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BRIEF STRATEGIC-SYSTEMIC APPROACH TO CANNABIS ADDICTION: INVOLVING THE FAMILY SYSTEM TO OVERCOME ADOLESCENT CANNABIS ADDICTION

Matteo Papantuono & Claudette Portelli

Drugs addiction: a social phenomenon

Advanced technology and medical advancement, has induced contemporary man to hold the illusion that his/her objectives (whatever they are), can be reached without linger and with very little effort invested (Nardone, 2003). Even when faced by mundane challenging life-hurdles, we tend to look out for miraculous remedies and potions, entailing very little fatigue from our side, to anesthetize this 'intolerable pain'. Fat busters, sleeping pills, anxiolytics, concentration pills, anti-aging *elixirs* and pain relief pills, alcohol and other substances such as hashish, marijuana, cocaine etc., even though officially illegal, are still easily accessed and consumed to smoothen out life in a more desirable way. Drug consumption embodies a key paradox of our society. Even though they are considered dangerous and are thus illegal, drugs are amongst the most profitable investments of our times, and unfortunately they are held by their consumers as a prohibited yet privileged means of reaching a state of being, free from pain, fatigue and effort.

The use, abuse and addiction of cannabis are often underestimated, often referred to as "innocuous light-drug". Yet cannabis can become both emotionally and mentally addictive. Addiction to cannabis is severe due to its affect on the user's brain. We are now aware of many facts about cannabis's effect on the body and how delta-9-tetrahydrocannabinol (THC), the major active chemical, acts in the human brain. When cannabis is smoked, THC travels quickly through the body and into the brain where it unites with specific receptors on nerve cells. Areas of the brain with the most receptors affected by THC are parts of the brain that control pleasure, thought, memory, sensory, concentration, time perception, and coordination. This is what induces physiological dependency.

Yet cannabis is highly addictive even psychologically. Once an individual becomes addicted to cannabis it develops into part of who

they believe themselves to be. Avoiding their friends who do not use, the addict will gravitate to others that do. Cannabis is a topic that is always on their mind, whether it be thinking about the next time they will be able to get high or where their going to get their next sack. We can call it addiction, when the person no longer does anything without first smoking. Their constant abuse is due to the misconception that cannabis is what they need in order to solve their problems (this will be elaborated further in the section ***Drugs an additional attempted solution: an operative diagnosis***). Sometimes addicts will take their stash with them wherever they go, just in case they need to make use of it to face the situation better. Individuals might keep in contact with several dealers in order to make sure they always have a constant supply of cannabis.

The cost of cannabis use to the individual (whose addiction tends to escalate), is quite high. Individuals may suffer health and social consequences, memory and learning problems, and high absenteeism might rise problems at work or even result in even losing a job. While they usually end up isolating themselves from friends and family, this often puts a heavy strain on relationships with loved ones. There is a vicious cycle to cannabis addiction in which these problems are often used as a rational or an alibi to smoke even more pot. Cannabis addiction is a no-win situation that many unintentionally fall for to solve the problems, but this is a clear example of when the attempted solution becomes the actual problem.

Drugs an additional attempted solution: an operative diagnosis

Especially during adolescence, where the young adult is easily bored, impatient demanding everything here-and-now, often unprepared for the challenges offered by life, he can easily fall into the illusionary trap set by drugs, that of being able to help him/her overcoming the problem, ending up entrapped in a psychological and physiological dependency which further aggravates his state.

Young people are even more prone to cannabis use since at this phase of life the individual is very vulnerable, very insecure about his self-worth and competence (Erickson, 1963). This seemingly "innocuous light drug" is often regarded by these self-doubting youngsters as an easy and efficient means of managing the emotional tempest (fear, anger, pain and search of pleasure), vividly and intensely lived during this critical age. Often drugs are regarded by the young inexperienced man, as a solution to reach desired yet rather challenging goals of prime importance at this age, such a: to be accepted and respected by one's peers, whose judgment is imperative for the young man; to facilitate socialization and social

integration, by overcoming one's fears and inhibitions; to put on a winning transgressive image, who is not afraid to dare rules, norms, authority, etc; to find one's own identity to measure one's own worth in the world; to let go the child image and lose free from his dependency from the adults; to explore unknown aspects of oneself and thus widen one's own identity; to avoid life responsibilities and others. Often faced by these challenges, the young man gets frightened and could believe that he "can't make it on his own". This sense of incapability makes him search for a miraculous effortless solutions and unfortunately drugs can at first, give this illusion. It seems as if the substance is regarded by the young consumer as a rapid means to become "*how I would like to be*" (Rigliani, 2004). But besides failing in reaching this illusionary goal, the use of drugs becomes a true addiction, both physiologically but also psychologically confirming the underlying irrational idea, "I cannot make it on my own", "I need the substance cause I cannot make it on my own". This becomes a clear example of what Watzlawick and Nardone (1997) explained as rational act that confirms an irrational belief. The frequent use of drugs ends up confirming the negative self-judgment, the negative prophecy. "As Hobbes (1969) writes in Behemoth, "Prophecy is many times the principal cause of the events foretold", thus the young before putting his abilities to the test, slave to his prophecy ends up "creating (a self-destructive future) out of nothing" (Anonymous, 1990).

Over time, this belief based on a negative prophecy, gets consolidated by the psychological relief and physiological pleasure given by the narcotic, entrapping the young person in a self-destructive viscous circle. The recurring use and abuse of the substance strengthens the negative self-perception to confirm the underlying credence of being incapable to manage life-hurdles with only one's own resources. In fact every time the Youngman turns to drugs he will be convey to himself two messages, which ensnares him in a double bind (Bateson, Jackson, Haley, Weakland, 1956; Nardone, Watzlawick, 2005; Nardone, Portelli, 2007). The first clear and most immediate message is "*drugs are the solution to my problems*", while the second which is more subtle yet equally powerful is "*Can not do it without drugs*". This last message slowly lays its foundations in the person's perceptions and reactions. This need to delegate one's responsibilities to the substance starts to grow, spreading like wildfire, granting drugs with an irreplaceable role in the life of the person, who fortifies his distrust in his/her abilities.

