CORE
Metadata, citation and similar papers at core.ac.uk
Provided by ScholarWorks at WMU

The Journal of Sociology & Social Welfare

Volume 6
Issue 1 *January*

Article 11

January 1979

The "Significant Other" in Marital and Family Therapy

Nathan Hurvitz
Crenshaw Medical Arts Center

Follow this and additional works at: https://scholarworks.wmich.edu/jssw

Part of the Marriage and Family Therapy and Counseling Commons, and the Social Work Commons

Recommended Citation
Hurvitz, Nathan (1979) "The "Significant Other" in Marital and Family Therapy," *The Journal of Sociology & Social Welfare*: Vol. 6 : Iss. 1 , Article 11.
Available at: https://scholarworks.wmich.edu/jssw/vol6/iss1/11

This Article is brought to you for free and open access by the Social Work at ScholarWorks at WMU. For more information, please contact maira.bundza@wmich.edu.

THE "SIGNIFICANT OTHER" IN MARITAL AND FAMILY THERAPY*

Nathan Hurvitz
Crenshaw Medical Arts Center
Los Angeles, California

ABSTRACT

The significant other (SO) is derived from the social behaviorism of G. H. Mead which is comparable to contemporary cognitive behaviorism. The SO is defined as an analytical concept by examining interaction in social acts; it includes attributes associated with the family member's role-reciprocity, meanings, affect, self-concept and modeling; and it is associated with concepts such as transformation, attribution and social interchange. The process by which the therapist becomes an SO to the family members individually and jointly, and how he or she utilizes transformation, attribution and social interchange are outlined.

The "significant other" (SO) has become an important concept in marital and family therapy that conceives of the family as a social system. This phrase, which was introduced into psychiatric, psychological and sociological literature by Sullivan (1940, 1953a, 1953b, 1954), is derived from Mead (1934) and Cooley (1902).

Sullivan's concept of the SO appears to refer to those whom the individual utilizes to form his or her self-concept, primarily the mother. Thus the individual's self-evaluation is based on the "reflected appraisals" of others, or on his or her perception of others' evaluation of him or her. Subsequent sociological investigators noted that this concept did not describe all the possible attributes of the SO, particularly those in which they had a theoretical interest. Consequently Gerth and Mills (1953), Shibutani (1955) and others proposed additional attributes. Their work culminated in the contribution of Kuhn (1964) and his concept of the "orientational other" which had four general attributes and became the basis for investigations that refined the sociological value of this concept.

Clinicians utilize the concept of an SO informally in somewhat

*This is a revised version of a paper with the same title presented at the annual meeting of the American Association of Marriage and Family Counselors in San Francisco, CA, September, 1977.

comparable ways to refer to someone who is important to the person in therapy--although one refers to the dog as a SO (Bikales, 1975). However, clinicians have not attempted to define the SO and develop it into an analytical instrument and utilize it for assessment and treatment in clinical practice. Such an effort is past due and an attempt is made here to initiate such an activity to further develop the symbolic interactionist perspective of marital and family therapy (Hurvitz, 1967, 1970, 1972, 1974, 1975).

A. The Interaction Processes and the Significant Other

In accord with Mead's social behaviorism, understanding people in interaction requires an examination of the social act, one in which the actors take account of each other. A social act implies the actual or symbolic presence of another with whom each individual engages in mutual adjustment (Mead, 1938). Under certain conditions the other becomes a significant other.

The Interaction Processes

Observation of social acts in the natural and clinical settings suggests the operation of the following processes between individuals:

1. The behavior required to effect a particular plan associated with the individual's values and goals. The behavior, which may not be associated with values and goals in an immediate sense, appears in the complementarity of the actors' role-performances and role-expectations based on their statuses. The individuals interact on the basis of "dialectical reciprocity," that is, reciprocity is not equal and/or opposite in cost, duration, amount, etc., but is based on the meaning of their interaction or their definition of the situation to maintain or to achieve justice, balance, equity, etc. The actors enable and constrain each other's behavior by the contingencies of reinforcement, the rewards and punishments, they present to each other. Their interaction usually occurs in customary, repetitive situations, and occasionally in unique situations.

2. The development of common meanings by assuming the perspective of the other through primarily verbal communication. The learned meanings then mediate the continuing learning process and are simultaneously modified by it. The meaning of people, processes, events and things for the individual is revealed in the way he or she behaves and in the feelings he or she displays toward them (Blumer, 1969). Behavior is organized into social acts when one individual's meaning evokes the desired meaning in another. Behavior is therefore a function of the meaning of the situation to each actor. The fact that the interactors impute and infer the same meaning to a message does not necessarily mean they will cooperate in their continuing interaction.

3. The affect or feelings displayed with and toward the behavior demonstrated in their role-relationship. When role-performances and role-expectations are complementary, role-hierarchies are similar, and role-reciprocity occurs voluntarily and regularly, the actors achieve positive meanings. They therefore have affirmative feelings about themselves and the other, and acceptance, comfort and ease ensue. If these conditions do not exist, negative feelings about themselves and the other, and rejection, discomfort, and stress ensue. The affect can be strong or weak, positive or negative; it can change from strong to weak, from weak to strong, and from positive to negative and negative to positive.

4. The effort to present oneself in such a way as to attempt to maintain or achieve desired self-esteem which each expects the other to perceive and support. Each actor has a self-concept and a concept of the other. In addition, each actor's concept of the other is mediated by his or her own self-concept and the way he or she presents himself or herself in different situations (Goffman, 1959). Whether or not the actors share the same perception and interpretation of their own and the other's self-concept is an important determinant of their definition of the situation.

