

## Chapter 4: STRATEGIC & SYSTEMIC

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### STRATEGIC FAMILY THERAPY

#### Overview

The strategic family therapy models were developed in the 1950s. They arose from two primary sources: first, **Gregory Bateson** and the **Palo Alto Group** who had applied the science of cybernetics to family communication patterns, and second, **Milton Erickson** who developed revolutionary paradoxical interventions that capitalized on people's natural reluctance to change to bring about rapid changes in psychiatric symptoms.

***The Palo Alto Group.*** Gregory Bateson was joined in 1953, first by **Jay Haley** and **John Weakland** and later by **William Fry**. In 1954, Bateson received a grant from the Macy Foundation to study schizophrenia and was then joined by **Don Jackson**. The group studied the family communication patterns of people diagnosed with schizophrenia to try to determine the origin of the symptoms. Guiding their work were concepts derived from *cybernetics*, the study of how information-processing systems are controlled by feedback loops. They viewed families as information processing systems and applied the cybernetics concepts to *patterns* of interaction. They "assumed that psychotic behavior in one member of a family might make sense in the context of pathological family communication" (Nichols & Schwartz, 1998, p.28). They hypothesized that a complex communication pattern, called the "double bind," (see below) might account for psychotic symptoms in a family member. The proposed explanation was intriguing but controversial since it challenged the prevailing biological "disease" theory. Although the researchers did find disordered communication patterns in these families, there is no definitive evidence that demonstrates that schizophrenic symptoms are the result, and the biological model dominates today.

***Double Bind.*** The term double bind has been commonly misused to simply describe a contradictory message, but the Palo Alto group was referring to interactions that are more complex. There are six characteristics of a double bind (Nichols & Schwartz, 1998).

1. The communication involves two or more people who have an important emotional relationship.
2. The pattern of communication is repeated.

3. The communication involves a “primary negative injunction,” (Nichols & Schwartz, p. 28) or a command not to do something on threat of punishment.
4. The communication also involves a second abstract injunction also under threat of punishment that contradicts the primary injunction.
5. A third negative injunction both demands a response and prevents escape, effectively binding the recipient of the demand.
6. The recipient becomes conditioned to respond, and as a result, the entire sequence is no longer necessary to maintain the symptom.

For example, a father demands that his son engage in a nightly discussion at the dinner table. When the child attempts to participate, the father is irritated that his dinner is interrupted. The father is then critical of his son’s lack of conversation. The son is caught in a bind since both his attempt to talk and his silence are punished. For the child, the meaning of communication becomes unclear and he develops a disordered style of communication that is labeled schizophrenia.

During that same period **Milton Erickson** proposed radical new ways to change “psychiatric” symptoms and problems. The prevailing theoretical assumption was that symptoms stemmed from deep psychological problems. “Curing” the problem required that patients gain insight into the unconscious impulses governing their behavior. By contrast, Erickson, focused on the specific symptoms and problems presented by the patient. He believed first, that people had the ability to solve their own problems if they could be induced to try new behaviors; second, that change could be swift rather than a long arduous process; and finally, that the patient’s own natural resistance to change could, ironically, be used to bring about change. As a hypnotherapist, he developed many ingenious techniques for “getting people to do something different in the context of the old behavior, or to do the old behavior in a new context” (Nichols & Schwartz, 1998, p. 358).

Erickson was masterful in his use of *paradox*. A paradox is a contradiction or a puzzle, and the interventions involving the use of paradox are based on the notion that families experiencing symptoms or problems find it difficult, or are naturally resistant to, instituting changes. In those cases, it is sometimes more useful either to forbid them to change or ask them to change in ways that seem to run counter to the desired goals. The therapist is counting on the family members’ rebelling against the directive, and as they do, the desired result is achieved. In a famous example – perhaps a fiction, but illustrative nonetheless – a farmer is attempting to push his cow into the barn. The cow naturally resists by pushing back against the farmer. The farmer then is instructed to pull the cow backward by the tail away from the barn. The cow again resists by pulling against the farmer, but this time the cow’s resistance lands her in the barn.

Strategic therapy models combine the concepts of the Palo Alto group and Erickson. The defining characteristics of these models of family therapy are:

- a focus on current family communication patterns that serve to maintain a problem;
- treatment goals that derive from the problem/symptom presented;
- a belief that change can be rapid and does not require insight into the causes of the problem;
- the use of resistance to promote change by applying specific strategies (Piercy, et al., 1996).

The models primarily associated with strategic therapy are the MRI brief therapy and the Haley/Madanes strategic models. They are presented below, together with Bandler and Grinder's model, neuro-linguistic programming (NLP).

### **Mental Research Institute (MRI)**

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The earliest strategic model came from the work at the *Mental Research Institute (MRI)* founded in 1959 in Palo Alto by Bateson's colleague, Don Jackson who was joined by Jay Haley, Virginia Satir, Paul Weakland, Paul Watzlawick, Arthur Bodin, and Janet Beavin (Nichols & Schwartz, 1998). They were interested in family communication patterns and feedback loop mechanisms (see below). The MRI group published many articles in the 1960s and 1970s and started one of the first formal training programs in family therapy (Nichols & Schwartz, 1998). In 1967 Haley left MRI for the Philadelphia Child Guidance Clinic.

*Brief Therapy Center.* In 1967 the Brief Therapy Center opened at MRI. As with all strategic therapies, the goal of treatment is to change the presenting complaint rather than to interpret the interactions to the family or to explore the past. The therapist first assesses the cycle of problematic interactions, then breaks the cycle by using either straightforward or paradoxical directives (Piercy, et al., 1996). In this model the therapist designs or selects a task or directive in order to solve the problem. Thus, the therapist assumes full responsibility for the success or failure of treatment.

### **Theory of Normal Development and Dysfunction**

MRI therapists do not speculate about normative patterns of development or use specific criteria to measure the health of a family. The model is more focused on techniques for change than on theoretical constructs (Piercy, et al., 1996). They are not concerned with changing the organization of a family (e.g., its hierarchy or power structure). Rather, they focus on the faulty cycles of interaction that are usually set into motion by misguided attempts to solve problems. Instead of solving the problem, the family's attempts can maintain or worsen it. Problems

are not viewed as having linear causes; rather, a problem behavior is just one point in a repetitive pattern. Causality is circular.

MRI therapists are guided by the principles derived from cybernetics.

Cybernetics is the study of how information-processing systems are self-correcting, controlled by feedback loops. Feedback loops are the mechanisms or cycles of interactions through which information is returned to the system and exerts an influence on it. There are both negative and positive feedback loops.

Negative Feedback Loops are ways that families correct a deviation in family functioning so as to return it to a previous state of homeostasis.

Positive Feedback Loops (Deviation Amplification) arise as a family attempts to add new information into the system. This can occur as a part of the growth process or increasing levels of complexity. Positive feedback loops are assumed to be responsible for the development of problems in families as they attempt solutions that worsen or maintain the problem. For example, if a child misbehaves, i.e., deviates from the norm (the family problem) because he is jealous of a new sibling and the father responds with harsh or punishing behavior (an attempted solution), it confirms the child's belief that he is loved less, and his behavior worsens (the deviation is amplified). MRI interventions would be aimed at changing the pattern of interaction so that the father could help the child calm his behavior and show him that he is not loved less.

### **Assessment and Treatment**

Assessment consists of determining the feedback loops and that govern the faulty behavior patterns by observing repetitive patterns of family interactions. Treatment is usually limited to 10 sessions, which sets up a "powerful expectation for change" (Nichols & Schwartz, 1998, p. 368). The changes that occur through treatment are classified as first-order change or second-order change.

First-Order Change. Family patterns of interaction or sequences are altered at the behavioral level only.

Second-Order Change. The family rules or underlying beliefs or premises that govern family members' behavior or promote specific reactions are altered. In the above example, two of the father's beliefs (that children should never show disrespect and that the child's behavior is disrespectful) may need to be changed. Family rules may be changed by the technique of reframing (see below) - helping the father reinterpret the child's behavior as reflecting his unhappiness rather than being disrespectful.

Treatment follows a six-step procedure (outlined by Nichols & Schwartz, p. 367-368):

1. Introduction to the treatment set-up. The therapist obtains basic information from the family; explains that sessions are recorded; obtains appropriate permission for recording; and discusses the length of treatment and the reasons for the involvement of multiple professionals.
2. Inquiry into and definition of the problem. The therapist asks the family about the problem that brought them to treatment. The problem must be one that the family can clearly define if treatment is to be successful. Vague complaints, such as “we just don’t get along,” do not lend themselves to interventions.
3. Estimation of the behaviors maintaining the problem. Certain behaviors or interactions among family members are assumed to be maintaining the problem. The therapist’s observations of the family interactions and inquiry into the problem should continue until he/she has a clear picture of the reinforcing behaviors.
4. a. Setting the goals for treatment. Once the problem has been articulated clearly, the therapist and family can negotiate goals for change. Goals should be measurable and observable. To help quantify the goals the therapist might ask questions such as, “What will be the first sign that things are getting better?”  
b. Exploring previous attempts to solve the problem. It is helpful to know what solutions the family has already tried for several reasons. The behaviors associated with attempts at solving the problem may be maintaining the problem. Knowing the attempts the family has made helps the therapist avoid strategies that repeat the family’s efforts and points to other strategies. There are three general types of solutions the family may have tried, and each suggests a specific intervention strategy.