Drugs become a reiterated failed attempted solution which like a heavy armor can at first give the illusion of protecting the person but which overtime end up imprisoning its consumer. The person, who uses abuses and/or is dependent on cannabis, is caught in this double bind, which renders himself resistance to change. We can call this subjects content oppositional persons (Watzlawick, Nardone, 1997) where the substance offers them numerous advantages (Watzlawick, Nardone 1997; Nardone, Mariotti, Milanese, Fiorenza, 2000; Nardone, Portelli 2005; Papantuono, 2007); advantages given directly from the substance (pleasurable physiological sensations, alienation from life problems, acceptance by the peer-group whose members share the same transgressive ritual, and others) and others which are granted indirectly and paradoxically by the family system (an not only- school, community, etc) around them. This is why involving the family members become a fundamental aspect of therapy. Also because it is they who often lament of the problem and ask for therapeutic and surely not the youngster who is still overwhelmed by the illusion of having found the right solution. There are so many secondary gains, to stop the youngster to look for help (Watzlawick, Nardone 1997; Nardone, Mariotti, Milanese, Fiorenza, 2000; Nardone, Portelli 2005, Papantuono, 2007).

Involving the family system: reducing secondary advantages

Unfortunately, literature reveals that often when dealing with addictions and other psychological problems, the family system is put into play, or better put under investigation, to find the causes or better to find whom to blame for the youngster's destructive behavior. Once more this approach entraps the individual and the entire family system in a vicious circle with no way-outs because as far as we know, nobody can erase or change the past. Moreover, nature has and continuous to offer us, consistent substantial evidence that all phenomena seem to develop not from a mere deterministic linear causality but actually from a circular one, where all the elements in a system effect unconditionally one another, and the family system is no exception.

Brief strategic-systemic interventions involve the family *in primis* because besides the fact that they are usually the ones to lament of the dependency as a problem, they are, in the great majority of the cases, responsible of offering further secondary gains to the use, abuse and addiction to drugs. In our contemporary society, individuals remain at home with their parents for an always longer period, taking advantage of the situation (attention, money, and home comforts). Often this "free-zone" allows the youngster to avoid

taking adult-life responsibilities. Parents, as Oscar Wilde denotes “*with all the good intentions, end up producing the worst consequences*”.

Family models: overly responsible-avoiding responsibility continuum

Usually the coping attempts put forward by the family members to help their children who use, abuse and dependent on drugs can be placed onto a continuum (overly responsible- avoidance of responsibility) with one end co-notated by the parents’ belief “*we have to do more because it is never enough*”. In other words, these are those families that become always more in-charge of their son’s/daughter’s responsibilities, taking the place of the “fragile incapable” child so as to avoid loading him/her with responsibilities and difficulties which would require too much effort from their poor sons (Nardone, Giannotti, Rocchi, 2001). As a consequence, the youngster will continue to make use of the rather advantageous attitude, resisting to anything that might sabotage this situation which “after all it is not so bad”.

The rigid ***overprotected, democratic-permissive*** and ***sacrificing “family models”*** (Nardone, Giannotti, Rocchi, 2001) can be located on this side of the continuum since all tend to act “*overly responsible*” with their children, especially in times of trouble such as their son’s addiction. While ***delegating*** and ***authoritarian families*** tend to “*avoid responsibility*”. These are parents who feel disarmed in front of their son’s/daughter’s addiction and give up on the situation. Delegating parents believe that they are incapable or inadequate to help their child thus delegate this problem to others: own parents, friends, school, experts, specialists, etc. Authoritarian can not accept the fact that their son has gone against their teachings and failed their expectations, often arriving to renegade them as their son/daughter. They feel that they have failed as parents and often react by giving up on their child. ***Intermitting families*** are in continuous doubt and tend to oscillate from one extreme to another. While abandoning the reassuring positivistic thesis of the existence of a “scientifically true” knowledge of reality (why is my son into drugs? What induced him to use abuse and depend on drugs? Was it the school, his friends, are moving house? Are we parents to blame? etc) and a deterministic cause-effect approach, Strategic-systemic interventions are concerned with identifying operative constructive knowledge, that is to increase what von Glaserfeld

(1984) has called “operative awareness”: *to discover how things function and how to make them function better* (Nardone, 1998; Nardone, Portelli, 2005).

Without any claim to a priori knowledge of phenomena at hand, the strategic therapist needs to have some “reducer of complexity” available, which will allow him to start working on the reality that needs to be modified, to gradually reveal its functioning and render it more functional. Based on the studies of the Palo Alto school (Watzlawick, Beavin, and Jackson, 1967; Watzlawick, Weakland, and Fisch, 1974; Watzlawick, 1977; Fisch, Weakland, and Segal, 1982), and on twenty years of research in the clinical context (Watzlawick and Nardone, 1997; Nardone, 1996; Nardone and Watzlawick, 2004; Nardone, Portelli, 2005; Milanese, Mordazzi, 2007), such a reducer of complexity has been found in the construct of *attempted solutions*. We have observed that in problematic situations such as their son’s substance abuse, the parents’ attempts to reiterate the same ineffective solution eventually give rise to a complex process of retroactions in which the efforts to achieve change actually keep the problematic situation unchanged. There seems to be a “circular causality” between how a problem persists and the dysfunctional ways people use to solve their problem (Nardone, Portelli, 2005).

