and theorized that they were common to schizophrenia and other human experience. Nevertheless, Bateson and Don Jackson received the 1961 Frieda Fromm-Reichmann Award from the American Academy of Psychoanalysis for their research on the "etiology, nature, or therapy of schizophrenia."[33] An interesting discussion elucidating the areas of disagreement occurred in *Psychiatric News*.[39–41]

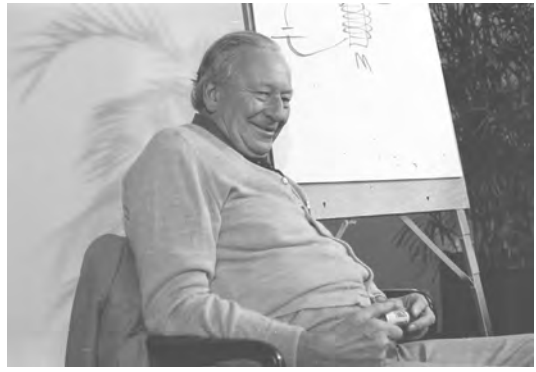

**Fig. 2.** Gregory Bateson at a weekend seminar in Chicago, December 2 and 3, 1978. The plan for this event had been a 2-day videotaped conversation between Bateson and Buckminster Fuller, with invited psychiatry residents as the audience. However, Fuller was unable to land in Chicago because of a snowstorm and flew on to California. Bateson landed in Indiana and made his way to the event via public transportation. (*Courtesy of* D. Kramer, MD, MS, Middleton, WI.)

### *Origins of the Idea: The First Family Interview: An Organic Beginning*

It is impossible to know who was present at the first family therapy interview, or when and where it occurred. Perhaps a whole family arrived for an appointment at a child guidance clinic. Perhaps the social worker scheduled to see the parents had left to care for a sick child at home. Perhaps there was no one with whom to leave the younger children while the oldest saw the psychiatrist. Perhaps the psychiatrist was of a cultural background that highly valued family interactions and openness. Perhaps the psychiatrist had read or heard Ackerman or Whitaker. The psychiatrist might have considered this dilemma and said, "Why don't all of you stay, and we'll talk?"

### *Origins of the Idea: The Founders*

Most histories of family psychiatry highlight the important thought leaders and clinicians in the early years of family psychiatry. Such an approach diminishes the grassroots origins and the organic nature of family psychiatry. As in the early days of psychoanalysis, when there were several prominent advocates shaping the field, each with a different

perspective, so with family psychiatry were there a variety of proponents and associated theoretic positions. The various orientations have become less important as the field matured, akin to an adolescent experimenting with different identities while developing a single unified character. None of the identities is necessarily wrong.

Table 2 presents a list of 11 founders of family psychiatry, the order reflecting the date of the author's first family-related publication. The citation for that publication is provided. The years of birth and death are listed, as well as the founder's primary theoretic orientation.

The first family publication was determined by MEDLINE search for each name (author), and family (any field). I reviewed the title for relevance to family psychiatry. All were first authors of the articles chosen except for Gregory Bateson and Virginia Satir. Books represent first publications for 3 authors: Bateson, Whitaker, and Bowlby. There may be earlier books or chapters of which I am unaware, or articles not cataloged in MEDLINE. All of the listed individuals had several publications before the one deemed family-related (eg, Ackerman had 7 psychiatric publications shown in MEDLINE beginning in 1946, before his first family article in 1950).

Bowlby presented an interesting dilemma. His work on attachment, first published in 1953, is an important scientific foundation of child and family psychiatry.[19] It was not until 1984 that one of his cataloged articles clearly reflected a family orientation. Therefore, I chose the first volume of *Attachment and Loss* (1969) as a sufficiently broad treatise to qualify as family. More early contributors could certainly be added to Table 2. The goal of this list is to portray the vigorous, multidisciplinary, intellectual activity that occurred during the founding years of family psychiatry.

