In the 1960's all this changed, not because psychoanalysis had been shown to be ineffective, but because of a change in the social structure. Numerous community mental health clinics, child and family clinics, and outpatient services sprang up all over the USA. These clinics served not rich private patients with a limited range of disorders, but the public as a whole. They catered to patients of all ages from a range of social classes suffering from a variety of problems. Brief therapies (notably behavior therapy and family therapy) began to replace therapies based on psycho-dynamic principles.

Unlike psychoanalysis brief therapies were developed and practiced largely by nonmedical mental health professionals. Whereas psychoanalysis had placed the responsibility for change on the patients' shoulders, the brief therapies defined behavioral change as the responsibility of the therapist. The new therapists were directive, unlike their nondirective predecessors. Psychoanalysts viewed change as a continuous step by step process. Many of the brief therapies viewed change as discontinuous. That is, they viewed change as occurring not in many little steps, but in one big leap. Because analysts saw change as a step by step process, they insisted upon frequent and regular contact with their patients. Brief directive therapists, who viewed change as discontinuous, began to schedule appointments less regularly, and to space them apart in time so that their directives would have time to take effect in the patients' lives. Sometimes these directives were straightforward, e.g., progressive muscle relaxation exercises. Other times they were paradoxical, e.g., requesting the symptom to be produced by the patient at specified times under clearly defined circumstances. Analysts fostered intellectual awareness. Brief therapists de-emphasized self-awareness, since it often
damper spontaneity. Analysts stressed the curative importance of remembering unpleasant events from the past. Many new brief therapists reject this. According to Haley "Being able to forget the wrongs we've done to each other is one of the things that makes it possible for us to live together!!".

At this point Haley identified behaviour therapy and family therapy as two of the major brief therapies, and devoted much of the remainder of his address to a comparison of these two schools of therapy. Behaviour therapy is based on principles which define how to control animal behaviour. Family therapy grew out of cybernetics, a science which defines the principles of machine control. Family therapists view symptoms as 'sensible' (meaningful) solutions to family problems. For behaviour therapy, symptoms are coincidentally learned irrational behaviour.

Because of its basis in S-R theory, behaviour therapy in practice focuses on the dyad as the major unit of study. Family therapists, on the other hand, focus on the triad. The use of triad as the fundamental conceptual unit gives family therapists a way to conceptualize the issues of interpersonal power, hierarchies within the family system, and the motivation of systematic behaviour within the context of the family. Haley argued, has no adequate framework within which to deal with these issues.

Haley then illustrated the effects of these conceptual differences through case examples. If an agoraphobic woman comes to a behaviour therapist, he will probably use in vivo flooding or systematic desensitization to treat her. This will involve, among other things, the therapist seeing the woman alone and taking her for a number of walks outside. A few weeks after the end of treatment the woman may well relapse. The behaviour therapist will be at pains to use his conditioning model to explain the 'relapse', and further treatment will simply involve 'more of the same'. The family therapist would expect the individual treatment of this agoraphobic woman with behaviour therapy to fail on two grounds. Firstly, he would be aware of the empirical evidence which shows that there is a high incidence of marital discord among female agoraphobics. Secondly, from family systems theory he would assume that the woman's agoraphobic behaviour serves some function in maintaining the homeostasis of her marriage.

Haley then recalled a case he had seen. An agoraphobic woman came to therapy accompanied by her husband. During the initial interview it became clear that neither partner was satisfied with the marriage. The husband feared that his wife would abandon him. The wife disliked the husband's dependent attitude. Haley assumed that the agoraphobic woman would not leave the house alone because if she did she would leave her husband altogether. It also allowed her to see her husband as more independent than her. From the husband's point of view his wife's symptoms reduced his fear of abandonment. Her symptom was a solution (albeit a painful one) to the couple's marital problems. Haley gave the couple a paradoxical directive. He asked the husband, each day before he left for work, to demand that his wife to stay at home. After the third day his wife went shopping alone. A two year follow-up revealed that the couple were still together, and the woman's symptoms had not returned.

In dealing with childhood conduct disorders, behaviour
therapists have focused on training mothers in the principles of operant control. Haley argued, that this approach with its emphasis on the mother/child dyad often fails because the child's symptoms may be a solution to his parents' marital problems. That is, when the child senses that his parents' marriage is in difficulty (and fears that they may separate) he develops symptoms which force his parents to get together and cope with him. This distracts them from their marital battle. The behaviour therapist in focusing on the mother/child dyad is missing the core of the problem. He is attempting to deal with an essentially triadic problem as if it were a dyadic one. When the therapist sees the mother and child in therapy, and excludes the father, he runs the risk of undermining the authority of the father in the family and thereby exacerbating the marital problems. This in turn will lead to increased symptomatic behaviour in the child. Some behaviour therapists have attempted to deal with this by training mother and father together in operant child management techniques. According to Haley, this approach too will fail unless the marital issues are addressed.

The problem here is that behaviour therapy can only deal with such problems in terms of the dyad. The behaviour therapist conceptually 'collapses' mother and father together under the rubric 'parent', and the child forms the other half of the dyad.

In the final selection of his address Haley pointed out that often family therapy fails because other powerful individuals are involved with the family. Such individuals may include personnel from the children's school, a psychiatric hospital where a family member has been hospitalized, The Children's Aid Society or personnel from other agencies with which the family has had contact. In such cases members from these agencies must be contacted and occasionally included in family therapy sessions if the therapy is to be effective.

Haley then asked the questions; "Effective for who? For the symptom bearer? For the family as a whole? For the school? For the treatment agency?". These questions he left for us to answer.

Haley concluded by asking how can we, as behavioural scientists, reconcile the evidence for determination with the issue of freedom and responsibility. From systems theory (on which family therapy is based) we know that our behaviour as individuals is determined by that of the group. As therapists, however, we are responsible for the changing behaviour of groups of family members. He asked us to live with this paradox.