With all the good intentions parents react in a certain way (attempted solutions- overly-responsible behavior, avoid responsibility) in line with their beliefs (perceptions), but by doing so they will end up confirming their own (my son is weak, I’m no a good parent, nothing can be done) and their sons (I can not make it on my own, I need drugs) often irrational beliefs, giving way to a self-fulfilling prophecy. Thus strategic-systemic approach focuses its intervention with the family by:

- Blocking the redundant attempted solutions through direct or indirect maneuvers.
- Using in-session reframing that change the underlying dysfunctional perception, along with between-session solution-oriented techniques to change the dysfunctional prophecy.

In the majority of the cases, substance abusers are reluctant to come to therapy, because they do not perceive drugs as a problem and often they minimize and ridicule their parents’ preoccupations. And as we have mentioned earlier, drug use seem to bring along various

secondary advantages which the youngster is often reluctant to lose. So often therapy involves in-direct intervention with parents, to help them minimize as much as possible the secondary advantages which they were unaware of giving their son/daughter. Often this is enough to make the son take in consideration looking for help, since the negative aspects of his addiction might come to out-weigh the positive.

Yet clinical experience has lead us understand that even when the youngster comes to therapy with a desperate need to be help, he/she is very much resistant to change. We have learnt that most youngsters are oppositional or else would like to collaborate but are not able to. Clinical- experimental research has showed us that if we had to focus therapy immediately on the abuse or addiction, defining it as the problem, this would increase the patients' resistance to therapy. First we need to create an adequate therapeutic alliance, by tuning in with the patient's "world", and we can start doing this first by using his own language (Nardone, Loredano, Zeig, Watzlawick, 2006). So to avoid creating symmetry with the youngster, the session will be proposed as a means to evaluate the situation and the actual level of severity of their abuse, which might not coincide with the version presented by the parents. This because in most cases, youngsters do not consider cannabis as a problem. They will only come to "regret" their abusive behavior and look for help, if the secondary advantages do not outweigh the negative aspects of their addiction.

During the first session, the therapist will try to identify what the youngster considers a problem, which can be his rapport with his/her parents who are too suffocating, his/her school profit, his/her relationship with the opposite sex, etc. The aim of the therapy would be that of helping the patient "*learn better ways to manage his life*". In other words, we start our work by defining with the youngster our objective by following a Chinese stratagem "lying by saying the truth".

If the therapist manages in this mission, to capture the youngster, one might say that a good deal of the work has been done, so that the therapist can then proceed in helping the youngster free himself from his addiction. Aristotle says "a good start is half of the work" which fit well in such cases. The intent is to shed a ray of light for the youngster to follow, so as to come out from this dark seemingly endless tunnel. Indirect-therapy can be the first step when there is

high resistance to change. This intervention follows an old saying which states “to block the door with the foot to make space for the rest of the body”.

Yet even when the youngster continues to be highly resistant to change, and does not actually arrive to therapy, in-direct therapy conveys the whole family system a sense of relief since during the therapeutic process they are given instruments that enable them to handle the problematic situation better, while helping them withdraw from being, with all the good intentions, accomplices of their son's abuse.

The use of indirect therapy involving the parents of the abuser, is the result of an over-twenty-year clinical experience at the Centro di Terapia Strategica of Arezzo and its numerous affiliated clinics around Europe, coordinated by Giorgio Nardone, which has been thoroughly presented in the textbook “*Come Smettere di fumare*”-How to stop smoking edited by Branka Skorjanec (in press). This indirect maneuver has resulted to be highly effective and efficient with cannabis addictions in young people since it overcomes the high resistance to change showed by the youngster, while empowering the parents in their often challenging child-rearing task.

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INTERACTION FOCUSED THERAPY OF ADOLESCENT AND YOUNG ADULT SUBSTANCE ABUSE

Wendel A. Ray and Matthew Borer¹

Five decades after the pioneers of family theory introduced the paradigmatic shift that is system therapy (Kuhn, 1962; Bateson, 1972; Bowen, 1978; Jackson, 1968 a & b) the prevailing view of adolescent/young adult substance abuse continues to be that, like addiction seen in adults, it is a medical disease, the treatment of which requires detoxification followed by a lifetime of complete abstinence, preferably following the AA 12 step approach to recovery (Pattison & Kaufman, 1982). Most treatment orientations place emphasis on peer influence, and to a lesser extent family dynamics are seen as relevant, but secondary to the physiological aspects of the substance abuse.

While not taking issue with the potentially physiological addictiveness of certain substances, we will approach the subject of young adult/adolescent substance abuse from a different direction. A team of researchers during the 1950's, 60's, 70's, and 80s that came to be known as the Palo Alto Group conducted a wealth of relevant research. During the past eighteen years the lead author has studied, practiced and taught the principals of Communication or Interactional Theory, and used them in teaching and the clinical supervision of more than 300 therapists trained here at the University of Louisiana at Monroe (ULM) Marriage and Family Therapy program, and in workshops and training seminars conducted across North and Central America, Europe and the Far East. Major contributions of other systemically focused researchers have been studied, and often incorporated into the Communication/Interactional approach that guides clinical practice here at our clinic, see for example the work of Stanton, Todd, and associates (1982), Todd and Selekman (1991), Haley (1980), Bowen

¹ Wendel A. Ray, PhD, is Professor of Family System Theory at The University of Louisiana at Monroe (ULM) Marriage and Family Therapy Program, a Senior Research Fellow at the Mental Research Institute (MRI), and Founder and Senior Archivist in the Don D. Jackson Archive. Matthew Borer, M.A., is a Doctoral Candidate in The University of Louisiana at Monroe (ULM) Marriage and Family Therapy Program and Research Assistant in the Don D. Jackson Archive.