5. Their modeling activities in which one or both imitate and/or serve as a model for the other during some periods of their relationship and some phases of their interaction in the social act. Such modeling may be an aware or unaware activity. Modeling or imitation is a basic form of social learning, and is the way language, role-behavior, values and goals, ideas and ideals, affect and expressive behaviors, etc., are learned.

The Attributes of the Significant Other

These processes occur in the interaction between individuals in a social act. Thus the attributes of the SO can be outlined as follows: the SO is someone who:

1. Participates in functional role-reciprocity with an other based on their statuses;

2. Holds meanings which are or become important to the other, whose meanings are or become important to the individual;

3. Has affective or expressive significance for and/or an affective relationship with the other, who has affective or expressive significance for and/or an affective relationship with the individual;

4. Participates in forming and modifying the other's self-concept; and attempts to maintain or achieve desired self-esteem;

5. Serves as a model for the other by his or her behavior, thoughts and feelings, and/or utilizes the other as a model.

These attributes of the SO are comparable to those outlined by

Kuhn (1964). However, Kuhn did not report the reciprocity that exists between SOs, several of the attributes he proposed are the same but expressed in different ways, one is a general statement that includes a similar attribute, and other attributes suggested here are omitted by Kuhn.

Becoming a Significant Other

Individuals become SOs to each other when they display most of the attributes most of the time in their interaction, and the attributes associated with meanings, affect, modeling and self-concept become more important than the attribute associated with role-reciprocity. They develop the type of role-relationship that enables them to make and fulfill plans associated with their values and goals which are derived from and are the basis for common meanings. These are the source of similar perceptions and interpretations of themselves and others; thus they profess the same reality. And if and when dialectical reciprocity is disturbed, they redefine and reconstruct their reality in the same way. Since the family members maintain role-reciprocity and hold the same meanings, they offer each other mutual reinforcements that foster their affective relationship and commitment. This relationship sustains and enhances their self-concepts and each regards the other as a desirable model for himself or herself and/or others.

B. Transformation, Attribution and Social Interchange

We have examined the processes that occur in social acts and derived from these the attributes of the SO. Each of these attributes is exercised differentially according to the type of activity, relationship, etc., of the SOs. Each individual interacts with the other according to his or her own unique meanings and according to his or her distinctive stance and style. The individual's meanings are formed in a process of continued learning, and are evidenced in the processes of transformation, attribution, social interchange, and others.

Transformation, attribution and social interchange are not associated with any particular theoretical orientation in social psychology; they can be utilized in the symbolic interactionist approach. Transformation, attribution and social interchange are ways of interpreting and explaining how the actors take account of each other in social acts. These activities are based on the individual's cognitive ability to communicate with himself or herself. As such it is particularly appropriate to apply these concepts to the interaction of SOs as defined in this paper.

The processes of transformation, attribution and social interchange occur with SOs and others who are not SOs. Those who are not

SOs participate in the processes partially, intermittently and inconsistently, and the other does not expect that the relationship will be different. Those who have become SOs are SOs because the individuals involved initiated and maintained their relationship by participating in the processes fully, regularly and consistently, and expecting each other to continue to do so.

Transformation implies fulfilling a commitment to continuing a relationship; attribution requires empathetic role-taking that enables each SO to better read the other; and social interchange requires effort to maintain reciprocity, equity, justice, balance, etc. Those individuals who meet and do not care to exert the effort to overcome the social inertia that prevents them from undertaking transformation and symbiotic attribution and from engaging in reciprocity, equity, justice, balance, etc., do not become SOs to each other.

The concepts of transformation, attribution and social interchange are related by their significance as ways to perceive and evaluate the SOs' interaction and relationships. These concepts are integrated by the fact that a slip, lapse, misunderstanding, etc., in social interchange causing a denial of reciprocity, of equity or justice, may be attributed to evil intent, to an oversight, to misinformation, etc. The individual may or may not respond to each attribution by transformation.

Transformation

Transformation is associated with the individual's "presentation of self" (Goffman, 1959); it is the fulfillment of a "deficit" of one attribute of the SO by offering a "surplus" of another attribute as these appear in the family members' interaction. Informally the process is called "making it up to him (her)" when one family member "fails" another one in some way. That is, if a breakdown in role-reciprocity prevents one family member, for instance the husband-and-father, from performing his roles so as to fulfill the wife-and-mother's role-expectations, the spouses can maintain their relationship because the husband-and-father offers a "surplus" of affection or he attempts to raise the wife-and-mother's self-esteem by enhancing her self-concept. Transformation enables effective and satisfying family interaction to occur despite disturbances in their dialectical reciprocity. Transformation to maintain reciprocity between dyad members required to effect a particular plan and/or the values and goals with which it is associated is accomplished by mutual modification of various combinations and permutations of behavior, meanings and feelings.

The concept of transformation is also applicable to the demonstration of power in the family. Whereas the husband-and-father customarily has power over the wife-and-mother because he earns the livelihood and controls the family income, the wife-and-mother may

exercise her power by derogating his sexual performance even though she participates in intercourse; and she may also exercise her power by withholding expressions of affection or by declaring her changed perception of him. And whereas the parents have power over their children, the children may demonstrate their power by rejecting their parents' values and goals and by choosing non-parental adults as models.

Attribution Theory

Interaction also proceeds on the basis of the SOs' attribution of motives and intent to themselves and to the other. Theories of attribution are concerned with concepts and notions about how people explain their own and the others' behavior, thoughts and feelings (Heider, 1958; Bem, 1972; McCall, 1970; Kelley, 1973) and thereby construct reality for themselves (Berger & Luckmann, 1966). Some attempt to explain how a human, as a "naive scientist," ascribes causes to particular actions, events, processes, etc. They attempt to explain how the individual's understanding of personal and societal motivation and causes of behavior, thoughts and feelings are applied in specific situations to enable him or her to interact effectively with others (Ellis, 1962). They also attempt to explain how individuals form hypotheses about the people, things, places, processes, etc., with which and in which they are involved, and how the individual's hypotheses affect his or her behavior, thoughts and feelings in subsequent similar situations.