### *Origins of the Idea: Psychiatry, Child Psychiatry, and Anthropology*

Of the 11 founders of family psychiatry, 8 were psychiatrists, of whom 4 were child psychiatrists (Ackerman, Whitaker, Minuchin, Bowlby). To my knowledge, Whitaker never referred to himself as a child psychiatrist, despite his training and early career experience in child psychiatry perhaps being the most extensive of any of the 11 founders. The contributions of the child psychiatrists have been the most lasting. I do not think that it is an accident that all 11 founders were born between 1904 and 1923, and thus their own childhoods, and their own families of origin, lived and developed in the environment of the social reform movements.

**Table 2**
**Founders of family psychiatry: 1950 to 1969**

| Founders (First Article Reference) | First Published | Birth | Death | Theoretic Orientation |
|---|---|---|---|---|
| Nathan W. Ackerman, MD[2] | 1950 | 1908 | 1971 | Psychoanalytic |
| Gregory Bateson, MA[18] | 1951 | 1904 | 1980 | Communication - ethnology |
| Carl A. Whitaker, MD, MA[20] | 1953 | 1912 | 1995 | Experiential |
| Donald D. Jackson, MD[42] | 1957 | 1920 | 1968 | Strategic |
| Lyman Wynne, MD, PhD[43] | 1958 | 1923 | 2007 | Family communication |
| Jay Haley, MA[44] | 1959 | 1923 | 2007 | Strategic |
| Virginia Satir, BA[45] | 1961 | 1916 | 1988 | Humanistic |
| Ivan Boszormenyi-Nagy, MD[46] | 1962 | 1920 | 2007 | Intergenerational |
| Salvador Minuchin, MD[47] | 1964 | 1921 | | Structural |
| Murray Bowen, MD[48] | 1966 | 1913 | 1990 | Family systems |
| John Bowlby, MD[49] | 1969 | 1907 | 1990 | Attachment theory - ethology |

The first 3 founders' initial family publications cover a brief 4-year period. The titles are fitting for this history: "Family Diagnosis: An approach to the Preschool Child," by Ackerman and Sobel[2]; "Communication: The Social Matrix of Psychiatry," by Ruesch and Bateson[18]; and, "The Roots of Psychotherapy," by Whitaker and Malone.[20]

## FAMILY PSYCHIATRY AND CHILD PSYCHIATRY

At the time family psychiatry was emerging as a new idea, in the context of a new intellectual landscape, and a new way of conceptualizing mental health and distress, the field of child psychiatry was defining itself with respect to the larger field of psychiatry. Landmark events included the APA Committee of Psychopathology of Childhood becoming the APA Section on Child Psychiatry (1943)[1]; establishment of the AAPCC (1948)[50]; formation of the AACP (1953)[1]; a ruling by the American Board of Psychiatry and Neurology (ABPN) that child guidance clinics must affiliate with approved psychiatry residency programs to train residents (1956)[50]; and creation of the Committee on Certification in Child Psychiatry by the ABPN (1959).[51]

Almost 10 years after the formation of the AACP, in an unsigned article in the first issue of the *Journal of the American Academy of Child Psychiatry* (1962) discussing the importance of an organization strictly for child psychiatrists, presumably written by the first editor, Irene Josselyn,[1] she states:

> *From these discussions, however, developed a conviction that just as the child is not a miniature man but an individual who through many vicissitudes will become a man, so child psychiatry, while directly related to the field of adult psychiatry as well as to other disciplines, is a specialty in itself.*[1]

Josselyn's statement reflects, in my opinion, ambivalence about the path taken by organized child psychiatry. The field could not be "a specialty in itself" while at the same time being an official subspecialty of psychiatry, and historically and organizationally descended from the APA and the AAPCC. In contrast, AAP was entirely separate from the American College of Physicians; pediatricians and internal medicine specialists had separate professional organizations and separate certification boards. It is surprising that an organization whose first practitioner was a neurologist (William Healy), second practitioner a psychiatrist (George Gardner),[52] and the third a pediatrician (Julius Richmond)[12] would be so certain of its pedigree with "adult psychiatry."