(1978), Berg and Miller (1992), and McCollum and Trepper (2001). And yet, the Interactional Theory introduced by members of the Palo Alto Group remains the foundation of clinical work here at our center principally because of our belief that our success in treatment is equal or superior to that of other centers using alternative theoretical orientations to guide their work. As one of the original members of Gregory Bateson's research group, John Weakland, was fond of saying, "If it is not broke, don't fix it".

This paper will briefly describe the principals of Communication or Interactional Theory pioneered by members of the Palo Alto Group which are used as guiding presuppositions for clinical work with adolescents exhibiting substance abuse behavior being treated by master and doctoral students supervised here at the ULM Marriage and Family Therapy Clinic, and in the private practice of the first author. It is the thesis of this report that the central therapeutic issue involved in adolescent/young adult substance abuse is fear of change (separation and loss) in the adolescent's family (Jackson & Watzlawick, 1963; Stanton & Todd, (1982). The onset of the symptom of substance abuse will be conceptualized as a problem for the individual young adult/adolescent and simultaneously as a solution for the developmental dilemma troubling the family. This developmental dilemma must be addressed for successful treatment of adolescent/young adult substance abuse. Substance abuse does not generally become problematic until adolescence. At this time the adolescent is expected to actively engage in heterosexual and other intense relationships outside the family. If she/he does, however, he/she becomes less available and less attached to the family. This threatened departure can cause fear and panic in the family (Haley, 1973; Jackson 1967; Jackson & Watzlawick, 1963). In essence, intense involvement outside the family on the part of the adolescent can be understood as a proposal by the adolescent that the existing definition of the nature of the relationship between themselves and parents must change. This emotional process occurs mostly outside the awareness of those involved. Typically, the parents have developed a pattern of interaction which involves triangulating the substance abusing offspring into their relationship, rather than communicating directly with each other about the dissatisfaction each feels about the nature of their relationship. Pressure on the adolescent/young adult not to leave (i.e. not to change the nature of the relationship) is so great that the family will endure terrible indignities (ex: lying, stealing, public shame, etc.) rather than take a firm unequivocal, position in relation to the adolescent becoming

responsible. The parents (or parent figures) usually split in terms of how to handle the inappropriate behavior of the adolescent/young adult substance abuser, with one protecting him from outside agencies and the other blustering but taking no effective action toward helping the adolescent to act responsibly (Ferreira, 1960). The only thing the parents can agree on is that the young adult/adolescent's behavior is bad (willful disobedience) or mad (senseless). Rather than accept partial responsibility themselves, family members usually blame external systems (peers, neighborhood, schools) for the substance abuser's problems.

Should the parents take effective action, such as evicting the substance abuser, they often undo their action by overtly encouraging his/her return; i.e., give them one more chance (Haley, 1980). It becomes nearly impossible for the addict/substance abuser to negotiate his/her way out of the family as the mixed messages from the parents seem to say, in effect, "we will suffer almost anything, but please don't leave".

The formal structure of the message to the adolescent is something like this:

1. Grow up and be responsible. (Verbal)
2. You are really not capable of it. (Nonverbal)

The message is often split, with one parent conveying one message and the other the opposite.

An Interactional Model of Adolescent Substance Abuse

Two main constructs form the underpinnings of an interactional model of adolescent substance abuse: family homeostasis (Jackson, 1954/1957) and the double bind (Bateson, Jackson, Haley & Weakland, 1956; Jackson & Weakland, 1961). The concept of family homeostasis emerged from

...observations that psychotherapeutic efforts with one member of a family might be hindered, or that another member might become disturbed as the member in treatment improved ... these observations, in connection with existing ideas about homeostatic systems, suggested that a family creates such a dynamic steady-state system; the character of the members and the nature of their interaction - including any identified patient and his sick behavior - are such as to maintain a status quo typical of the family, and to

react toward restoration of this status quo in the event of any change, such as is proposed by the treatment of any member (Jackson & Weakland, 1961, p. 30).

Family homeostasis provides the conceptual tool necessary to comprehend the interconnected nature of human behavior.

The double bind concept is based on the idea that communication taking place in the present between members of the identified patient's primary group is the most relevant source of explanation for behavior. According to Jackson & Weakland (1961):

in actual human communication a single and simple message never occurs ... communication always and necessarily involves a multiplicity of messages, of different levels, at once. These may be conveyed via various channels such as words, tone, and facial expressions, or by the variety of meanings and references of any verbal message in relation to its possible contexts. The relationships among these related messages may be very complex. No two messages, at different levels of communication, can be just the same; however, they may be similar or different, congruent or incongruent (p. 31).

The double bind concept does not represent an isolated instance of incongruent message. Rather, the double bind represents a prevailing style of communication which occurs within a family or other primary group over time. One kind of double bind pattern exists when there is a prevailing pattern of communication within the family in which at one level the message is given to the adolescent to be responsible. Simultaneously, at a different level of communication, a contradictory message is given which conveys that he/she is incapable of acting responsibly. The relationship is one in which the adolescent feels it is of vital importance to accurately respond to these incongruent messages, and there is a prohibition against commenting on the incongruency or on leaving the situation.

The concept of the double bind provides the means by which to grasp the almost intangible nuances of behavior as communication. It is in the context of complex and often contradictory messages within the matrix of family relationships that the behavior of the adolescent substance abuser finds meaning. Selection of the

symptom of substance abuse, rather than other kinds of acting out behavior, seems to be related to the style of conflict resolution that prevails in the family and to an intense fear of loss or separation. In families that present with adolescent substance abuse, the prevailing method of handling disagreement over how to define the nature of the relationship between the parents seems to be pseudo-agreement coupled with covert disagreement and the use of alcohol and/or other substances to mask the disagreement.