The present approach to attribution theory is related to the individual's self-perception and to his or her self-concept. It is also identified with the way he or she evaluates his or her own qualities, characteristics, etc., in relation to the different situations in which he or she has interacted with others and the different others with whom he or she has interacted in these situations. And it is also identified with the way the individual's self-perceptions determine his or her continuing behavior, thoughts and feelings, including his or her locus of control (Rotter, 1954). Attribution theories recognize that there are non-scientific and personal modes of perceiving and interpreting reality in interaction. These include concepts of primacy and recency. That is, in some instances that which was done first explains current behavior; and in other situations that which was done most recently explains current behavior. Other aspects of attribution are associated with situational or psychological explanations of behavior. Ordinarily an individual uses situational factors to explain his or her own behavior, thoughts and feelings, and psychological constructs to explain the other's behavior, thoughts and feelings.

Social Interchange

Social interchange theories have their roots in behaviorism and are related to the experimental analysis of behavior and to concepts of reinforcement. The findings of psychologists and sociologists utilizing social interchange theories were made in field and laboratory experiments (Burgess & Bushnell, 1969; Chadwick-Jones, 1976; Hamblin & Kunkel, 1977). These theories are also related to concepts of cognitive behaviorism. The central elements of these theories that are pertinent here are those that declare that the causes of the interactors' behavior are to be found in their interaction itself.

One of the first concepts a child learns is fairness. When he or she can recognize and complain, "That's not fair!" in his or her interaction with others, the child has assumed distinctly human concerns and qualities. Family members desire fairness in their interaction and it is the basis upon which they often determine whether a problem or conflict exists.

The issue of fairness between SOs is related to issues of power, threats and promises. Power, in studies of marital and family interaction, is customarily regarded as the ability of one person, Jack, to make another person, Jill, do what Jack wants Jill to do, or to prevent Jill from doing what Jack does not want Jill to do. However, there is a tipping point in the exercise of power. If Jack exerts power upon Jill to do X, Jill may leave the relationship and in this way demonstrate her power over Jack. It is a common situation in marital therapy for a husband who has exerted his power over his wife in various ways for a long time to come to the therapist and request him or her to get back his wife who finally left him precisely because he exercised his power over her--until she decided she had enough and left him.

Social interchange, which is defined differently by various social psychologists, embodies the concept that interaction between members of a social system involves mutual and reciprocal role-performances and role-expectations, rights and duties, privileges and obligations, rewards and costs, etc. It also embodies the concept that the SOs must benefit in some way from their interaction in order to maintain their relationship or the one who loses will leave it and destroy it. In each instance something in the form of material things, behavior, thoughts or feelings is given in return for something in the form of material things, behavior, thoughts or feelings that has been received.

A norm of social interchange guides the give and take of interaction in general and is applied to specific situations to determine whether the particular exchange is "fair." The norm of interchange is based on many different elements that are called into play in various situations. Two elements that are called into play often are

transformation based on the definition of the situation and social exchange. Social interchange includes such concepts as the norm of reciprocity, distributive justice, equity, balance, and social exchange. Following are brief explanations of these concepts:

a. The norm of reciprocity "makes two interrelated, minimal demands: (1) people should help those who have helped them, and (2) people should not injure those who have helped them" (Gouldner, 1960, p. 171).

b. Distributive justice proposes that rewards and costs which are evaluated according to material goods or services or abstract principles are presumed to be proportional. That is, the greater the rewards the greater the costs or effort. When an individual evaluates his or her own cost-reward balance as equal to the other's cost-reward balance, a state of equity exists. If the cost-reward balances are not equal, the individual who believes he or she has been taken advantage of will attempt to re-establish the balance. The concept of justice comes into play when the SOs recognize the injustice in the imbalance, and attempt to distribute justice equally on the basis of each member's rewards and costs (Thibaut & Kelley, 1959; Homans, 1961).

c. Balance theory states that people learn to believe that badness causes unhappiness and is punished; and goodness causes happiness and is rewarded. SOs therefore may expect that their interaction will be guided by goodness which will be rewarded and thereby cause mutual happiness. Such balance is justice (Heider, 1958).

d. Social exchange proposes that interpersonal behavior is oriented to ends that can be achieved only by relationship with and through interaction with others, and the individual attempts to adapt particular means to achieve agreed upon ends (Blau, 1964).

Each of these theories or concepts of social interchange is somewhat different from each of the others; however, their differences are not significant in the clinical approach and setting. What is important is the general concept of social interchange which enables the therapist to assess behavior and interaction in such a way that something can be done to change it.

Other Concepts

Other concepts and principles of social psychology that can be applied in the clinical setting to understand and change the relationship and interaction between SOs include the following: relative deprivation, level of aspiration, status consistency and inconsistency, anticipatory socialization, cognitive dissonance, vigilance hypothesis, congruity, and similar concepts that have an interactional aspect.