### *Child Psychiatry and Family Psychiatry: A Complicated Relationship*

On the first page of her history of AACP, Josselyn[1] hints at the necessity for an organization only for child psychiatrists despite their ongoing participation in Ortho. I suspect there are things she did not say. However, an unintended consequence of the decision was a tendency toward a cultural division between child and family psychiatrists.

> *The birth of a new psychiatric organization inevitably raises the question as to why, with those already in existence, an additional organization is necessary… It was probably chiefly the experiences in the Orthopsychiatric Association, in the American Association of Psychiatric Clinics for Children, and on various committees of other organizations that caused leaders in the field of child psychiatry to conclude that there was a great need for an organization specifically devoted to that field… After many discussions of the functions and limitations of those organizations, they crystallized the discontent of the child psychiatrists and formulated a solution. They contacted a group of seventeen leading child psychiatrists suggesting the possibility of an organization whose membership would be composed of child psychiatrists.*[1]

I believe the decision tended to exclude most practicing child psychiatrists in the field (ie, those in the child guidance clinics, and those exploring the idea of a "psychiatry of the whole family"[28]). I believe the family-oriented psychiatrists felt at home in Ortho, and enjoyed working organizationally alongside the psychologists and social workers who were their colleagues in the clinics. They were already publishing in the *American Journal of Orthopsychiatry*, the *American Journal of Psychiatry*, and *Psychiatry: Journal for the Study of Interpersonal Processes*. Three landmark articles over 40 years (1974–2013) describe the evolving relationship between child psychiatry and family psychiatry.

### *Impasse (1974): The Undeclared War*

Jack McDermott and Walter Char,[53] in their article, "The Undeclared War Between Child and Family Therapy," did a major service by identifying the relevant issues:

> *A good part of the problem may rest with our own specialty of child psychiatry, which seems to have been reluctant to accept a major ongoing involvement and identification with the development of the family therapy movement. Our textbooks often do not even list family therapy as a treatment modality for children. Our child psychiatry journals have pathetically few articles on work with total families.*[53]

They suggest the differences included the "family therapy movement, incorporating a strong social science element, seemed to become decidedly anti-medical,"[53] and a real or perceived desire within the family therapy community "to avoid completely individual dynamic and diagnostic terminology."[53] McDermott and Char[53] were certainly prescient. Schowalter[50] reviewed 50 years (1944–1994) of child and adolescent psychiatry in 16 pages, mentioning "family" only 5 times, and "family therapy" just twice. The only family psychiatrist named is Minuchin, with a brief uncomplimentary description, "who developed a combative and assertive style that briefly attracted many adherents."[50]

### *Détente (1988): Compare and Contrast*

David Keith, Jack Westman, and Carl Whitaker were colleagues at the University of Wisconsin. They trained in child psychiatry in 3 different eras. In their article, they compare and contrast child psychiatry and family therapy. Whitaker's training and career are reviewed earlier. Westman trained in a psychoanalytically oriented program at the University of Michigan. Keith trained with both Westman and Whitaker but affiliated primarily with Whitaker. They describe the main differences as 2-fold: (1) is family therapy a therapeutic method or a field of practice? (2) Is the patient an individual family member, or the family as a whole?[54]

For child psychiatrists, family therapy is one of several therapeutic methods used; for family therapists it is a field of practice, a profession. For child psychiatrists, the patient is the individual family member, the treatment encompassing multisystem levels (eg, individual, family, organizational, and societal). For family therapists, the family system is the patient, the family being a "synergistic system whose whole is greater than the sum of its parts."[54]