With the concepts of family homeostasis and the double bind serving as theoretical underpinnings, adolescent substance abuse can be thought of as part of a cyclical process involving three or more individuals, commonly the substance abuser and his/her two parents or parent surrogates. These people form an intimate, interdependent, interpersonal system, with the behavior of each, in effect, acting to protect the relationship of the other two. At times the equilibrium of this interpersonal system is threatened, such as when discord between the parents is amplified to the point of impending separation. When this happens the adolescent substance abuser becomes activated, his/her behavior changes, and he/she creates a situation that dramatically focuses attention upon him/her (Stanton & Todd, 1982). This can take a number of forms. He/she may lose his temper, come home high, commit a serious crime, or overdose on drugs.

Whatever the form, this action allows the parents to shift focus from their (usually covert) marital conflict to a parental over-involvement with the adolescent/young adult. Movement is from an unstable dyadic interaction (parents alone) to a more stable triadic interaction (parents and substance abuser). By focusing on the problems of the addict, no matter how severe or life threatening, the parents choose a course that seems safer than dealing with longstanding marital conflicts.

After the marital crisis has been avoided, the substance abuser shifts to a less provocative stance and begins to behave more competently. This is a new step in the sequence. As the substance abuser demonstrates increased competence, indicating that she/he can function independently from the family, (ex: get a job, getting married, staying clean, etc.) the parents are left to deal with their previously unresolved conflicts. At this point in the cycle marital tensions increase and the threat of separation arises. The substance abuser then behaves in an attention getting or self-destructive way, and the cycle continues (Haley, 1980).

When viewed from this perspective, the behavior of the adolescent substance abuser serves an important protective function and helps maintain the homeostatic balance of the family system (Ray & Saxon, 1992). Thus, the family of the substance abuser becomes stabilized or stuck at this developmental stage in such a way that the addict remains intimately involved with the family in a chronic way.

The cycle of interaction gives the appearance of dramatic movement within the family as the triad is dissolved, reestablished, dissolved, and reestablished. The adolescent substance abuser shuffles back and forth between the family and peer group in such a way as to reinforce his involvement in the family while overtly denying this involvement and claiming independence (Madanes, et al, 1980).

Therapeutic Issues

Keeping the basic cycle of interaction previously described in mind, the focus of assessment and therapy of adolescent substance abuse, from an interactional perspective, is as follows:

1. Avoid reductionistic thinking about symptomatic behavior, i.e., in terms of bad (willful behavior) vs. mad (senseless).
2. With rare exception, symptomatic behavior exhibited by adolescent substance abusers differs only in degree from that of so called normal behavior. With profound consistency, experience in treating adolescent substance abuse seems to bear out Jackson's early observation that, when viewed in its family context, adolescent substance abuse behavior resembles the behavior of other family members, though it may be exaggerated almost to a caricature (or possibly be an inverted form at times) ... and appears to serve important functions within the family (Jackson & Weakland, 1959, p. 20).
3. Recognize the therapist's active participation in labeling the behavior of the adolescent and family.
4. Place primary emphasis on what transpires between the patient and other members of his/her family, rather than focusing on what may be going on inside the patient (either intrapsychically,

genetically, or biochemically) that may be motivating him/her.

5. Pay attention to the typical pattern. Be aware of the probability of conflict emerging between the parents when the addict begins to stabilize and be prepared to manage it before the adolescent is triggered into relapse.
6. Assume that all people make the best choices available to them at any given moment (Jackson, 1952).
7. Keep in mind that there are relational constraints impinging upon all members of the family.
8. Recognize that the first important therapeutic task is to elaborate the context in which the adolescent's behavior finds relevance.

Two questions are useful in helping the therapist remain focused on what is transpiring in the relationship between the identified patient and other family members:

1. How does this behavior help preserve the status quo in the family?
2. How will change or improvement in the identified patient's behavior disrupt or disturb the relationship of other family members (i.e., parents), at least temporarily (Jackson & Weakland, 1959)?

Based upon information gained during the assessment phase, a relationship focused hypothesis is developed about the nature of the family difficulties. Conceptual strategies useful to consider are:

1. Adolescent difficulties can usually best be characterized in terms of a developmental dilemma of stability and change (Jackson & Watzlawick, 1963; Keeney & Ross, 1985).
2. Once contextual sense is made of the behavior in question, the next phase of assessment involves considering the advantages and disadvantages of change (Jackson & Yalom, 1964; Ray & Saxon,

1991; Keeney and Silverstein, 1987) for the adolescent and all other members of the family.

3. How will change in the adolescent's behavior (improvement or decompensation) effect ongoing efforts of family members to define the nature of relationships? This question is particularly revealing when applied to parents or care takers.
4. Develop hypotheses about the function of the troubled adolescent's behavior as a crystallization of developmental difficulties being experienced by the entire family (Ray & Saxon, 1991). It is useful to conceptualize the difficulty displayed by the adolescent as indicative of a struggle to redefine the nature of relationships among the adolescent and his/her parents and between the parents themselves.

Using these concepts as guides, the goals and objectives of family therapy with adolescent substance abusers center around helping the parents take a united stance toward the adolescent as he/she moves toward more developmentally appropriate behavior; and supporting the adolescent in taking more developmentally appropriate responsibility. Goals are revised as new information about the family relationship system unfolds. A key is to take one's time, remembering a principal John Weakland was fond of repeating, that brief therapy is done slowly. Find ways to work with the family that avoid implying blame of one family member while trying to encourage another family member.