The family might have:

- a. denied a real problem (ignore evidence of drug abuse in a teenager) – suggests an intervention that gets the family to act.
  - b. tried to solve a nonexistent problem (punish a toddler for masturbating) – need to get the family to stop acting.
  - c. taken the wrong action (buying gifts for a daughter instead of giving her attention) – need for different action.
5. Selecting and making behavioral interventions. As noted above, the type of problem and the solutions previously attempted suggest particular strategic interventions. Strategic interventions fall into broad categories:
    - a. **Reframing.** “The use of language to give new meaning to a situation” (Piercy, et al., 1996, p. 63) which may lead to changes in reactions to behaviors (first-order change) or to the alteration of rules that govern

behavior (second-order change). Reframes do not necessarily have to reflect the actual truth of the situation. For example, an angry hurt teen who has been locked out of the house by his father may be told that it is the only way the father has to demonstrate his love. Armed with a new way to interpret his father's behavior, the teen may then change his behavior toward the father who may in turn soften his behavior toward his son. MRI therapists have been criticized for an overly pragmatic approach in which *any* reframe that might lead to a change was allowable. As a result, they have increased their efforts to be sensitive and respectful in the formulations they offer families (Nichols & Schwartz, 1998).

- b. ***Paradoxical Interventions.*** Asking the family to do something that *seems* in opposition to the goals of treatment (note: According to Nichols & Schwartz, as strategic therapy models have evolved, the use of paradoxical interventions has declined due to the necessary use of deception.). For example:
  - Symptom Prescription:*** The family is requested to continue to perform or even expand the symptom. The intervention may be compliance based if the therapist wants the family to do as suggested or defiance based when he/she wants the family to defy the directive.
  - Restraining Techniques:*** Family members are warned of the dangers of change, are restrained from trying to change, or are asked to change slowly. The restraint of change technique is used when the family seems ambivalent about changing. The therapist aligns with the side of the ambivalence that resists change so that the family will align with the side that wishes to change.
  - Positioning:*** The therapist amplifies or exaggerates the family's explanation of the problem to a point that the family will disagree.
6. **Termination.** Therapy ends when the behavioral change objectives are met. The therapist reviews the treatment and anticipates the future with the family. He/she explains that therapy is intended to help provide a starting point on which the family might build.



Weakland, J., Fisch, R., Watzlawick, P., Bodin, A. (1974). Brief therapy: focused problem resolution. *Family Process, Vol. 13* (2). June, 141 - 167.

In this classic article, Weakland, et al., (1974) describe The Brief Therapy Center of MRI in Palo Alto and their model of therapy. The brief therapists view

dysfunctional behavior as a social phenomenon that occurs as one part of a system. The MRI approach does not consider that “payoffs” or the advantages of symptomatic behavior contribute significantly to problems or hinder change.

The methods of therapy draw from the work of Milton Erickson in two ways. First, Erickson’s goal was to modify a problem by redefining it rather than clarifying it. Second, Erickson designed a creative strategy based on a client’s own starting point. Brief therapy also draws from, among others, the work of Jay Haley. The main principles of brief therapy are as follows:

1. Brief therapy is symptom oriented. The therapist assumes the responsibility for alleviating specific complaints that the family can define and are ready to address. The presenting problem is both a representation of the problem and an index of progress.
2. Problems are viewed as faulty interactions among people.
3. Symptoms stem from problems in ordinary family life that have been mishandled and the situation reaches an impasse or crisis.
4. Transitions in the family life cycle are the most vulnerable to the development of problems. Symptoms are likely to develop if people overreact to ordinary difficulties, or if they ignore problems by underemphasizing life’s difficulties.
5. When a problem develops, its continuation and exacerbation are usually the result of a positive feedback loop. The solution that arises in response to a problem simultaneously worsens it.
6. Chronic symptoms are not a defect in the system, but a problem that has been repetitively mishandled.
7. The solution requires an interruption of the positive feedback loops through altering behavior patterns.
8. Paradoxical, seemingly illogical interventions, often succeed in changing the family’s behavior.
9. Change is effected most readily if the goals are relatively small and clearly stated. Change in one part of the system affects change in other parts of the system and may lead to changes in other areas of life.

The brief therapy approach is pragmatic. Interventions are based on direct observation in the session about how a behavior functions. Understanding “why” a behavior occurs – insight – is not a goal of therapy. In fact, attending to such inferences may detract from observing the system.

The Brief Therapy Center uses a team consisting of observers and a therapist. The team uses a room with a one-way mirror for observation, a telephone connecting the observers with the therapist, and equipment to tape the sessions. The therapist may offer suggestions to the family or the team of observers may

intervene. These therapist-observer interventions have been found helpful in promoting change in even the most resistant or difficult families. The therapist and observers meet briefly after each session to discuss their observations and interventions. Cases are also discussed weekly in a longer meeting.

Treatment has six stages:

1. Obtain basic demographic data and introduce families to the treatment arrangement. Families are not screened in advance of treatment.
2. Formulate a clear statement of the presenting problem. If a number of problems are presented, the family is asked which is most troubling.
3. Estimate which behaviors maintain the problem by determining how family members are attempting to solve the problem. Observation and inquiry continue until the therapist has a concrete picture of the reinforcing behaviors. The therapist must decide which behaviors are most salient.
4. Delineate treatment goals. Small, definable, observable goals are selected. The therapist may ask the family to indicate the smallest change acceptable. The goals are refined through discussion, clarification, and further inquiry. The therapist should have a defined goal by the end of the second session.
5. Formulate behavioral interventions. Brief therapy emphasizes behavioral intervention. The therapist uses the family's special characteristics to determine interventions. Homework tasks are assigned to utilize the time between sessions and broaden the within-session gains to the real world. Behavioral suggestions are usually indirect, implicit, suggestive, seemingly insignificant, or contradictory. When change is recommended directly, the family may be told to enact the changed behavior only once or twice until the next session.

An important paradoxical intervention is to *prescribe the symptom*. The family is asked to engage in the symptomatic behaviors. The goal is for the family to rebel and in the process, lessen symptomatic behaviors or bring seemingly automatic behaviors under voluntary control as the family engages in the behaviors by choice. This *therapeutic double bind* promotes progress no matter how the family responds.

Paradoxical instructions are also used in more general ways. For example, despite the emphasis on the brevity of treatment, families are advised to change slowly or refrain from changing at all. When change is reported, the therapist might advise slowing down. This usually produces more rapid results. When rapid change is produced, the therapist might suggest a relapse to the old behavior. Refraining from change often increases control over behavior.

6. Termination. Therapy is usually terminated by the end of ten sessions. The family's gains are discussed and the therapist helps the family look ahead to any remaining unresolved problems. The client or family is reminded that the purpose of this treatment was to provide them with a base on which to build future changes. With oppositional clients, the therapist may downplay the gains and predict more pessimistic outcomes.

If the family expresses apprehension about termination, it is done without the usual ending. Any of the unused ten sessions are "deposited," for later use at the family's request. Most families do not use them.

Treatment Evaluation. The brief therapy group stresses the evaluation of treatment. A group member not involved in the treatment, compares the treatment goals to the observable results by determining: if the specific treatment goal was met; the current status of the presenting complaint; if the family sought additional therapy; if improvements occurred in other areas of the patient's life; and if new problems have arisen (in order to address the possibility of symptom substitution).

The group reports that 40% of treatments succeed, 32% show significant improvement, and 28% fail. In some cases the team did not formulate a goal concretely and specifically enough to evaluate its outcome adequately. In other cases the changes did not provide relief. According to the authors, these results compare favorably with those of longer-term therapies.

The MRI group are considered the "engineers" of the family therapists, and some critics have called the brief therapy techniques manipulative. The brief therapy group counters that some influence is necessary to change behavior and that therapists are specialists in influence. By engaging the therapist, the family is saying change is desired. In their view it is the therapist's responsibility to apply his/her skills - considering all possible interventions - to help bring about that change.



Weber, T., McKeever, J., & McDaniel, S. (1985) A beginners guide to the problem-oriented first family interview. *Family Process*, Vol. 24, (3). 357-364.

Family therapy supervisors Weber, McKeever, and McDaniel, provide a framework and approximate times for guiding therapists through the initial sessions, which serves both as a teaching device and an assessment tool for supervisors to use with beginning therapists. For them, the beginning of treatment is critical. In the first interview the therapist joins with the family by noting the particular organizational style of the family members and using a therapeutic style that helps family members feel supported and safe. The session structure should provide family members with a sense that the therapist has a

plan and will take the lead. The session allows the family's process to surface and become defined. A therapy contract is developed with emphasis on the family's goals and desired changes.

If the first contact is by telephone, the therapist: gathers basic information - names, addresses, telephone numbers; asks for a brief description of the problem; identifies members of the family and others who may be involved with the problem; contracts for the first session, including who will be present, date and time, location, directions to the office or facility; and explains the fees. The family member making the call may be the most highly motivated member of the family. The therapist might wonder why he/she is calling now and how other members of the family would represent the reason for seeking therapy.

If the family is not self-referred, the therapist obtains the referring person's perspective and relationship to the family and clarifies the circumstances of the referral. He/she defines when and how communication and possible ancillary involvement will ensue (obtain releases of information).