### *Synthesis (2013): A Developmental Psychodynamic Therapy*

Josephson's[55] 2013 article, "Family Intervention as a Developmental Psychodynamic Therapy," is a major contribution and reflects an emerging synthesis in the treatment of families. He returns to the traditional basic science of child psychiatry: child and adolescent development. He proposes the emerging discipline, developmental psychopathology, as a nontheoretic window into cause and pathogenesis. He echoes Westman's perspective,[54] the treatment including "multiple levels of analysis, from

the molecular to the cultural." He views development as "the result of continual interplay between individual (developmental) and extraindividual (family) contexts."[55]

Josephson's definition of *family intervention* states, "Family intervention is defined as a coordinated set of clinical practices that alters family interaction, family environment, and parental executive functioning and, in doing so, optimizes the development of all family members."[55]

He prefers "family intervention" to "family therapy." He notes that family intervention reflects a maturation of the field beyond that of the disparate schools of family therapy. Reminiscent of both Ackerman,[28] and Whitaker and Malone,[20] his intervention, developmental psychodynamic therapy, is consistent with the natural healing mechanisms both hypothesized to be the targets of psychotherapy. Ruesch and Bateson,[36] their minimal unit of study being at least 2 persons, would likely agree with Josephson's conclusion: "What goes on between individuals affects what goes on within individuals."[55]

## FAMILY PSYCHIATRY

### *Definition of Patient*

For treatment purposes, the patient is the vehicle for achieving health, a more important consideration heuristically than the vehicle considered to be disordered. An infection requiring intravenous antibiotics requires a circulatory system for delivery, an immune system for healing, and an endocrine system for responding to acute stress. The whole-patient concept is about the entity receiving care, not about the cause or locus of the disorder.

In the *Psychiatric News* discussion about double-bind theory, Bateson's[39] response included the following (italics added), "What I will not agree to is the maltreatment of language, which would separate psychosis from the remainder of the vast spectrum of human antics–both greatness and misery. *Nor will I agree to that monstrous premise of medieval epistemology that would separate 'mind' from 'body.'*"[39]

Separating person from family is equivalent to separating mind from body, with the same unhealthy result. The other preeminent twentieth century Renaissance person (in addition to Bateson), neuroscientist Walter J. Freeman, III, agrees. He attributes the philosophic foundation on which the science of nonlinear brain dynamics rests to "one of its originators," Thomas Aquinas (1225–1274): "The core concept of intention in Aquinas is the inviolable unity of mind, brain and body."[56] In his book, *Societies of Brains,* Freeman addresses the brain and family:

> *The problem is not information overload. There is always too much information. It is the misdirected search for meaning. In this they neglect the most important function of brains, which is to interact with each other to form families and societies… Meaning arises in social relations.*[57]

### *Definitions of Family*

#### *Ackerman/Murdock definition*

Ackerman[29] addresses the definition of family, insisting that it recognize production of offspring. He settles on Murdock's[58] (1949):

> *The family is a social group characterized by common residence, economic cooperation and reproduction. It includes adults of both sexes, at least two of whom maintain a socially approved sexual relationship, and one or more children, own or adopted, of the sexually cohabiting adults. The vital functions of the family are sexual, economic, reproductive, and educational.*[58]

### *Josephson definition*

Josephson[55] defines family as follows (2013):

> *The term "family" refers to those who have regular interaction with its children and assume the responsibility of meeting their developmental and emotional needs. It implies biological, affective, and legal bonds occurring together or separately.*[55]

### *Kramer definition*

When discussing the name of the entity to be treated, I prefer the extended family social group, the term used for all primate families (2008):

> *The extended family social group: The default social condition among chimpanzees, bonobos, and primitive human groups is a community wherein most individuals are related to each other genetically or through mating and parental care. As hunting, gathering, and surviving enemies and predators occurred at this level of social organization, these human groups were subject to natural selection.*[7]

## *Primate Social Organ System (PSOS)*

### *Organ system concept*

Medical education and practice is based on the concept of the organ system (eg, the gastrointestinal, cardiovascular, reproductive systems, etc). Attention to the organ system concept maintains intellectual integrity regarding the anatomy, physiology, development, function, and evolution of the entity being addressed. What is the organ system of interest to psychiatry? Presumably, the organ of interest is the brain. What composes the organ system to which the brain belongs?