Conclusion

A growing body of research literature (Friedman, Utada, & Morrissey, 1987; Hirsch & Imhof, 1975; Madanes, et al, 1980; McCollum, E. & Trepper, 2001; Stanton & Todd, 1982; Todd & Selekman, 1992; Berg & Miller, 1992; Ray, Keeney, & Stormberg, 1998) suggests that successful treatment of adolescent substance abuse necessarily places primary emphasis on family relationships of which the adolescent's symptomatic behavior is a part; rather than attempting to compel the substance abuser to abstain in isolation from his/her family. This article has described a typical pattern of interaction observed to occur in the family of the adolescent substance abuser. Some suggestions for successful family therapy with this population have been set forth.

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CHALLENGING BELIEFS: A TRIBUTE TO JOHN WEAKLAND

Katharina Anger, Ph.D.

John Weakland was an extraordinary clinician whose modest recognition reflects his understated style. He was not only brilliant in his contributions to the framing of the MRI Brief Therapy approach, but also in the masterful and elegant way in which he executed the model. Although he is no longer with us, John left a rich legacy in his writings, and even more so in the recordings of his work with clients, including years of videotaped sessions at the MRI's Brief Therapy Center. In this paper, I would like to describe some of his more subtle work, giving examples of a type of intervention that was quintessentially John's, and to add some examples from my own practice.

During the years of my training in the Brief Therapy model (beginning in 1990), I have had the good fortune of working with its originators, Paul Watzlawick, Dick Fisch, and most closely in those early years, with John Weakland. I spent hours examining John's therapy (both *in vivo* and on tape) and had the opportunity to question him about what he was doing. Most often his responses were immediate and he would refer me back to chapters in the text (Fisch, Weakland, & Segal, 1982). Sometimes, however, he would pause, even ask, "Do I do that?," and then search for an explanation as to why he might intuitively be doing a particular thing.

One such technique is something I have come to call "challenging beliefs". I first became aware of it in obvious places where John would challenge assumptions clients made. In viewing the tapes with this intervention in mind, however, I noticed that he did this routinely whenever someone expressed a strongly held belief. I liken it to inserting a question mark whenever he heard an exclamation point. When asked, John admitted that he was not aware of doing it so routinely but reasoned that it is precisely in a person's rigidly held beliefs that they are likely to get stuck. Furthermore, by challenging beliefs, one opens the possibility that there may be alternative ways of looking at a situation.

John could challenge directly, or by more subtly questioning as when he would say, "I can see where you might need to see it that way," or just by raising an eyebrow. In working with this technique I have learned that a subtle approach works better because an overt challenge may be met with a further digging in of heels. A more subtle challenge is often enough to suggest - without force - the possibility of alternative ways of viewing a situation and therefore of behaving in the situation. This was the case in a session with a man who is in the habit of discounting any change and where John said, "There seems to have been a change but it probably is a fluke." Here John preempts the man's tendency to discount, but his use of the word "probably" introduces the possibility that it is not a fluke.

Challenging can take many forms. It can come as a positive connotation when something that is perceived as "bad" gets put in a positive light as in the case of a woman who was rear-ended in her car and complained about her subsequent anxiety about driving. John responded, "I might say that whatever we do here, I don't recommend that you get totally relaxed on Highway 17. That you preserve a degree of vigilance. It's a dangerous road."

Challenging can take the form of a reframe or an effort to normalize as with a client who complains that he has an obsessive need to look at women other than his wife. In this case, John asked, "What's the difference between obsessive looking and what other men call normal?"

Often challenging doesn't fit neatly into any tactic we have identified; it is a tactic all its own. As with a case of a couple where the father is being blamed for their adult daughter's problems because he had been too authoritarian and harsh with his family, a belief that the father himself readily accepted. John challenged this family myth on at least two occasions. One occurred when the mother reports that the daughter "felt that she was never able to express her feelings growing up. They were always squashed.... She was very submissive growing up...and our next daughter was just the opposite. She speaks her mind to this day." Here John commented, "She [*the second daughter*] didn't get squashed? ... How come the old jailer didn't squash that one too?"

A second challenge to the family myth occurred later in the same session when the father reports, "I don't think I have the authoritarian attitude anymore - but you would know better than I would [*turning*

to his wife], you're the recipient." And the wife replies, "You do. Not as bad, but you do." John at this point intercedes and innocently asks; "How come he hasn't crushed you?" The wife replies, "Oh he has." To which John challenges, "I guess I somehow missed seeing how spiritless you are."

Actually, much of what we do in therapy is to challenge people's beliefs about the problem and the solution. The fact that we try to get clients to do something that is 180^o from what they have done in the past to fix their problem (Fisch, Weakland, & Segal, 1982) challenges their beliefs about what it takes to fix the problem. The suggestion that people "go slow" (an intervention often used by John) challenges the belief that one can not move quickly enough towards a solution to a problem.

Challenging beliefs accomplishes several things. It can serve to challenge heightened expectations as in a case written about by Wendel Ray and Barbara Anger-Diaz (2004) where a client talks about having seen multiple therapists over the years who have been unable to help, and how the client has greater expectations from the Brief Therapy Center. Here John responded: "But since you've had that experience more than once that should suggest to you that, while I'm not saying don't be hopeful, don't get too bloody optimistic this time and build yourself up for a big let down." And a couple of moments later – "You should think of this with an attitude of positive skepticism just to be on the safe side," a theme John returns to time and time again in his work.