A recent contribution to an understanding of interpersonal interaction and the manner in which individuals display "cognitive

recognition" of the other is described by the concept "opening encounters" by Schiffrin (1977, p. 679). Another recent contribution is the concept of "aligning actions" introduced by Stokes and Hewitt to describe "largely verbal efforts to restore or assure meaningful interaction in the face of problematic situations of one kind or another" (1976, p. 838). Aligning actions, according to Stokes and Hewitt, are reported in:

> A substantial body of literature (that) has been developed within the symbolic interactionist tradition that focuses upon various tactics, ploys, methods, procedures and techniques found in social interaction under those circumstances where some feature of a situation is problematic. Mills' (1940) concept of *motive talk*, Scott and Lyman's (1968) discussion of *accounts*, Hewitt and Hall's (1973) and Hall and Hewitt's (1970) *quasi-theorists*, and Hewitt and Stokes' (1975) *disclaimers* are among the contributions to this literature. In addition, some of Goffman's work (1959; 1967; 1971) addresses itself to a similar set of issues, and McHugh's (1968) analysis of the concepts of the definition of the situation is pertinent to the question of how people deal with problematic occurrences (1976, p. 838. Italics in original).

The SOs' interaction is associated with types of situations which facilitate or constrain the individuals to behave in characteristic ways and to display appropriate associated feelings. Thus, understanding the SOs' interaction also requires an analysis of situations. Progress is being made in developing ways to analyze situations which may also be applicable in the clinical setting (Frederickson, 1972; Krause, 1970; Siporin, 1972).

This analysis of the SO is identified with cognitive behavior modification methods since it recognizes the importance of learning the family members' meanings in order to change their behavior, thoughts and feelings which is done by cognitive restructuring or cognitive relabeling. This analysis also suggests the importance of each family member in forming, directing, etc., his or her own behavior, thoughts and feelings, and that of his or her SOs as well. Thus, each family member can be taught to function as a therapist for himself or herself and for his or her SOs, an activity to which the professional therapist introduces him or her and which the professional therapist guides.

C. The Therapist Becomes a Significant Other

In the clinical setting the therapist sees spouses and family members who are SOs who once may have had the type of role-reciprocity that enabled them to make and fulfill plans. Now they no longer share common meanings, they do not have similar perceptions and

interpretations of themselves and others, and they do not profess the same reality. When their dialectical reciprocity is disturbed they do not redefine and reconstruct their reality in the same way. Since they do not hold the same meanings and do not offer each other mutual reinforcements their affective relationship disintegrates. The disintegration of their affective relationship undermines their self-concepts and each rejects the other as a model for himself or herself and/or others.

Some family members whose relationship changed from affirmative to negative want to re-establish their affirmative relationship. They want to modify each interaction process because failure to maintain an affirmative relationship denies the individual's value as an object of affection and as a model, which undermines his or her self-concept. This condition not only has a negative effect on the SOs but it also has considerable negative public attention and interest.

These family members come to us for help. How does the concept of the SOs presented here assist us to help them? It can be applied to assess, explain and change the family members' interaction according to concepts and constructs of transformation, attribution, social interchange, and others, so that each one can change his or her own and his or her SO's behavior, thoughts and feelings. It can also be applied to indicate how the therapist becomes and functions as an SO in his or her relationship with the family members.

The therapist becomes an SO to each family member as an individual and to all the family members as a group by joining the family members' interaction in each aspect of the interaction processes to facilitate the development of all the processes. Every individual has the potential for becoming an SO to every other individual with whom he or she interacts. The waitress and diner, the soldier and enemy civilian, teacher and student, physician and patient, employer and secretary, clergyperson and congregation member, salesperson and customer, caseworker and client--each may participate in interaction which may lead to their becoming SOs. It is the therapist's awareness of this possibility and the knowledge that this relationship can be used constructively that makes the experience of the therapist and client different from the other potential SO relationships. The therapist's awareness that he or she can be a more effective helper by becoming an SO motivates him or her to foster the development of this relationship.

The Therapist and Role-Reciprocity

The therapist's potential for becoming an SO is found in factors that pre-exist his or her contact with the families who come to him or her for help. One of these is community recognition of the therapist as a professional with certain privileges and responsibilities. These are based on and determined by his or her professional training,

license or certificate to practice, membership in professional and academic associations, compliance with the ethical code of his or her profession, and participation as an informed professional in community activities and events that are related to his or her field of competence.

Other factors that pre-exist the relationship with his or her clients are the therapist's listing in the telephone book, the neighborhood and building in which his or her office is located, his or her reputation in the community, and his or her referral sources. The preferred referral source is the therapist's national and international reputation; the next most preferred referral source is a satisfied client; and the next most preferred referral source is a physician, clergyman, attorney, or other professional, who refers his or her own patient, parishioner or client to the therapist while the patient, parishioner or client is sitting in his or her office. Also desirable are referrals from the county psychological, medical, marriage counselors', social workers', etc., organizations that maintain a referral service, or from a college or university. These sources do not know the therapist personally, and his or her name may be one of two or three given to the caller. The therapist is least likely to become an SO prior to his or her face-to-face contact with the family members if they found his or her name in the Yellow Pages of the telephone book.

The therapist's becoming an SO is facilitated by the appropriate setting in which he or she offers his or her services. The therapist's office should state that it is the workplace of a competent professional, and also foster comfort and relaxation. Diplomas and licenses help reassure the family members that they have come to someone who has the required credentials. Carpeting, drapes, pictures, lights, furniture, etc., should have quality, but the therapist should be able to work with a family without becoming disabled with fear that a child will vomit, urinate, or defecate on his precious material objects. The therapist's professional library of books and journals often inspire awe in a layperson.

The family members' initial contact with the therapist is made on the basis of his or her status as an expert. The therapist's status, and the family members as persons who require his or her services, becomes the basis for his or her role-reciprocity with the family members, individually and jointly. The therapist informs the family members what they will do, what they will talk about, and how they will talk about it. He or she tells them his or her procedures and what he or she expects from them. By his or her differential interest in the information, behavior, thoughts and feelings the family members report and display, he or she reinforces them to produce that which he or she regards as important. He or she also

tells them what to expect from him or her when he or she defines his or her procedures, and when he or she tells them what he or she regards as relevant. For instance, when the therapist requests permission to tape the therapy session or when he or she tells the family members, "I'll keep confidential whatever information you share with me," he or she defines their role-reciprocity.