*Building A Strategy/Making Hypotheses.* The tentative hypotheses, generated from the initial telephone contact, form a working framework through which a therapist begins to make sense of the family's organizational structure, especially as it relates to the presenting problem. This working hypothesis helps the therapist develop both a strategy and specific questions for the first interview. However, the therapist must treat the early hypotheses tentatively as he/she gathers additional data and formulates new hypotheses. The hypotheses are tested and reformulated. The therapist ascertains the family's place in the life cycle and predicts the tasks and issues surrounding that particular phase.

#### The Interview

1. Welcoming or Greeting (5 minutes). The therapist introduces him/herself to each member of the family and invites members to sit where they like. The use of equipment such as a one-way mirror, video or audiotape is explained, and appropriate consent obtained.
2. Social Stage (5 minutes). The therapist should create a safe environment in the sessions where no reprisals are given. The therapist is human and non-intimidating and develops relationships with family members by finding out more about their interests and involvements. Special attention and respect are given to the adults in the family, and the therapist reaches out to more distant family members, especially ones that did not initiate therapy. Neuro linguistic programming (NLP) techniques (see section C. below) geared towards matching the verbal and nonverbal styles of the family can be helpful in this engagement process.
3. Identifying the Problem (15 minutes). The goal is to explore each person's view of the problem - beginning with the adult who appears most distant

from the problem – by asking each to describe concretely the behaviors associated with the problem. Discuss all previous attempts to solve the problem and the outcomes. Ask about recent changes in the family (births, deaths, change of employment, moves, etc.). Maintain the focus on the presenting problem while gathering additional data. Affirm each family member's view and avoid offering interpretations or advice, even if asked. Block interruptions and note disagreements or discrepancies in family member's statements. The therapist remains empathic and non-critical.

4. Observing Family Patterns (15 minutes). The therapist needs a clear picture of the behaviors of each family member. Having members clarify a specific aspect of the presenting problem by having them talk to each other about the problem or by having them enact the dilemma facilitates this goal. Family members can be asked to describe behaviors of other members as they discuss the problem, e.g., "Mary, when you and Tom are fighting, what does Mom do?" Family members might reenact the problem, e.g., "Tom, show me what happens when Mary comes in late." The therapist should observe and listen to the family, making note of the interactional patterns and repetitive sequences.

Any suggestions during this phase should be directed toward the therapy goal and/or directly related to the behavior that was observed in the session. For example, if a younger child continually interrupts a parent, the therapist may suggest that an older child help with the younger one so the parent can focus on the session. Compliment family members when their behavior is positive, for example, "Tom, you are really helpful with little Jimmy. Thank you."

5. Define the Goals (5 minutes). Ask each member to identify specifically what he/she would like to be different in the family as well as what he/she would like to stay the same. Help the family define the changes in clear positive terms and underscore their strengths. Ask them what minimum level of change would be acceptable and indicate that they are moving in a positive direction. As homework, the family might be asked to gather more information about a specific issue.
6. Contract (5 minutes). If they intend to return for treatment, discuss the number of sessions and the option of a time-limited contract. Review all business aspects including insurance information, fees, etc. Ask the adults to sign release of information and consent forms for taping sessions, or for gathering information from physicians, school personnel, or previous therapists. Provide an opportunity for family members to ask any questions before ending the session.

Weber, et al., provide the following checklist to evaluate the initial interview. The therapist should have:

1. made contact with each family member and helped him/her feel as comfortable as possible;
2. established leadership by providing a clear structure in the interview;
3. developed a working relationship with the family without being either too professional or too personal;
4. recognized strengths in the family and in family members;
5. maintained an empathic position, supporting family members and avoiding blaming or criticizing;
6. identified the specific problems and determined attempted solutions;
7. started to learn the family's view of the world and each member's language, style, and perspective on the problem;
8. began to understand the family's repetitive behavioral interactions associated with the problem;
9. gathered information about significant other family friends and professionals involved with the problem;
10. negotiated a mutually acceptable contract.

Following the initial session and the checklist review, the therapist should refine the hypotheses and plan for the next session. The referring person, if applicable, should be contacted. The therapist should decide what information, if any, will be shared. The circumstances of any collaboration should be determined. The therapist should obtain records or other relevant external data.

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### **Haley and Madanes**

**Jay Haley** left the MRI group in 1967 and worked for the next 10 years with Salvador Minuchin (see Chapter 6: Structural Family Therapy,) and Braulio Montalvo at the Philadelphia Child Guidance Clinic (Nichols & Schwartz, 1998). He then formed the Family Therapy Institute in Washington, DC, with **Cloe Madanes**. Although Haley's model is presented with the strategic models, his work is also clearly influenced by the structural view. Like Minuchin and other structuralists, Haley believed that not only must the symptoms or presenting problem be addressed in treatment, but also the underlying family structure that results in the symptoms. Haley's work is also clearly influenced by Erickson with his use of directives (between session tasks) and paradoxical interventions.

### **Theory of Normal Development and Dysfunction**

The Haley-Madanes model is more theoretical than the non-normative MRI model. Like the structural theorists, they "consider family life cycles...and

general systems concepts (e.g. homeostasis, positive feedback) in their conceptualizations of family functioning” (Piercy, et al., 1996, p. 51). They contend that symptoms stem from a faulty *organization* within the family and serve a function in maintaining its structure and homeostasis. In their view, the *hierarchical* arrangement of family members is critical. “Haley (1976) suggests that, ‘an individual is more disturbed in direct proportion to the number of malfunctioning hierarchies in which he is embedded’” (cited in Nichols & Schwartz, 1998, p. 360). Madanes adds that symptoms may also function in what she calls *incongruous hierarchies* “created when children use symptoms to try to change their parents” (Nichols & Schwartz, p. 361).

### **Assessment and Treatment**

Like MRI brief family therapists, Haley and Madanes are interested in present behaviors and sequences of interactions. They use strategic interventions to alter the interactions, but they differ from the purely strategic models in that the goals of therapy are not only to alter the sequences of interactions, but also change the structure of the family (Piercy, et al., 1996).

A prominent feature of the early Haley (1976) model is the strong recommendation that therapists actively plan the therapy from the beginning. The first session is critical. “If therapy is to end properly, it must begin properly” (Haley, p. 9). The therapist and family must define a solvable problem, and the therapist must discover the “social situation that makes the problem necessary” (p. 9). For example, a child’s problem or behavior actually reflects a marital problem.

Haley strongly advises therapists to require all people living in the household or who are integrally involved with the problem be present at the first session. At the same time, therapists may be flexible regarding the place of therapy (school, home, office), the length of the first session, or the fee charged. Because of the importance of the first session, he developed a detailed four-stage process and outlined the goals of each stage:

1. **Social Stage.** The therapist welcomes family members who may be nervous or defensive about being in therapy and greets *each* family member, paying attention to appropriate cultural norms.

*Goals: help family members feel comfortable and relaxed; begin observations of interactions and make tentative hypotheses about family structure, e.g., who tries to enlist the therapist to his/her side? How do the parents discipline the children? Hypotheses should be tentative since the early observations may reflect a tendency for the family to act in the way they think the therapist expects.*

2. **Problem Stage.** The therapist shifts to a therapy situation by introducing him/herself, outlining what he/she already knows about the family, and inquiring about the problem. He/she should explain that they have all been

asked to come so that each may contribute his/her perspective. The therapist often decides whom to ask first based on his/her observations. The therapist's choices are goal directed (e.g. beginning with the least involved parent in order to increase his/her involvement). Typically, he/she avoids starting with the person who has been identified as having or being the problem. The therapist asks a general question regarding the reasons the family has come or what changes each would like to see. As each member speaks, interruptions are observed for what they might reveal about the family, but the focus is quickly returned to the speaker.

*Goals: The therapist continues to observe and make mental hypotheses about hierarchical structure and triangles, but does not "interpret" family interactions to them. He/she notices disagreements in the explanation of the problem, which will provide the basis for the interactive discussion to follow. The therapist takes charge of the session, for example, bringing in under-involved members, preventing an overly talkative member from dominating, sitting near a child reluctant to speak, or moving a child closer to the parent to whom he is the least close. These interventions are strategic since the family is prevented from repeating their previous patterns of interactions.*

3. **Interactional Stage.** The therapist asks the members to discuss with one another the various perspectives and disagreements regarding the problem. In this stage Haley (1985) cautions, "It cannot be overemphasized how important it is to have the family members interact with each other, rather than the therapist" (p. 37). The therapist may intervene to bring more members into the discussion or to bring *action* into the discussion, i.e., family can be asked to enact the problem in the session. Demonstrating the problem allows the therapist to observe the relevant interactions in ways that the family cannot express in words.

*Goals: test hypotheses; observe sequences and the structure governing behaviors such as malfunctioning hierarchies, coalitions, quality of parental functioning, and the like.*

4. **Goal Setting Stage.** The therapist asks family members what changes each would like from therapy. He/she helps articulate the problem in terms of what "one can count, observe, measure, or in some way know one is influencing" (Haley, p. 41). A **directive** (discussed below) is given to the family as homework. The session ends by setting the next appointment.

*Goals: to delineate a solvable problem that can be addressed in therapy. If articulated in such a way, the therapist and the family know when treatment is completed.*

Haley provides an extensive checklist to evaluate the first session.

**Directives.** In his early work, Haley designed tasks, called directives, for three purposes:

1. to get family members to do things differently and have different experiences;

2. to involve the therapist in the treatment and “intensify the relationship with the therapist” (p. 49);
3. to gather additional information about how the family responds to the task. The family may be directed to do something they have not done (when your wife and son are arguing, you should take control of the situation) or refrain from doing things they have done in the past (do not interrupt your husband when he is talking to your daughter).