Challenging can get someone's attention as in the case of a woman with whom I worked who complained about hitting a glass ceiling in her career. She had been told that she was too harsh and lacked the interpersonal skills required for a higher level job. She, however, complained about the degree of stupidity in her staff and how, although she knew she should not be thinking like this, she felt frustrated with their lack of performance and therefore her own ability to be productive with this team. I casually commented that "of course they're stupid. [*Siding with the client's position.*] What I don't understand is why, knowing that, you continue to be surprised?" I then went on to draw the bell curve and demonstrated how, if you are at the edge of the curve as she clearly was, most everyone else will appear stupid. The trick is to learn how to work with stupid people. This challenge from within her position that others are stupid

both gets her attention and sets the stage for her doing something different in spite of that position.

Challenging beliefs can serve to plant seeds for a direction you may or may not pursue later on, as in a recent case when a mother was expressing her belief that of course she needed to learn how to stay calm at all times when dealing with her difficult and frustrating daughter. I observed that “yes, it is good to stay calm at all times, unless, of course, it’s strategically relevant not to.” As this is a new case, I don’t know whether I will continue with this theme or not, but I have set the stage for doing something different if need be.

And challenging can help someone to more openly express thoughts that they may feel are crazy or unacceptable. This was the case with a woman who, after resolving a difficult work situation, said that she should probably talk about the affair she was having. When I asked “Why?”, she replied that it was not good to be having an affair. It was only when I challenged “Why not?” that she admitted that she thought that in fact the affair made her a better wife and mother, a statement that took the therapy in an entirely different direction. I do not believe these thoughts would have come so readily to light had I not challenged her initial statements and, in doing so, suggested that I may be open to an unconventional view.

Much as I observed in John’s work, I too find myself challenging as part of my dance with clients - often without a plan - as a way to loosen the knot that is the problem, pulling a little at this aspect or that, until I find a thread I can follow to untangle the situation. In this way, I continue to discover new uses for this most ingenious technique.

Often I am asked “what’s new in brief therapy”, or people comment on the fact that the work that has come out of the MRI’s brief therapy center is “old.” Although I would like to support the effort to find new ways of understanding and working, I would like to add to this discourse: What is in the old that we have not yet articulated or understood or explored or expanded well enough that would further enhance our practice? And, what are some of the possible ramifications, unintended as they may have been, as was the case with John’s challenges, that promise to provide us with fertile ground for further enriching our work? Over these many years I have not been able to find a case that John failed, neither *in vivo*, nor on tape.

Challenging Beliefs: A Tribute to John Weakland

He was truly a remarkable psychotherapist and I encourage all who are interested to examine and learn from his work.

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ON ETHICS IN PSYCHOTHERAPY AND THE INFLUENCE OF HEINZ VON FOERSTER

Barbara Anger-Díaz, PhD

On reflecting upon how to define my own ethical position or stance as a therapist, I continuously find myself thinking of Heinz von Foerster.

Heinz von Foerster, scientist, cybernetician and constructivist, born in Vienna on the 13th of November of 1911, died on October 2nd, in 2002, in his home in Pescadero, California. Yet for those of us deeply influenced by his ideas and his personal enchantment he remains quite alive, especially when interacting in psychotherapy, be it with individuals, couples or families, or when training others.

I will try to present some of Heinz's ideas (mainly taken from his last book, written with Monika Bröcker [2002]¹), and tie them to my own thinking and doing.

The endeavor of writing an essay that involves the ideas of Heinz von Foerster on ethics is not easy, given that Heinz himself declared that it would be difficult to explicitly define what ethics is, citing the now famous Wittgenstein (1963) pronouncement that "ethics cannot be articulated" (Heinz's own modified translation). But how then, while keeping in mind the quote from Wittgenstein about ethics defying articulation, could we communicate on this topic? - precisely the question that Monika asks Heinz in the afore- mentioned book, a book that evolved from a long series of conversations that they had with one another. In his resolve to show that ethics can flow implicitly, without having to become explicit, Heinz responds that the best way of communicating his reply is through stories, tales from his life. Thus a book came about, rich and enchanting, and, in spite of Monika's effort to capture the essence of Heinz's conception of ethics, still somewhat elusive, especially when one searches for something tangible to guide oneself by. Nevertheless, letting oneself be enrapt by his tales, reading between the lines, and perhaps sharing his understanding that human beings are basically inscrutable and yet part of oneself, the encounter with an emerging

¹ A book with which I spent a few years, translating it into English

construction of what could be understood to be Heinz's position can result in the putting together of an ethical stance of one's own. That is my intent here.

Perhaps it is best to begin with what, according to Heinz, ethics is *not*. Ethics is *not* about morality: it is *not* about managing oneself with a code of acceptable and non-acceptable behaviors, such as the Ten Commandments that God gave to Moses, who then gave them to the Jewish people. According to Heinz, ethics is part of a *position* that one assumes in the orchestration of one's life. Heinz maintained that in those cases where there were no rules of the game to follow (cf. his writings on *un-decidable questions*), one has the freedom to make decisions and live accordingly. From a finding in geometry, Heinz took the idea that there are questions that are fundamentally un-decidable. As a result of being able to demonstrate that there are limits to certain operations (of logical structures or systems of thinking), it follows that constructing on these operations, or demonstrating with them, becomes futile. Heinz thought that many scientific or philosophical questions fall within this realm and are therefore not decidable, except within certain cultural frameworks (such as the existence of a divine being, the creation of the universe, the advantages of certain economic policies, the benefits to the psyche of certain specific therapies, etc.). On recognizing the relativity of all cultural constraints, on deciding that there are instances with no implicitly binding rules of the game, one gains the freedom to decide for oneself.