The therapist and family members enable and constrain each other's behavior by their questions and answers and by their exchanges which the therapist examines with the family members. The family members learn that the therapist's response to anger, tears, requests for help, etc., is not always the same as their friends' responses. When he or she does not respond to the family members in the accustomed, socially defined way, they do not know how to behave in the therapy situation. The therapist uses this ambiguity of the therapy situation to guide the family members in an examination of their behavior, thoughts and feelings in a way they may never have experienced before.

Even though some of these situations are unpleasant the family members perceive that they are potentially helpful. This interaction also shapes the behavior of the family members, they learn the processes utilized by the therapist, and a particular kind of role-relationship is established. Their continuing interaction creates social acts which have the potential for recreating the participants in these social acts.

The therapist projects unconditional positive regard (Rogers, 1957) which has been likened to the quality of a succoring parent and good friend. The therapist's unconditional positive regard and his or her "understanding" of the family members is therefore a positive reinforcer which encourages the family members to offer more information and feedback. Unconditional positive regard is a reinforcer because people who have demonstrated such a relationship in the past gained the desired behavior, thoughts and feelings from the individual. When the therapist projects unconditional positive regard he or she fosters the likelihood that the family member will display desired behavior, thoughts and feelings. At the same time the therapist must be aware that his or her solicitous concern and interest may reinforce the particular behavior he or she is responding to and must guard against this likelihood.

It cannot be assumed that a relationship marked by unconditional positive regard, non-possessive warmth, accurate empathy, emotional congruence, genuineness, and similar qualities is by itself sufficient to bring about needed changes in behavior, thoughts and feelings. Change is brought about by effort and trial. The emotional environment created by the therapist encourages effort and trial in four ways: the

family member (a) perceives the therapist as someone who is competent to help and who is committed to the family members, therefore his or her suggestions to attempt change are more readily accepted than similar suggestions by others; (b) accepts the therapist's explanations, interpretations and hypotheses because they "make sense"; (c) recognizes the value of the planned program of change activities the therapist outlines for each individual and for the family as a whole; and (d) begins to regard himself or herself as someone who has the right, the desire, and the capability to live more effectively and satisfyingly than he or she does.

The Therapist and the Family Members' Meanings

While the family members enact their role-reciprocity the other attributes of the SO also develop, although not at the same rate. Perhaps the first additional attribute is the therapist's and family member's assumption of each other's meanings through taking the role of the other as the therapist engages the family members individually and jointly in reflective, analytical and directive discussion. The ability to assume the other's meanings is an aspect of the therapist's and the family members' membership in the same society and the fact that they share a common culture.

The therapist attempts to perceive each family member's meanings and he or she assists each family member to perceive every other family member's meanings. The therapist asks "What does his behavior mean to you?" "What do you think his behavior means to him?" "What do you think he thinks his behavior means to you?" Each family member is requested to explain his or her interpretation of each SO's behavior, thoughts and feelings which is checked against the SO's own statement of its meaning to him or her. Such offerings of perceptions of others' meanings and the others' feedback exposes misperceptions, misinterpretations and limitations of communication. Determining the others' meanings and learning how to communicate about them enables the family members to develop effective and satisfying interaction--if this is their therapy goal.

The family members disclose information about themselves, about each other, and about their relationships. The therapist organizes and interprets this information differently from the way the family members perceived and interpreted it. His or her interpretation, using social psychological constructs, is different in two ways: (a) it does not threaten or disparage anyone; and (b) it makes sense in a way that enables the individual to do something about it. It thereby facilitates treatment activities that offer the family members ways to develop effective and satisfying interaction. When the family members understand the therapist's definition of their situation and act on it, the family members individually and collectively notice desirable changes.

The Therapist and the Affective Relationship

The therapist's ability to empathetically assume each family member's perspective in the family interaction fosters his or her affective or expressive significance for and/or an affective relationship with each family member. The family members come to the therapist during a crisis when anxious and dependent feelings associated with earlier crises may be evoked and because of their inability to solve their problems and conflicts.

When the therapist attempts to be helpful, a condition is created in which one or more family members develop the same kind of feelings toward him or her that they felt toward others who helped them solve problems or resolve conflicts in earlier crises when they felt dependent. They regard him or her as a succoring parent, a helpful teacher, and a supportive friend. They ascribe qualities to him or her which he or she may not have but which are associated with a succoring, helpful, supportive person in a crisis situation.

The family members who disclosed their feelings of anxiety and dependency to parents and other significant adults were given support and comfort. When they come to a therapist who creates the relationship which encourages them to disclose their present feelings of anxiety to him or her, he or she also gives them support and comfort. Therefore the same feelings they had toward the parents and others are aroused and projected on the therapist. The disclosure of feelings not ordinarily shared in social relationships creates a unique situation. As the members recognize their feelings toward the therapist and identify them with their early socialization by their parents and SOs, they also identify the therapist as an SO who can help them in their continuing socialization. This phenomenon can be explained on the basis of the learning principle of generalization.

When the family members recognize that the therapist cares about them, they in turn care about him or her. They express this care in various ways. They give him or her affirming feedback to let him or her know they are aware he or she cares about them, that he or she wants to help them and that they are being helped. They express their appreciation for the fact that their family situation is changing in a way they desire by telling him or her they thought about him or her or about something he or she said during the week, coming to appointments as scheduled, paying their bill, sending holiday cards, bringing him or her clippings they believe will be of interest to him or her, etc., and in other direct and indirect ways.