Directives should be concise and may involve part or all of the family. The task may begin during the session with instructions to continue at home. As in all strategic therapies, the therapist tracks the sequences involved in the problem and assigns directives that alter the sequence. But in addition for Haley, the goal is to alter the family structure in order to correct malfunctioning hierarchies, often by strengthening the parental unit. The family’s attempts at directives should be reviewed in the next session. For example, if a mother is behaving in a helpless way with her children, forcing the exasperated father to assume a primary parenting role, the father may be directed to instruct the mother nightly on parenting techniques. The mother will rebel against being instructed and thus become a more effective, and equal, parenting partner.

Haley’s earlier therapy was also characterized by the use of *ordeals* (Nichols & Schwartz, 1998). Ordeals are directives that are aimed at making the symptom harder to keep than give up. The ordeal requires the clients to do something they do not want to do, but is something that would benefit them in some way. (A husband might be instructed to give a present to a brother-in-law with whom he does not get along each time the symptom occurs. If the husband finds giving the gift unpleasant enough, the symptom will disappear and the relationship might improve as well.) Like all directives, ordeals are aimed not only at symptom relief but also family restructuring.

The most recent Haley – Madanes therapy model, *strategic humanism*, is “more oriented toward increasing family members’ ability to soothe and love than to gain control over one another” (Nichols & Schwartz, 1998, p. 374). Madanes has separately elaborated her own theories and strategies.



Madanes, C. (1980). Protection, paradox and pretending. *Family Therapy Process*, Vol. 19, 73 – 85.

While still considered a strategic therapist because of her approach to solving problems within families, Madanes (1980) proposes a *structural* explanation for psychopathology in children. In a well-functioning family, parents are hierarchically superior to their children and can usually “pull themselves

together” to help their child, even if there is a marital conflict or if one parent is struggling with an issue.

In dysfunctional families, the child has become hierarchically superior to one or both parents, a powerful but detrimental position. He/she becomes a benevolent protector of the parents’ by taking on symptoms, causing the parents to focus on the child’s behavior rather than their own problems. The child and one parent may form a coalition against the other parent or a grandparent – a structural misalignment referred to as *triangulation*. The child’s problem behavior provides a bond that holds the parents together. Conflict between the parents, or even family issues from prior generations, can be expressed through the child. Regardless of how the parent responds to the child (soothing, demanding, punitive, concerned), it focuses the parents on their child and away from their own issues.

### **Assessment and Treatment**

The first task of treatment is to decide who is being protected by the child’s behavior and how. The therapist then designs a directive to change the pattern of interaction to reestablish the parents in a superior position by helping the parents take back power from the child. The changed structure no longer supports the child’s problem behaviors. The emphasis is not on helping the family understand how or why the problem behavior is occurring, but rather on solving the problem. Directives are developed to fit the unique needs of the family. The strategic paradoxical interventions are: dramatizations, pretending, and make-believe play.

***Dramatizations.*** A parent is directed to request that his/her child intentionally perform the problem behavior. Here the relationship between the parent and the child is based on *benevolent helplessness* in which the child’s symptom helps the parent by diverting attention from the problem as the parent helps the child try to overcome the symptom. For example, a mother is worried she may lose her job (the real problem) and the child develops a headache. The child is protecting the mother and trying to “solve” her problem. The strategy works in that the mother ignores her own problem to attend to her son’s headache. To alter the pattern, Madanes directs the parent to encourage the child to have the symptom. In this way the symptom will not draw as much parental attention, no longer serves a purpose, and will usually be dropped. The mother’s fear will resurface, and she can address the real problem with the therapist’s help.

***Pretending.*** Madanes directs parents to ask the child to pretend to have the symptom and the parents to pretend to help the child. This intervention makes the child’s need to act out and the parent’s need to help a kind of game. For example, a child developed stomachaches in order to get affection from his grandmother. Not only was this a way for the grandmother and grandson to express tenderness for each other, it also added an element of drama to the

grandmother's otherwise routine existence, but at a cost to the child. During therapy, the child was asked to pretend that he had a stomachache and the grandmother to pretend to care for him. They were to do this at home every day for one week. Through the directive, the child and grandmother could still be affectionate, grandmother was still needed and loved, but since the stomachaches were no longer necessary, they disappeared.

***Make-Believe Play.*** When a child protects his/her parents through symptomatic behavior he/she is helping them *covertly*. Instead, Madanes (1980) asks parents to make believe they need the child's help and the child to make believe helping them. Since the parents explicitly ask for help and the child overtly helps them, there is no need for the covert symptomatic behavior. Additionally, when parents intentionally assume an inferior position, they may feel at odds with what is appropriate and reassert their superior position. For example, a mother with several children was in fear of losing her welfare benefits because of a live-in boyfriend. Her son sensed her fear and helplessness and developed night terrors. His nightmares were both a metaphor for the mother's fears and an attempt to help her since she had to set aside her own fears to comfort him.

The family was asked to make believe that the mother was afraid because she thought someone was breaking into the house and that she needed the child's help. The therapist designed a play in which the son was to make believe he was protecting his mother. They were directed to perform this play every night at home. If the mother heard her son screaming in the night, she was to awaken him and his sisters and replay the drama, no matter the time. This intervention was designed to encourage the son and his mother to change the way they were protecting each other. The mother's need for help was transformed into play, as was the son's helpfulness. Follow-up sessions found the night terrors had ceased, the mother was in a productive job and working on her relationships, and the son was involved in sports and in school. The goals of therapy were reached in two stages. At first the paradoxical directive blocked the ways in which the symptoms of the son served to help his mother avoid confronting her problems. Later, the mother regained her appropriate position in the hierarchy.

Most recently, Madanes has moved away from strategic and structural models and is closer to the work of Satir (see Chapter 6: Experiential). She now hypothesizes that family problems result from a "dilemma between love and violence" (Madanes, 1990, cited in Piercy, et al., 1996, p. 52). In this model, family members have four aims, and problems in each area tend to lead to different types of symptoms: 1) to dominate and control – leading to behavioral problems such as delinquency and drug abuse; 2) to be loved – leading to depression, psychosomatic problems, phobias, eating disorders; 3) to love and protect – leading to suicide, abuse, neglect; and 4) to repent and forgive – leading to incest, murder, abuse (Nichols & Schwartz, Piercy, et al.). The goal is to intervene in the family through a 16-step program to bring the family toward love and

away from violence. She also includes “growth-oriented objectives like balance, harmony and love” (Nichols & Schwartz, p. 365).



Hoffman, L. (1981). *Foundations of family therapy*. New York: Basic Books. Chapter 11: *Breaking the Symptomatic Cycle*. 197-218.

Hoffman presents three family cases, each illustrating symptomatic sequences that influence the schismogenic tendency of relationships. The families are each seen by therapists with different theoretical perspectives, but in each case the treating therapist interrupts the dysfunctional recursive sequence to help the family move to a desired level of functioning. Changing the symptomatic sequences involves two types of corrective action: first and second-order changes.

Behavioral sequences in families tend to fluctuate within a limited and acceptable range. Therapeutic modifications that occur within this range are called first-order changes. Making these limited first-order changes solves many problems. For example, a mother striving to improve her family’s nutrition may broaden her choice of what to serve for dinner so long as it does not exceed her family’s preferences. Second-order change falls outside of the accepted range of behaviors, and is often precipitated by new circumstances and/or the family’s natural evolution through developmental stages. Second-order change is often preceded by a major shift in the family rules and may result in a fundamental change in the family structure.

When first-order changes no longer bring about an adequate solution, many families are able to make a second-order change. But in other circumstances the attempted solution to the problem may become a problem itself. Thus, when these families seek treatment, the therapist might provide direct advice, or help the family generate alternate behaviors, which may be within the realm of first-order change. However when the cycle that maintains the problem is too rigid or a structural change is called for, the therapist may need to consider second-order change. For example, a parent who is struggling with an adolescent child’s eating habits may try to force him to eat particular types of food. The child responds by refusing to eat, reinforcing the parent’s concern that the child is not eating properly, and she tries to take even greater control. The mother’s escalating attempts to control her son and his increasingly stubborn refusal have become the problem. Watzlawick, Weakland, and Fisch (in Hoffman) refer to this recursive cycle as the *game without end*.

The therapist might first try “a little push,” for example advising the mother to allow her son greater freedom to determine his own diet. The push may not work, and perhaps the therapist needs to help the family focus on what is at the

root of the symptomatic cycle, for example, explaining that since this child is now an adolescent, he has less need for guidance regarding food. Further, it may be that the parent needs to allow the adolescent to take on more responsibility in this and other areas, and the parent needs to loosen control. This realization can disrupt the cycle, resulting in second-order change, new rules, and a new organization of the family.

Families become stuck in repetitive patterns of behavior, however, and the therapist may need to actively interrupt the cycle in order for the family to make a change. He/she must first identify the cycle. Some cycles are obvious, but others are not easily recognized, such as with psychosomatic illnesses or communication disorders associated with psychosis. In those situations, the therapist can gather information on how the condition or problem is managed, which often reveals the cycle. In most cases, these problems and recursive sequences are a reflection of a dysfunctional triangle which brings the child into what is actually a *mirror-image disagreement* between the parents. The solution to the problem in such cases often involves helping the parents get together so they can make the child behave.