### *Social brain concept*

For primates, particularly the great apes, virtually the entire evolution reflects selection pressure for social competence.[59] The primate brain is a social brain primarily.[60,61] Social competence includes (1) the ability to categorize social stimuli, including vocal and nonvocal communication; (2) recognize kin and non-kin; (3) understand dominance hierarchies; (4) engage in courtship and mating behavior; (5) form alliances; (6) resolve conflict; (7) cooperate in predator vigilance and defense; (8) cooperate in foraging and hunting; (9) engage in deception; and (10) participate in social learning.[62,63]

### *Primate social organ system concept*

An organ system for a social organ must, by definition, include other social organs (ie, other brains). One brain cannot evolve in isolation from other brains. Social organs, by necessity, interact just as fluidly as the liver and pancreas or the heart and lungs. The science of the last 25 years is consistent with the philosophies of Ackerman, Bateson, and Whitaker. The Primate Social Organ System (PSOS) is thus the organ system of interest to psychiatrists.[64,65] The PSOS is the application of the organ system concept to Walter J. Freeman's, "societies of brains."[57] The science of attachment, around which Bowlby suggested the term, *developmental psychiatry*,[66] demands a minimum of 2 persons. It is an artificial distinction that the organs in this organ system are located in separate individuals, an irrelevant distinction biologically. It would only be relevant in a reductionistic system. Relating, which is the function of primate brains, is not reducible.

## SUMMARY

### *The Sciences of Interaction*

During the preceding quarter century, the sciences of interaction have been extraordinarily productive. These sciences include nonlinear brain dynamics,[67–69] gene-environment interaction,[70–74] and epigenetics.[75,76]

As early as 1991, Freeman's lifetime work on nonlinear brain dynamics, or brain-environment interaction (BxE), showed that the brain (1) actively and intentionally tests the environment, (2) encodes information as a whole, (3) changes electroneurophysiologically (ie, anatomically) with each learning event, and (4) remains unchanged anatomically until a new learning event occurs.

Gene-environment interaction (GxE) is the theoretical foundation of ontogeny. In recent years, Moffitt, Caspi, Suomi, Wynne, and others have shown that offspring phenotype can be predicted from known parental phenotype, known environment, and known interaction. In some instances, the specific alleles involved have been identified.

Weaver and colleagues[75] changed entire the understanding of genetics and heredity in 2004 with "Epigenetic Programming by Maternal Behavior." In their model, maternal characteristics are transferred to offspring nongenetically, but biologically, by way of maternal behavior, through a process called *epigenetics*, which is a fundamental GxE mechanism. Cross-fostering at birth to a mother with an identical genotype, but a different phenotype, results in offspring characteristic of the foster mother.

### *The Thesis*

The sciences of interaction, in the context of the PSOS, make obsolete all prior theories of psychiatric etiology, all prior diagnostic classifications, and all prior underpinnings of prevention and treatment strategies in psychiatry. Furthermore, the findings from the sciences of interaction are consistent with the observations, theories, and hypotheses of Ackerman, Bateson, Whitaker, Bowlby, and the other founders of family psychiatry. It all began a century ago in the context of the social reform movements of the early 20th century, and in the child guidance clinics, where for the first time children, parents, and families were treated in a coordinated fashion by teams of child mental health professionals. In conclusion, the Primate Social Organ System (PSOS) involves all of the brains that are typically in relationship, ie, the brains of each extended family social group. Thus, the patient in psychiatry is always the family, especially in a psychiatry that calls itself biological.[57,64,65]

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