The family members ask the therapist questions about himself or herself and about his or her family. They ask whether he or she is married and has children; and when he or she replies that he or she is married and that he or she has children, they may say that his wife

is a fortunate woman or her husband is a fortunate man to be married to such a sensitive and intelligent man or woman, and his or her children are fortunate to have such an informed and understanding father or mother. When the therapist tells them that he or she also has limitations that his or her family members must bear, they find it difficult to believe.

Many qualities, characteristics, capabilities, traits, etc., are considered necessary or desirable for the effective therapist; however, many therapists do not have them. The fact that the family members ascribe qualities, etc., to the therapist that he or she obviously does not have suggests that if the therapist is helpful the family members regard him or her as having the qualities they associate with a helping person. That is, the family members develop a definition of the situation in which they ascribe a particular meaning to the therapist's activities; and it is the definition of the therapeutic relationship and not the therapist's characteristics that cause the family members to ascribe the desirable qualities to him or her. In this way the family members assume the therapist's values whether or not he or she informs them about his or her values or attempts to prosletyze the family members.

The Therapist and the Family Members' Self-Concepts

The experiences that lead most family members to seek therapy have caused anxiety, depression and demoralization. Since earlier SOs may have told them how incapable and worthless they are, they know their limitations and failings, and may have come to believe the others' most disparaging evaluation of them--fostering a self-fulfilling prophecy.

The therapist challenges this situation. He or she emphasizes the individual's strengths and competence, and indicates that he or she has potentials he or she has not fulfilled because of his or her specific life circumstances. The therapist tells each family member who needs such support that he or she is much better informed about "most people" and the family member's comparative ability than the family member himself or herself, and he or she knows that the family member is not unintelligent or incompetent. What is true is that he or she has come to tell himself or herself that he or she is unintelligent, incompetent, etc., and to believe this is so. And by believing it, he or she has come to act according to this belief.

The therapist helps each family member to develop a concept of himself or herself as an effective person because his or her self-feelings enter into his or her evaluation of his or her will, desire, and capability to change. His or her self-feelings enter into his or her self-concept as a victim or scapegoat to whom things happen instead

of as an initiator and changer of his or her interaction and relationship with others. This self-concept then becomes associated with a philosophy of the world and existence, with his or her locus of control, by which the family member rationalizes his or her plight and resigns himself or herself to it--or attempts to assert himself or herself in the world and in relation to others.

The therapist informs the family member that he or she does not have to regard himself or herself and live the way he or she does. He or she encourages him or her to offer hypotheses about family interaction based on "What is the other doing or not doing that causes family problems and conflicts?" as well as hypotheses based on "What am I doing or not doing that causes family problems and conflicts?" The therapist supports the member as a competent individual who has the ability to be self-directing, etc., but he or she also offers specific types of assistance that enable the member to exercise his or her ability. He or she compliments a desirable activity, he or she corrects pronunciation in the protected therapy setting so the family member will feel freer to use the words outside the therapy setting, he or she suggests readings and may supply appropriate information. The therapist also supports the family members as competent people by behaving toward them as though they are, treating them the way he or she would like to be treated in a comparable situation, and he or she guides and instructs their joint and reciprocal behavior change efforts and activities.

The Therapist as a Model

The family members who accept and respond to the therapist's efforts to help them achieve their asserted goal begin to imitate the therapist's behavior or the way they believe the therapist would behave in a particular situation. The therapist behaves in a certain way with the family members and explains why he or she does so. He or she states what he or she thinks is the meaning of the family members' behavior toward him or her and toward each other. The way the therapist behaves toward the family members becomes the way they behave toward each other, and he or she thereby becomes a model and social reinforcer.

The therapist serves as a model by being an interested and empathetic listener, by describing and explaining what the family members' behavior, thoughts and feelings toward each other and toward him or her mean to him or her, by role-playing situations with one or more of them, and by sharing information about himself or herself. He or she discusses his or her philosophy of the world and existence, shares his or her gratification with the family members' achievements, and accepts the family members' criticism without becoming defensive

or retaliating. The therapist's openness and self-disclosure of experiences that caused him or her to have shame and guilt feelings models behavior for the family members to emulate. In doing so they may gain greater acceptance of the therapist as an SO. The therapist's behavior may enable family members to reveal the guilty secret that may prevent them from undertaking self-enhancing behavior, thoughts and feelings and thereby develop a more positive self-concept.

The Therapist and the Concepts of Transformation, Attribution and Social Interchange

If the SOs do not spontaneously practice transformation the therapist investigates the basis for their attribution and social interchange and whether they agree it is "fair." In addition, the therapist involves each family member in efforts to modify, as required, the behavior, thoughts and/or feelings of every other family member; and in this process each family member necessarily changes his or her own. Although the family members customarily attempt to change their own and the other's behavior, that is their role-performances, since such changes in behavior can be observed and recorded, this process also involves changing meanings, affect, and their self-concept.

Many behavior change efforts are undertaken on a quid pro quo basis in which the spouse (for instance) who wants the other to demonstrate affection to him or her is advised to demonstrate it to the other and to reward him or her in some way when he or she does so (Stuart, 1969; Rappaport & Harrell, 1972). In clinical practice the concept of transformation, applied to the concept of justice or equity, suggests that it is not necessary to change the same attribute of the SO, e.g. behavior, in return for modification of one's own and the SO's behavior. That is, the wife who wants to gain expressions of affection from her husband does not have to do so by demonstrating affection toward him. She may attempt to enhance his self-concept, she may assume certain pertinent meanings, or she may perform her marital roles differently in order to gain the affect she desires.