The three cases Hoffman discusses are briefly outlined below.

#### **Minuchin – Structural Approach to Anorexia**

Minuchin first arranged to meet with the parents and anorectic daughter over lunch, then excused himself to observe them. The parents consistently took opposite positions. One reasoned with their daughter, while the other demanded she eat. When the reasoning parent started to become more demanding, the demanding parent became gentler and began to reason. The configuration that was revealed was one of a disciplinary father, a permissive mother and a daughter caught in the ongoing mirror-image disagreement. Each person covertly gives cues for behaviors to one another. The family members could not stop the spiraling cycle on their own, and the cycle kept them from launching their daughter into the adolescent departure stage.

Minuchin's goal was to provoke a *runaway positive feedback loop*, which throws the family out of equilibrium and increases stress. He removed one member of the triangle at a time. Each parent had to try to deal with the daughter on his/her own. This eliminated the constraints that each placed on the other and forced the behaviors in the sequence to pass their usual limits. Mother became feebler and father more forceful and violent. Minuchin then reframed the problem as being one in which their daughter was stronger than they. Thus, he moved the parents from a detouring-benevolent triangle in which the daughter was conceived of as "sick" to a detouring-attacking triangle in which she is perceived as "bad." The parents were then able to talk to Minuchin about the more threatening problems in their relationship, freeing the daughter from the cycle. The girl quickly resumed normal eating habits. The family had undergone second-order change.

**Haley, Hoffman, Fulweiler: Interpretive Approach**

Hoffman reports on a family in which the parents are locked in a battle with their son over his smoking. Fulweiler was the therapist and Haley was the supervisor. Again the family members formed a triangle: domineering father, rebellious son, and an ineffectual mother who tended to side with her son. The father would attempt to force his son to quit smoking; the son would rebel and the mother's lack of support for the father caused him to back down from his position. Similar to Minuchin's family, the sequence kept attention off of the marital problems and places the son in the middle. If he quits smoking, he supports his father against his mother; if he rebels against his father and smokes, he supports his mother. Thus, the son is caught in the mirror-image struggle. Fulweiler's strategy was to use blocking maneuvers to disrupt the sequence. He used a technique in which he entered and exited the therapy session without warning. At first entrance he first helped the mother clarify her position, the second to highlight a marital disagreement, the third to bolster the father's authority, and the subsequent entrances to stop the father in his role of victim. According to Haley, this family illustrates standard roles: over-involved parent, peripheral parent, with the child as secret agent defying the over-involved parent for the peripheral parent.

**Fisch: Parsimonious Technique**

Fisch argues that a very small change in a system can have a wide-reaching effect. He presents a case in which parents were having trouble dealing with their children, one of whom they characterized as willful and obstinate and the other as well behaved. They also characterized their marriage as loving and close. The mother got into daily battles with the daughter and the father would intervene to subdue the daughter. Fisch told the parents they were having trouble controlling their daughter because they were too predictable and instructed the father to give his daughter a penny during the next mother-daughter battle. The surprising intervention was aimed at interrupting the dysfunctional sequence. A covert mirror-image disagreement that had been hidden before the intervention emerged when the mother expressed little hope for her impossible daughter, while the father held higher expectations. In this type of intervention the therapist creates confusion aimed at breaking the cycle and uncovering mirror-image disagreements that have been hidden.

In sum, Hoffman illustrates several ways to encourage first-order change, where possible, by giving the family a little push, offering advice, or suggesting alternative behaviors. Where second-order change is necessary, therapists might escalate positive feedback loops, increase stress, create therapeutic confusion and interrupt, and alter rigid recursive cycles.



Hoffman, L. (1980). The family life cycle: a framework for family therapy. New York: Gardner. Ch 3. *The Family Life Cycle and Discontinuous Change.* 53-57.

In this article Lynn Hoffman integrates common, though sometimes ignored, observations about the surprising ways families change, together with the scientific research on change process models, particularly those drawn from biology or physics. She outlines mechanisms for change that expand the family system's cybernetic view, reexamines the meaning of symptoms, and suggests ways that therapists can intervene with families in crisis to foster creative leaps in functioning. She also relates these observations to the family life cycle.

The systems model of families is, at its core, a *homeostatic* model. Most behaviors, particularly symptomatic behaviors, are thought to keep the family functioning within a relatively unvarying range with respect to such characteristics as closeness, independence, power structures, and the like. When the system threatens to exceed that range, *feedback mechanisms* work to bring the behaviors back into a familiar static state. The model would predict that when change occurs, it happens slowly. Hoffman suggests that the model is compelling, in part, because it seems to explain the apparent "stuckness" that family therapists observe. Family members' tenacious resistance implies that they need the symptom to maintain equilibrium.

But as Hoffman observes, families often do not change in a smooth continuous progression. Instead, they make sudden, often creative, shifts – called *discontinuous changes* – either on their own or in therapy. Platt (cited in Hoffman, 1980) distinguishes three kinds of change, depending on the type of system. If the system is externally designed, like an engine, then change will have to be made by someone outside, like a mechanic. If it is internally designed, like a flower that contains a genetic blueprint, change occurs through mutations of the genetic material. In human systems that follow a self-maintaining design, change can take place in the form of a transformation, a shift or change in the ways in which the pieces are organized within the system. Hoffman reports on the writings of Dell and Goolishian, of Bateson, and of Ashby that help to explain sudden discontinuous change.

### **Discontinuous Change Mechanisms**

Dell and Goolishian's work is based on a notion of change that they refer to as "order through fluctuation" (p. 53). Families maintain homeostasis so long as the pressures on the system are relatively stable. But often events put considerable stress on the family, requiring that they function beyond their previous level of functioning, or they will break down. The growth process is facilitated by a feedback mechanism described by physicist, Prigogine, called "evolutionary feedback...[which is] a *non-equilibrium* ordering principle" (p. 53, *emphasis added*) that operates when the fluctuations in a system exceed its homeostatic range. Systems tend to operate inside of a

range of stability within which fluctuations are damped down, and the system remains more or less unchanged. Should a fluctuation become amplified, however, it may exceed the existing range of stability and lead the entire system into a new dynamic range of functioning (p. 53-54).

Dell and Goolishian contend that families cannot be understood by using a "cybernetic analogy on a mechanical model of closed system feedback" (p. 51). The cybernetics of living systems is different, they claim, vividly illustrated by their discontinuous changes, and sudden leaps into new levels of integration.

Bateson also spoke of the human capacity to move beyond simple behavioral replication to creativity, art, learning, and change. The "processes of change *feed on the random*. The essence of learning and evolution is exploration and change" (p. 53).

According to Ashby, families seem to operate on a ***bi-modal feedback mechanism***. The system remains unchanged so long as the internal or external environment is stable, but when the fluctuation exceeds the range of stability the system must respond in some new way. The system either breaks down or it makes a leap into new levels of functioning. The change results in a new set of patterns which, like the old pattern, is also bound by rules, and it, too, remains unchanged so long as the environment is stable.

Hoffman summarizes the process: in response to environmental changes for which the system is not yet designed, patterns of responding that have served the family well, begin to fail. The family tries new solutions, many of which are necessarily abandoned, leaving them in a state of confusion. The system enters a period of crisis as their homeostatic tendencies result in increasingly wild corrective attempts. Finally, the system either breaks down or "may spontaneously make a leap to an integration that will deal better with the changed field" (p. 56).

These discontinuous changes often occur, like symptom development, at times of stress. Changes in the family composition are particularly demanding. There are ***crises of accession*** when someone joins the family (marriage, birth) and ***crises of dismemberment*** when members leave (divorce, death).

Symptoms and rapid changes in family functioning also tend to occur during the negotiation of developmental stages. There are pressures, for example, as an adolescent reaches a new, more independent, maturational level. While there is no uniform agreement about how many developmental stages there are, Hoffman names the major categories: "courtship, marriage, advent of young children, adolescence, leaving of the children, readjustment of the couple, and growing old and facing death" (p. 58).

Hoffman reports on the mechanism for discontinuous change. It draws from Ashby's work on similar changes in the physical world. Of the several types of change mechanisms he reports, the most salient to families is "step-function [in which there are] intervals of constancy separated by discontinuous jumps, like a set of stairs" (p. 58). The changes occur suddenly as the system exceeds its capacity, such as when a fuse blows as the load of a circuit exceeds specific amperes. Without a fuse, the whole system would break down, but once the system is back within its limits and the fuse is replaced, the system is functional. He refers to this as a step mechanism.

In a family, the stressor may be temporary. For example, a teenage daughter runs away from home when she fails a mid-term exam. When the family discovers she is only at her friend's house and quickly hires a tutor, the circuit load has returned to acceptable levels, and the fuse is replaced. On the other hand, the stressor may be permanent and may result in a breakdown or require rapid creative changes. For example, the fuse may blow when Dad loses his job. The family might resort to old ways of functioning – replacing the fuse, so to speak – without fixing the circuitry. If Dad becomes depressed and starts drinking, the system may break down as former patterns of behavior fail and the fuse blows again. The breakdown is a "step mechanism signaling the failure of the family's homeostatic mechanisms" (p. 60). Alternatively, Dad may decide to take an early retirement and expand his gardening hobby into a business, and the family can reorganize itself around the change.

Thus, in this model "symptomatic displays could...be thought of negatively as aborted transformations – a failed leap – or positively as negotiations around the possibility of change [or even as a] compromise between pressures for and against change" (p. 61). Symptoms can function to prevent too rapid a change from occurring, albeit at the expense of one member. They may also help maintain pressure on the family to make needed changes. But, as Hoffman points out, while a shift to a symptomatic pattern may be an immediate solution, it neither indicates nor leads to a more functional transformation.

### **Implications For Treatment**

Hoffman explores the implications for these ideas in helping families negotiate the environmental stressors and developmental stages so that they make the necessary creative transformations and prevent the symptom from spiraling into chronic behavior patterns. That is, how does a therapist prevent morphostasis and encourage morphogenesis? It is important that therapists not interpret conflict or apparent dysfunction as an omen of impending disaster, but rather "that pressure toward a new and more complex integration is mounting" (p. 55). Understanding various aspects of communication and the affect of messages is also important. Hoffman discusses the related concepts of paradoxical injunctions and double and simple bind communication.

A *paradoxical injunction* is a statement “that intrinsically contradicts itself unless teased apart into a ‘report’ level and a ‘how this report is meant’ level, the second level inclusive of the first” (p. 62). This concept corresponds to what the Palo Alto researchers called the *double bind* in which a message is given to another person requiring contradictory, mutually exclusive, responses, i.e., do something and do not do something. This concept was initially used to describe the communication patterns in families in which one member was diagnosed with schizophrenia. Hoffman notes, however, that such contradictory messages are common throughout society and do not usually result in madness. Instead, she refers to them as *sweat-boxes* since they indicate a mild or severe threat to the continuity of the relationship and the system. She asserts that these types of pressures may be a necessary precondition to morphogenesis.

But, she makes an important distinction between the double bind message and a *simple bind* message. In the double bind, whatever response the message recipient gives, his/her “leap in behavior” is disconfirmed; whereas, in the simple bind, the new response is rewarded. “In other words, the double bind is a simple bind that is continually imposed, and then continually lifted” (p. 64). Hoffman offers the example of a teenager whose mother exhorts him to behave in a more mature way. If he disobeys and stays immature, he fails. If he acts more maturely, he is being an obedient child in a mother-child relationship, and he fails again. Since neither response is rewarded, the child is in a double bind. If, however, mother and son spontaneously find themselves relating to one another more as adults, the son’s new behaviors are rewarded. This injunction, then, was a simple bind, and the two have transformed their relationship with a creative leap.

Stress, development, and change cannot be avoided. When seeing families in treatment, Hoffman suggests a radical departure from models that support homeostasis. Instead, the therapist should expect – even welcome – crises as opportunities to foster creative transformations.

The knowledgeable clinician...will know that these behaviors are expectable concomitants of family change. He or she will *seek to disrupt the homeostatic sequence* that forms about a symptom so that pressure for change will be allowed to build and a transformation will hopefully take place that makes the presence of a symptom unnecessary (p. 67, emphasis added).

## **Neuro-Linguistic Programming (NLP)**

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This model has its roots in the works of Gregory Bateson, Milton Erickson and Virginia Satir. It evolved from **Richard Bandler** and **John Grinder’s** extensive study of audiotapes and movies of Satir and Erickson’s clinical work. NLP

examines the relationship between language and reality, following the ideas of Alfred Korzybski, "A map is not the territory it represents, but, if correct, it has similar structure to the territory, which accounts for its usefulness" (Korzybski, 1958, p. 58). The NLP model attends to how language reflects a person's ability to change or not to change. Through the structure of language, concepts such as generalizations, deletions, and constraints emerge which shape belief systems and life choices. The NLP therapist carefully assesses the structures found in a person's language of experience. Then he/she initiates therapeutic conversations and techniques, similar to trance or hypnotic induction, in order to restructure the client or family's beliefs, instill a sense of possibilities, and increase the likelihood of change. *The Structure of Magic I and II* and *Frogs into Princes* by Bandler and Grinder are three volumes that detail the methods and techniques that NLP practitioners use.

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## MILAN SYSTEMIC FAMILY THERAPY

### Overview

Systemic therapies originated in Milan, Italy with **Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata**. Like the strategic models of MRI brief therapy and Haley-Madanes, the Milan systemic model grew out of Bateson's work on cybernetics in which problems were viewed as being maintained by interactional sequences. While Erickson further influenced MRI and Haley-Madanes as noted above, the systemic therapies, at least originally, held more strictly to the Bateson formulations (Piercy, et al., 1986). Their 1980 seminal article, *Hypothesizing, circularity, & neutrality: Three guidelines for the conductor of sessions*, is summarized below.

The original Milan group, started by Mara Selvini Palazzoli, treated severely disturbed children using traditional psychoanalytic methods. They became increasingly frustrated at the lack of progress working with the children alone and were influenced by the writings of family therapists who worked with whole families instead. They first tried applying the psychoanalytic model to the families. After reading Bateson's work, Boscolo, Cecchin, and Selvini Palazzoli broke from the original Milan group and formed *The Center for the Study of the Family* with a goal of working in the new systems model. Watzlawick was originally a consultant to the group (Nichols & Schwartz, 1998). In the early years, the team conceptualized family problems as being maintained by homeostasis, or a tendency to resist change and devised paradoxical interventions to counter this tendency.

## Theory of Normal Development and Dysfunction

Like the MRI team, the Milan group adhered to a “non-normative” stance. Further, they maintained a neutral stance toward therapy outcome, trusting that if families were helped to see new ways of understanding their problems, they would find better ways of organizing themselves, without a need for reference to norms. Symptoms simply functioned to preserve family homeostasis and were maintained by interactional sequences.

## The Original Milan Model

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The first model was strongly influenced by the MRI strategic methods. Families were seen by a male-female dyad and observed by other team members. Each session had five parts:

1. Pre-session - the team formed an initial hypothesis.
2. Session - the hypothesis was validated or modified.
3. Intersession - the team met alone to form an intervention.
4. Intervention - the therapists returned to deliver the intervention, either a positive connotation or a ritual (see below), which was given in the form of a statement together with a prohibition against change, using paradox to counter resistance to change.
5. Post session discussion - team analysis of the session and formulation of a plan for the next session (Nichols & Schwartz, 1998).

The sessions were held one month apart to give families time to react to the interventions, and the total number of sessions was usually limited to ten. Two basic interventions, positive connotation and rituals characterized the early model.

***Positive Connotation.*** Positive Connotation is the hallmark of the early Milan systemic model. They believed that people could not easily change under the influence of negative connotation. For example, diagnostic labeling (a negative connotation) implies causality and implicates the person with the diagnosis. Positive connotation, by contrast, avoids linear causality and blame by *assigning a positive motive or value* to each family member’s behavior. Their initial intervention technique was similar to reframing (used by the MRI therapists) since the symptom was assumed to serve a protective function, and the goal of the intervention was to alter the way the symptom was viewed by the family. However, these therapists objected to the technique of reframing to the extent that family members feel blamed for creating problems in their families. Positive connotation “eliminated the implication inherent in such reframes that some family members wanted or benefited from the patient’s symptoms” (Nichols & Schwartz, 1998, p. 375) which might lead to greater resistance.

Positive connotations should be distinguished from reframing. Reframing can be positive or negative. It is directed toward one family member and ascribes meaning to a behavior. A positive connotation, on the other hand, always addresses every family member's part in the circular process that maintains the problematic interactions.

By contrast to the strategic therapies, in this model the problem is not thought to be "useful" so much as it is something the family has gotten used to. In a positive connotation, the family might be told, for example, that the patient should "continue to sacrifice himself by remaining depressed as a way to reassure the family that he will not become...abusive...like his grandfather. Mother should also remain overinvolved with [her son] as a way to make him feel valued while he sacrifices himself. Father should continue to criticize [mother and son's] relationship so that mother will not be tempted to abandon [her son] and become a wife to her husband" (Nichols & Schwartz, 1998, p. 375).

The Milan systemic model originated as a meta-consultation model. Treatment often included all people who might be part of maintaining the problem. For example, if the family had been referred by another therapist who, in the view of the Milan team, had become part of the impasse preventing change, the therapist might be brought in with the family (who might also be invested in keeping the therapist enlisted in its coalitions and the maintenance of its homeostasis) and would be included in the positive connotation. For example, the therapist might be thanked for helping the family by failing to require changes. Later in the development of the model, the Milan therapist dyad might also be included in a positive connotation by the observing team.

***Rituals.*** Rituals are interventions that enhance a positive connotation or require the family to either exaggerate or violate family rules. For example, to exaggerate a positive connotation a family might be asked to thank the symptomatic family member for having the problem. The family that maintains loyalty to an extended family to its own detriment might be asked to violate the family rule by holding secret meetings.

Over time, the team increasingly turned away from paradoxical interventions and focused instead on the processes that occurred during the therapy session itself. They developed interventions based on the concepts of *hypothesizing*, *circularity*, and *neutrality* (Piercy, et al., 1986). In 1979 the Milan team split. Selvini Palazzoli and Prata formed one group and Boscolo and Cecchin another. Selvini Palazzoli and Prata focused on interrupting the destructive family games in which disturbed families have become involved (Nichols & Schwartz, 1998). Based on this notion, they developed the invariant prescription (see below) for treating severe pathology. By contrast, Boscolo and Cecchin stayed with the concepts of hypothesizing, circularity, and neutrality (Piercy, et al., 1986) and became interested in changing family belief systems - *epistemologies* - which

eventually led the way into the solution-focused and narrative therapies (see Chapter 7: Postmodern).