The therapist attempts to modify, as required, each attribute of the SO of each family member directly. He or she examines how each member attributes motives about his or her own and about the others' behavior, thoughts and feelings. He or she also investigates the family members' interaction hypotheses as part of their problem-solving efforts. He or she rejects terminal hypotheses which interpret behavior, meanings or feelings so each individual who participates in the interaction does not understand his or her own and the other's behavior, meanings or feelings in their interaction in such a way that

something can be done to change their relationship. Instead he or she applies instrumental hypotheses which explain behavior, meanings or feelings so each individual who participates in the interaction can understand his or her and the other's behavior, meanings or feelings in their exchanges in such a way that something can be done to change their relationship (Hurvitz, 1970).

In a way that was unknown when the concept of interaction hypotheses was proposed, it is now apparent that this concept is related to attribution theory. As Kelley states, attribution theory is about how people "answer questions beginning with 'why?'" (1973, p. 107). The importance of such a perspective is that instead of the therapist offering--read imposing--his or her insights or interpretations upon the client, the client offers his or her perceptions of the interaction and the situation within which it occurs. By doing so the client reveals his or her perception of the world and reality, his or her locus of control, self-concept and other "meanings." And by doing so he or she informs the therapist what kinds of cognitive and behavior modifications are required to enable him or her to interact in an effective and satisfying way with his or her SO.

The therapist assists the family members to examine their interaction on the basis of reciprocity, justice, balance, social exchange. To do so the therapist asks each family member involved in a particular problem or conflict situation: What happened according to your perception: What did the SO say or do that disturbed you; what did you say or do that may have disturbed the SO; what did you say or do in response to the SO's disturbing statement or behavior? The therapist also asks: What happened according to the SO's perception: what does the SO think you said or did that disturbed him or her; what does the SO think he or she said or did that may have disturbed you; what did the SO say or do in response to what he or she thought was your disturbing statement or behavior? The therapist also asks: How do you account for what happened: why do you think the SO said or did the thing that disturbed you; why do you think the SO responded as he or she did to what he or she thought was your disturbing statement or behavior? The therapist also asks: How do you think the SO accounts for what happened: what do you think the SO thinks is the reason you said or did what he or she believes disturbed him or her; what do you think the SO thinks caused you to respond to what you thought was his or her disturbing statement or behavior as you did? These questions do not have to be asked in precisely this form; however, it is often necessary to secure the information elicited by these questions. When the information is secured the spouses and family members can determine whether fairness exists in their relationship and whether they want to do something about it.

Once the therapist has inducted the family members into the

appropriate role-relationship with him or her, the role-relationship becomes the basis for the therapist's and the family members' joint participation in the interaction processes. When the therapist and the family members interact, the other attributes of the SO also develop and the therapist participates in transformation. Concepts of attribution and social interchange are also applied to the relationship between the therapist and the family members just as the therapist applies them to the relationship between the family members.

The Therapist's Interaction as an SO

The fact that the therapist becomes an SO means that the family members recognize that the therapist, whatever sterling qualities he or she has or presumes he or she has, is a human being with his or her own limitations. He or she will not perceive everything that occurs about him or her during his or her sessions with the spouses or family members; and he or she will not interpret correctly everything he or she perceives. He or she may not catch the nuances of an aside, the significance of a glance between the family members, the meaning of a child's request to go to the toilet when he or she asks to go, etc. There are times when he or she will start a sentence on the wrong foot and find it in his or her mouth, and have to start the sentence over again. There may be momentary confusion when the therapist uses the wrong word, calls a family member by the wrong name, makes a funny comment that the family members do not find amusing, etc. Such confusion does not mean that their therapist cannot help the family members.

Just as they accept each other in their own families, the family members accept the therapist's limitations benignly when things are going well. However, when the reasons that the family members resist therapy appear to be validated by something the therapist says or does, the reciprocity between the therapist and one or more family members is disturbed, and the limitations are no longer accepted benignly. Nevertheless the therapist's limitations are evidence of his or her common humanity with the family members which he or she expects them to accept just as he or she accepts their limitations. The therapist must recognize and help the family members to recognize that he or she cannot supply all the needs of each and every family member. However, he or she will exert himself or herself on their behalf to help them achieve their asserted therapy goal.

Conclusion

The SO, defined informally in the past, can be utilized to understand, evaluate and modify the interaction of family members in the clinical setting. The SO, defined as an analytical concept by

examining interaction in social acts, is associated with the social behaviorism of Mead, which is comparable to contemporary cognitive behaviorism. The concept of the SO is associated with such additional concepts as transformation, attribution, social interchange, and aligning actions. These describe various ways in which SOs interact and modify each other's behavior, thoughts and feelings. These concepts, principles and actions describe behavior on a "horizontal" plane, and explain and interpret behavior on the basis of the SOs' interaction itself. Such a view supercedes the attempts to modify an SO's behavior, thoughts and feelings by "vertical" or "depth" exploration to seek putative unconscious sources or heavenly causes of their behavior. The horizontal understanding of behavior is applied by the therapist to the family members' interaction as SOs, and to his or her interaction as an SO with the family members individually and collectively to help them achieve their asserted therapy goal.

REFERENCES

Bem, D. J., Self-Perception Theory, pp. 1-62 in Leonard Berkowitz (ed.), Advances in Experimental Social Psychology, Vol. 6. New York: Academic Press, 1972.

Berger, Peter L. and Thomas Luckmann, The Social Construction of Reality: A Treatise in the Sociology of Knowledge. Garden City, New York: Anchor, 1966.