### **Selvini Palazzoli and Prata**

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This team hypothesized that *power games* in the family lead to the development of symptoms in order to protect the family. Their theory of how psychotic games develop in families has six stages (Piercy, et al., 1996):

1. There is a marital stalemate between the partners.
2. The child becomes an ally with the parent he/she perceives to be the “loser” in the stalemate.
3. The child develops a symptom in an attempt to both challenge the winner and demonstrate to the loser how to contend with the winner.
4. The loser does not understand the purpose of the symptom and sides with the winner in disapproving of the symptomatic behavior.
5. Now desperate, the misunderstood child continues the game and the symptom.
6. The game becomes stabilized as the family believes the child is crazy and develops methods of dealing with their crazy child. In this way the psychotic behavior is maintained.

### **Assessment and Treatment**

Before the 1990s when Selvini Palazzoli and Prata were engaged in systemic work, the goal was to help the parents form a stable alliance and thereby alter the patterns of interactions among family members. The intervention, the *invariant prescription*, was the same for all families (Nichols & Schwartz, 1998). The team directed the parents in the formation of a secret coalition. First, the parents met with the therapists without the knowledge of other family members and then began taking longer and longer secret trips so that eventually they were away for several days without telling other family members. They were asked to keep notes on family members’ reactions to review with the therapists.

By the mid-1990s, although still influenced by her years of systemic work, Selvini Palazzoli returned to long-term psychodynamic treatment models for individuals and families. “This new therapy revolves around understanding the denial of family secrets and suffering over generations” (Nichols & Schwartz, 1998, p. 376).

### **Boscolo and Cecchin**

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Boscolo and Cecchin became interested the processes that occurred during the therapy sessions. They believe that when families gain new information in a

session, providing them with an understanding of the tacit beliefs and rules under which they operate, or its *epistemology*, they are stimulated to find a new epistemology that allows new ways of operating. The goal of therapy is simply to introduce new information rather than set specific goals for changes (Piercy, et al., 1996). The therapist asks the family questions that “are designed to decenter clients by orienting them toward seeing themselves in a relational context and also seeing that context from the perspectives of other family members” (Nichols & Schwartz, 1998, p. 376). The therapist is curious about how the family system operates, but indifferent to any particular outcome because to do so would unduly pressure the family (Nichols & Schwartz). Instead, the therapist generates multiple new hypotheses to help the family find different ways of viewing and understanding their problems.

The model is characterized by the concepts of *hypothesizing*, *circularity*, and *neutrality* that originated in the work before the split in the Milan group.

### **Assessment and Treatment**

*Hypothesizing* is an assessment tool through which the therapist begins an exploration into the family system and invites the family to join him/her in the investigation. Hypotheses must be systemic. That is, they must take into account all relational components of the family. The working hypothesis guides the circular questioning. “Without [a] hypothesis [the therapist’s] questions will lack a coherent meaning and bring no new information to the family” (Piercy, et al., 1996, p. 61). Alternate hypotheses develop through the questions the therapist poses to the family; responses from the family lead to new hypotheses by the therapist, which leads to new questions, more responses, and new hypotheses. All hypotheses are considered equally valid (Piercy, et al., 1986) so long as they provide new information about how the family system operates.

Influenced by Bateson’s work, the Milan group (i.e., Boscolo and Cecchin) believe that premises, values, or guiding principles might be unconscious. In forming hypothesis and questions, they look for a premise or myth that holds the behaviors attached to a problem. If the premise can be shifted, change might occur together with the change in beliefs.

*Circularity* refers both to the attributes of member-to-member interactions and to the form of interactions between the therapist and the family. Any individual family member’s behavior must be understood to be *part* of a circular sequence of behaviors, but *not* its origin (as it would with linear causality).

*Circular Questioning* is the therapy interview technique. Most interactions between the therapist and the family consist of questions and responses. The questions posed to the family are based on the therapist’s hypothesis and require responses that are *relational* descriptions of family interactions. This helps members see the perspectives of other members. For example, a father may be

asked to tell how his wife sees her relationship with her son or a child might be asked what might happen to his brother (who is symptomatic) if their mother and grandmother didn't fight so much. Circular questions also explore aspects of family interactions such as the degree and time of the problem, e.g., Did that occur before or after? How much? How often?

***Neutrality (Curiosity) and Irreverence.*** Neutrality was the term originally used to describe the attitude of the therapist toward the hypotheses generated in treatment. It has been replaced by "curiosity" and is the basic therapeutic stance. The therapist conveys an attitude of curious exploration when asking questions or responding to the family members' answers. Recently, Cecchin suggests that therapists also convey "irreverence," that is, he/she should not be inclined toward any one or another set of rules or beliefs that might govern the family interactions and should encourage a similarly irreverent attitude in family members (Nichols & Schwartz, 1998). One way the therapist could encourage irreverence and/or a more flexible view of the family beliefs, is through the ***odd day/even day ritual***. The therapist would give a directive that on odd days one set of opinions would be true, but on even days, false. The directive for the seventh day is to act spontaneously.

The therapist is also neutral with respect to his/her relationship to each family member, being careful not to form coalitions or take one side against another. He/she avoids a moral or judgmental position toward a family's ideas or preferred outcome, since they believed that the therapy could and should only perturb or disrupt the system, not direct the family toward any particular outcome.



Boscolo, L, Cecchin, G., Hoffman, L. & Penn, P. (1987). *Milan systemic family therapy: Conversations in theory and practice*. New York: Basic Books. Introduction: From psychoanalysis to systems. 3 - 28.

This chapter describes the evolution of the authors from a psychoanalytic to a family systems orientation and the changes that have occurred in their model over time. Boscolo and Cecchin joined Selvini Palazzoli's group in Milan, Italy. The group originally treated severely disturbed children and their families using a psychoanalytic model, but found this model discouraging and frustrating and the treatment prolonged. They turned to the work of the Mental Research Institute (MRI), particularly the ideas of Bateson on double bind communication in his 1972 book, *Steps to an Ecology of Mind*.

The MRI therapists focused on relationships rather than individual pathology. The Milan team expanded on the MRI work. Changes in symptoms and problems, then, proceeded from changes in interactional patterns. Pathology

derived from double bind communications with their contradictory messages. Schizophrenia, for example, was seen as a “mistaken epistemology that any one person can unilaterally control relationships” (p. 5). This epistemology implies linear causality and leads to one person trying to exert control, which in turn leads to the other trying to re-exert control in an endless and fruitless game. Based on their own work with families with a member diagnosed with schizophrenia, the Milan group concluded that: 1) the families are involved in unacknowledged family games; 2) family members, through these games, try to control each other’s behavior; 3) the therapist’s job is to discover the games and stop them.

Evolving from the MRI game and coalition theories, the Milan group, in those early years, assumed an adversarial style; the family against the therapists, and they focused on resistance to change. The therapist did not challenge the family directly, but rather used “creative deceptions – paradoxical prescriptions – that would bypass...resistance” (p. 7). A family could hardly resist changing if a therapist told them to continue the behaviors they were already engaged in.

The heart of the early Milan treatment model was *positive connotation*, an outgrowth of the MRI symptom prescription technique. “A positive connotation is a message to the family from the therapist[s] that the problem is logical and meaningful in its context” (p. 4). They argued that simply prescribing the symptom “negatively connoted family members’ anti-symptom views [and to the extent that the ] symptomatic member [was] exonerated, other family members would feel at fault (p. 7). Instead, they positively connoted not only the symptom, but also the behavior of other family members. The intervention was aimed not at an individual, but at the *self-maintaining tendencies of the system as a whole*. The symptom was prescribed *in relation to its social context*, and resistance was reduced. The method was in keeping with the emerging “nonlinear, systemic consciousness that was to distinguish the Milan method from previous approaches in the family field” (p. 8-9).

In their early treatment in the 1970s, the team was divided into two male-female dyads. One would interview the family while the other observed from behind a one-way mirror. Families were seen weekly for ten sessions. The team later changed to having one member of the team with the family and one other observing, and the time between sessions lengthened to monthly. The use of observation teams (O-Teams) originated with the Milan group. It offers a way to bring in trainees and provide on-going supervision. Rather than being fixed in one method, the teams have shown the ability to experiment and evolve into different forms. Although there are Milan teams around the world, they have been less numerous in the United States where they have often been absorbed into strategic teams working in the MRI model or using an Ericksonian approach.

During this time, the Milan group was again influenced by Bateson's writing, particularly the idea of cybernetic circularity as a model for human systems. Boscolo and Cecchin began a dramatic shift in their work from strategic to a systemic view. Their work and teaching then led to the method of circular questioning and the publication of, *Hypothesizing, circularity and neutrality: Three guidelines of the conductor of the session* by Selvini Palazzoli, Boscolo, Cecchin, and Prata.

The team translated Bateson's ideas of cybernetic circularity into a systemic treatment model. Hypothesizing is the assessment process; circularity and circular questioning is the technique; and neutrality is the basic therapeutic stance. Their systemic hypotheses account for all the elements of the family problem and how they are connected. It is a model that emphasizes that the team and the family are engaged in a research project together. The validity of the hypothesis is less important than its utility in providing new information about how the family operates and helps the family progress.

***Circular questioning*** was based on Bateson's idea that "knowledge is always apprehended by mechanisms that scan for difference" (p. 11). The questions provide feedback to the therapist regarding family relationships. The therapist conducts the investigation and hypothesizing based on information gained about relationships in the family and about differences and change. The questions fall into several categories: differences in perceptions of relationships (who is closer to grandfather); differences in degree (how bad was the fighting this week); now/then differences (did the fighting start before grandfather died or after); and hypothetical or future questions (if grandfather had not died, how would life be different).

***Therapeutic neutrality*** grew from Bateson's assertion that all parts of the system should be accorded equal weight. In being neutral the therapist regards each person in the system as equal and each person's viewpoint, valid. The therapist does not take a moral position with regard to any part of the family process. The therapist can observe a variety of collusions and coalitions without being inducted into any of them. Neutrality maintains the therapist in a hierarchically superior position (meta-level) without being authoritarian, such as Haley or Minuchin.

In the 1970s the Milan group addressed a difficulty they often encountered when the family was referred by another therapist. When these families failed to improve, the team surmised that the original treatment had reached an impasse because the therapist had been inducted into the system. Further, the family's loyalty to the therapist hindered progress in the new treatment context. As a result, the Milan team began "honoring" the therapist by including the therapist in the treatment and positively connoting the homeostasis. They might, for example, thank the therapist for helping the family by failing to produce change,

leading to shock and surprise in the therapist and family. The team would confer without including the therapist as if he/she were a member of the family. If the team cautioned the family not to change, the referring therapist was free to disagree. The family maintained its loyalty to the therapist, siding with him/her to prove the consulting team wrong by changing. This process, known as meta-consultations, solidified the use of the observing team, and the Milan therapist in the room with the family was not exempt from being included in the positive connotation if the therapist and family were stuck.

More recently, the model has been characterized as a *second-order cybernetic systems approach*. First order cybernetics “pictured a family system in trouble as a homeostatic machine....with symptoms playing an important part of maintaining the homeostasis” (p. 14). The therapist and family were separate entities. Second-order cybernetics conceives of the therapist and family as one unit. As von Foerster (1981) noted, “[T]he observer enters into the description of that which is observed in such a way that objectivity is not at all possible....There is no such thing as a separately observed system” (p. 14). It is misleading to conceptualize the family as a separate entity; rather it is “better to think of the treatment unit as a meaning system to which the treating professional is as active a contributor as anyone else” (p. 14). The system does not create the problem; the problem creates the system.

Other changes have evolved in the Milan approach. Newer interventions reflect greater neutrality. Formerly, the closing statement of a session included a statement of paradox or so-called *sacrifice intervention*. The person with the symptom was characterized as being *in the service of* the homeostasis, an intervention that overcame resistance by causing a rebellion against the symptom. While the family improved, members might feel guilty or blamed. More recently, paradox is used less and the messages are more neutral, in that they place “all the behaviors related to a problem in the service of a shared premise, value, or myth” (p. 16). In this way, no one in the family feels blamed, and the message “elucidates the double-level bind” (p. 16).

Additionally, the team has changed the positive connotation. When a symptom was positively connoted, it implied that the symptom was needed by the family and, therefore, was good. But the family experienced the problem as terrible, and the characterization of it as good could be perceived as mocking. The team began using more of a *logical connotation*. “There is no need to say that a problem is useful, beneficent, or functional – only that people have gotten used to it and that such habits are hard to break” (p. 16). The development of the symptom is neither good nor bad, but understandable, given the context.

The team has also altered its use of *rituals*. “A ritual is an ordering of behavior in the family either on certain days...or at certain times” (p. 4). In the past, the ritual amplified a symptom to explode it. (The family might solemnly thank the

symptomatic member each day for having the symptom.) More recently, the ritual consists of simultaneous conflicting directives. (The mother is asked to be simultaneously wife to her husband and mother to her daughter. But on even days she is told to be wife to her husband and on odd days, mother to her daughter.) In general, Boscolo and Cecchin believe that all interventions should try to do is perturb the system so that it can react on its own terms. Interventions, then, are not geared toward any particular outcome, but rather to jog the system to find its own solution, often in ways that are surprising to all.

The Milan team has been influenced by cognitive biologists (e.g., Maturana and von Foerster) and radical constructivists (von Glasersfeld). Greater validity is given to the concept that reality is a social construct rather than based on “real” external events and objects. “Ideas, beliefs, myths, values, perceptions, fantasies, and other internal productions” (p. 19) assume greater importance. Families unconsciously construct maps or premises about their world to help them understand what is happening. The therapist looks for the premise that attaches the behaviors to a problem, and tries to articulate it to the family. The family may then shift its premise, and change behaviors accordingly. Thus, *meaning*, for the Milan team, is primary, and the new behavior, in MRI terms, would be characterized as stemming from a second-order change.

In the 1980s Boscolo and Cecchin split from Selvini and Prata, becoming the Milan Associates. The Associates focused on training, while Selvini and Prata focused on research. The training that they have done has helped shape the treatment model. The trainers worked in small private clinics; whereas, the trainees tended to work in public settings where the ideas espoused by the family systems therapists were met with hostility. In addition, the families were resistant to the idea that the whole family needed treatment, since the existing models suggested that only the person with the symptoms needed treatment. The trainees were dealing not only with families, but with the treatment milieu as well. Clearly, the larger context, or the “significant system” in which the treatment occurs had to be considered. The schools, courts, clinics and cultures that the therapists and families are involved with may all have an effect on the treatment. The impact of the feedback from the students and the systems has caused the Milan Associates to “think of themselves not as family therapists but as systems consultants” (p. 24).



Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1980), Hypothesizing – circularity – neutrality: Three guidelines for the conductor of the session, *Family Process*, 19 (1), 3-12.

This article outlines the three principles – hypothesizing, circularity, & neutrality – developed by the Milan group for conducting therapy. The

information that is known about a family prior to the first meeting forms the basis for an initial hypothesis about the family process: names, ages, jobs, education, referral source, reported problem, and the like. According to Selvini Palazzoli, The hypothesis is an

unproved supposition tentatively accepted to provide a basis for further investigation (p. 5) based upon the information [the therapist] possesses regarding the family....The hypothesis establishes a starting point for his [or her] investigation as well as his [or her] verification for the validity of this hypothesis based upon specific methods and skills. If the hypothesis is proven false, the therapist must form a second hypothesis based upon the information gathered during the testing of the first (p. 4).

The hypothesis, then, helps the therapist decide what he/she might particularly attend to in the first session and leads to uncovering essential information. It may be that the data gathered in the first session rules out the initial hypothesis completely and the new information forms the bases for an alternative hypothesis. *Making hypotheses requires that therapists take account of all observations and organize them into a meaningful construct.* Thus, the action regarding hypothesis building is experimental. New information leads to confirmation or rejection of the working hypothesis followed by the formulation of refined or altogether new hypotheses.

The value of a hypothesis is not tied to whether or not it is true or false, but whether it is more useful or less useful as a guide to furnishing the therapist and family with new information. The hypothesis functions as a discipline to the treatment and a guide to gathering new information. It helps the therapist track the interactional patterns. Working through a hypothesis keeps the therapy from falling into disorder and muddle. Systematic, active hypothesis testing helps counter *entropy*. Entropy in a system refers to “the disorder, disorganization, lack of patterning, or randomness, [and a] decrease in entropy can be taken as a measure of the amount of information” (p. 6).

*Circularity*, to Selvini Palazzoli, refers to “the capacity of the therapist to conduct his [or her] investigation on the basis of feedback from the family in response to the information he [or she] solicits about relationships and, therefore, about difference and change” (p. 8). The Milan team defines circularity as the ability to obtain authentic information from the family. Using a construct from Bateson – “that all knowledge of external events is derived from the relationship between them” (p. 8) – suggests that in order for the therapist to obtain authentic information, every member of the system must describe his or her view of the relationship between other dyads of the system. For example, a wife would be asked how she sees the relationship between her husband and their son.

Resistance is lessened if one part of the system comments on another. In this way, circular questions unearth a wealth of information about the triadic

relationships in the family and effectively break the rule(s) in dysfunctional families about secrets.

The Milan team offers other suggestions for gathering information:

- Gather information in terms of specific interactive behaviors – not feelings or ideas – in specific circumstances, e.g., who does what, when, how many times?
- Ask questions about differences in behavior, e.g., who does it the most? the least?
- Get information regarding ranking of behaviors of interactions, e.g., who goes to church more often? next frequently? least often?
- Ask hypothetical questions and listen to how each member of the family reacts to the symptom behavior, e.g., if this were to happen, how would it affect mom? dad? The model is triadic, i.e., family members relate to one another through the problem or through other family members.
- Obtain information about changes in relationships, e.g., before dad got ill who was fighting? how much?

The more information gained from each subsystem member, the larger the field of observation. Once a relatively clear picture is assembled, the field is enlarged to include relationships with extended families and families of origin.

The Milan therapists maintain a neutral relationship with each family member. At the end of the session, family members might have a sense of what the therapist is like, but should have no sense that he/she has sided with anyone or made any judgments about the entire family. Circular questions shift the alliance from one member to the next as each is asked to comment about the other relationships. The more interested the therapist is in obtaining information, the less he/she is apt to make moral judgments. Therapists make a conscious effort to thwart family members' efforts to form coalitions with him/her. The therapist is effective only insofar as he/she is able to remain at a different level – a metalevel – from that of the family.