Bikales, G., "The Dog as a 'Significant Other'," Social Work 20:150-152, 1975.

Blau, Peter M., Exchange and Power in Social Life. New York: Wiley and Sons, 1964.

Blumer, Herbert, Symbolic Interaction: Perspective and Method. Englewood Cliffs, New Jersey: Prentice-Hall, 1969.

Burgess, Robert L. and Don Bushell, Jr., Behavioral Sociology: The Experimental Analysis of Social Progress. New York: Columbia University Press, 1969.

Chadwick-Jones, J. K., Social Exchange Theory: Its Structure and Influence in Social Psychology. New York: Academic Press, 1976.

Cooley, Charles Horton, Human Nature and the Social Order. New York: Charles Scribners' Sons, 1902.

Ellis, Albert, Reason and Emotion in Psychotherapy. New York: Lyle Stuart, 1962.

Frederickson, Norman, "Toward a Taxonomy of Situations," American Psychologist 27:114-123, 1972.

Gerth, Hans, and C. Wright Mills, Character and Social Structure. New York: Harcourt, Brace and World, 1953.

Goffman, Erving, The Presentation of Self in Everyday Life. Garden City, New York: Doubleday Anchor, 1959.
_______, Interaction Ritual. Garden City, New York: Anchor, 1967.
_______, Strategic Interaction. Philadelphia: University of Pennsylvania Press, 1969.
_______, Relations in Public. New York: Harper and Row, 1971.
Gouldner, Alvin W.,"The Norm of Reciprocity: A Preliminary Statement." American Sociological Review, 25:161-178, 1960.
Guiot, Jean M., "Attribution and Identity Construction: Some Comments," American Sociological Review, 42:692-704, 1977.
Hall, Peter M. and John P. Hewitt, "The Quasi-Theory of Communication and the Management of Dissent," Social Problems, 18:17-27, 1970.
Hamblin, Robert L. and John H. Kunkel, Behavioral Theory in Sociology: Essays in Honor of George C. Homans. New Brunswick, New Jersey: Transaction Books, 1977.
Heider, Fritz, The Psychology of Interpersonal Relations. New York: Wiley and Sons, 1958.
Hewitt, John P. and Peter M. Hall, "Social Problems, Problematic Situations and Quasi-Theories," American Sociological Review, 38: 367-74, 1973.
Hewitt, John P. and Randall Stokes, "Disclaimers," American Sociological Review, 40:1-11, 1975.
Homans, George C., The Human Group. New York: Harcourt Brace Jovanovitch, 1950.
Hurvitz, Nathan, "Marital Problems Following Psychotherapy With One Spouse," Journal of Consulting Psychology, 31:38-47, 1967.
_______, "Interaction Hypotheses in Marriage Counseling," The Family Coordinator, 19:64-75, 1970.
_______, "Symbolic Interactionism: A Social Psychological Theory for Marriage and Family Counseling," Proceedings, 80th Annual Convention, American Psychological Association: 853-854, 1972.
_______, "The Family Therapist as Intermediary," The Family Coordinator, 23:145-158, 1974.
_______, "The Miller Family: Illustrating the Symbolic Interactionist Approach to Family Therapy," The Counseling Psychologist, 5:57-109, 1975.
Kelley, Harold H.,"The Processes of Causal Attribution," American Psychologist, 28:107-128, 1973.
Krause, Merton S., "Use of Social Situations for Research Purposes," American Psychologist, 25:748-753, 1970.
Kuhn, Manford H., "The Reference Group Reconsidered," The Sociological Quarterly, 5:5-21, 1964.
McCall, George J., Social Relationships. Chicago: Aldine, 1970.

Mead, George Herbert, Mind, Self and Society. Chicago: University of Chicago Press, 1934.

_______, The Philosophy of the Act, Charles Morris (ed.). Chicago: University of Chicago Press, 1938.

McHugh, Peter, Defining the Situation. New York: Bobbs-Merrill, 1968.

Mills, C. Wright, "Situated Actions and Vocabularies of Motive," American Sociological Review, 5:904-13, 1940.

Rappaport, Alan F. and Jan Harrell, "A Behavioral-Exchange Model for Marital Counseling," The Family Coordinator 21:203-212, 1972.

Rogers, Carl, "The Necessary and Sufficient Conditions of Personality Change," Journal of Consulting Psychology, 21:95-103, 1957.

Rotter, Julian B., Social Learning and Clinical Psychology. Englewood Cliffs, New Jersey: Prentice-Hall, 1954.

Schiffrin, Deborah, "Opening Encounters," American Sociological Review, 42:679-691, 1977.

Scott, Marvin and Stanford Lyman, "Accounts," American Sociological Review, 33:46-62, 1968.

Shibutani, Tamotsu, "Reference Groups as Perspectives," American Journal of Sociology, 60:562-569, 1953.

Siporin, Max, "Situational Assessment and Intervention," Social Casework: 91-109, 1972.

Stokes, Randall and John P. Hewitt, "Aligning Actions," American Sociological Review, 41:838-849, 1976.

Stuart, Richard B., "Operant-Interpersonal Treatment for Marital Discord," Journal of Consulting and Clinical Psychology, 33:675-682, 1969.

Sullivan, Harry Stack, "Conceptions of Modern Psychiatry," Psychiatry, 3:1-117, 1940.

_______, Conceptions of Modern Psychiatry. New York: W. W. Norton, 1953a.

_______, The Interpersonal Theory of Psychiatry. New York: W. W. Norton, 1953b.

_______, The Psychiatric Interview. New York: W. W. Norton, 1954.

Thibaut, John W. and Harold H. Kelley, The Social Psychology of Groups. New York: John Wiley and Sons, 1959.