Heinz further speaks of *non-trivial machines (systems)*, where outcomes are totally dependent on the past – on past operations – and yet, because these machines operate with continuous cybernetic adjustments to environmental feedback, their outcomes are not calculable, and therefore not analyzable: not explainable and therefore not predictable. In his opinion, the human being is such a non-trivial “machine”, ergo system. Knowledge of ourselves, of our history, the understanding of our actions and intentions, becomes modified as a result of our adaptation to new experiences. In other words, the continuous cybernetic effect that our experiences afford us, successively, little by little, modifies our views, our memory, and therefore also, one might say, who we are. In the end, it renders us un-analyzable and therefore un-predictable. (Such an understanding of the human being surely has tremendous implications for the field of psychotherapy, calling in question many of our intents of intervening, such as when we try to apply specific psychotherapeutic

treatments to cases where a shared etiology is assumed. Since according to this cybernetic view of development, etiologies are not ascertainable, treatment should not be based on them. In fact, one begins to ask oneself if the problems with which our clients come to psychotherapy are in fact “treatable”, for that would not only imply that as therapists we are able to ascertain what went wrong, but that we are also able to predict the outcome of given interventions. Bereft of these certainties, perhaps the only recourse left is the capability of provoking a change – away from a painfully stuck situation – without, however, being able to predict all of the consequences.)

For Heinz, putting together the idea of non-trivial systems, not analyzable and therefore not predictable, and the idea of questions that are, in principle, un-decidable, which undoubtedly come up every day in our lives, a space of liberty, of freedom, opens up, where a human being can *decide* what he or she believes and must do. It is clear, of course, that with that freedom comes the responsibility for what one believes and does.

Towards the end of this book (von Foerster & Bröcker, 2002), his last, Heinz comments that he presented his development as a scientist, as a human being, as a thinker, because he wanted to create a basis for what he calls his “curious position regarding ethics”. What he thinks came about as a result of this effort, is that ethics for him is intertwined with freedom: “That is to say: a fundamental freedom must exist so that I may act without having been forced”... a condition *sine qua non* for ethical behavior. And Heinz adds, that his “invention” of the questions that are, in principle, un-decidable, came in very handy, for

...when faced with an in principle un-decidable question, I can really do as I would like; for nobody, no logic, no rule, no rule of the game, nothing forces me to now act in such and such away.

What does the invitation of freedom give rise to? This invitation gives rise to my establishing, only just now, the framework, within which I will make my decision. That is to say, I don't avail myself of a framework like mathematics; I don't come with a framework like a moral code, a Decalogue; I don't avail myself of any of these frameworks, but say to myself, “Now, Heinz,

invent the framework, within which you want to decide now”, and this depth of a new framework is for me most crucial for the problem of ethics. (p.295)²

It was my personal contact with Heinz (which I was so lucky to have over a number of years) and my trying to understand – in an effort to render an adequate translation of his and Monika Bröcker’s book from German into English - the ideas he developed in relation to what for him was the meaning of ethics, that gave impetus to my writing this paper, and the ethical implications that this space of freedom and responsibility has for my own work with clients. Needless to say, one can only write about this and any other topic from one’s own experience and point of view. While attempting to use Heinz’s ideas – of what led him to his own consideration of the nature of ethics - for determining what would constitute ethically responsible ways of acting as a psychotherapist and consultant, it is clear that I must assume total responsibility for how I understand these, and the conclusions I arrive at with and through them. I let myself be guided by Heinz’s positions, but as interpreted by me. In the final analysis, I lean upon my own construction of what I attribute to Heinz von Foerster – just as the reader will be left with his or her own construction of what he or she reads here.

If I adopt the idea that the human being is one of those non-trivial “machines”, not predictable or analyzable, and also the idea that there are questions intrinsically un-decidable (outside of their culturally normative contexts, such as how to raise children, how to behave as a couple, how to manage any interpersonal problem, including that within the therapist-client system), then I may conclude, like Heinz, that it is up to me to decide how to define my role, that of my client from my point of view, and the space that I wish to allow us for interacting. That is to say, it is up to me to decide how to manage my part of the interaction with a particular client or clients. I will *not* assume that there is an authority that might direct me, nor that I have such authority over my clients. It is for the client or clients to decide what is within his, her or their domain, and our interaction might be viewed as a kind of dance between postures that we assume in the moment of interacting, dancing towards a mutually accepted goal.

² Translated into English from the original German by Barbara Anger-Díaz

It might be opportune here to mention that Heinz considered it a mistake to think that we can transfer knowledge as if through a funnel into the brain of others, reminding us of the old Nürnberg picture in which, through a giant funnel, the ABC's and the multiplication tables flow into the head of a young boy. Knowledge cannot be transmitted as if it consisted of objects to be infused. One might say, borrowing from the famous developmental psychologist Jean Piaget (1954), that knowledge is constructed through experience. Heinz therefore preferred to invite his university students to participate in experiments (mathematical, for example), in which the rules applicable to playing the game were to be jointly invented and then abided by.

I'd like to think that a therapy or a consulting session might proceed in similar fashion. The therapist might begin with a certain idea – for example the idea that a problem comes about and is maintained or even intensified through the repetitive use of a solution that doesn't seem to dispel it – and might invite a client to collaborate in an experiment to find out if a small change in the situation defined as problematic by the client can be accomplished through the design of a different solution. And yet, probably not much will be accomplished, if the therapist or consultant assumes the authority over what constitutes the content of what is to be resolved (i.e. defines the problem), or what the change to be effected is to be. Inviting a client to participate in an interaction dedicated to the search for a different solution to a problem, where both the problem and the desired change are defined by the client, is more likely to bring success: much like inviting to a dance, where certain ideas as to how to go about taking the first steps might be indicated, but a dance that is solicited and mutually consented to, with rules mutually subscribed to, perhaps even invented along the way, allowing for a unique dance to evolve.

Considering Heinz von Foerster's differentiation between morality and ethics, it is probably wise to leave morality out of this therapeutic dance, for who is to say what moral ways are applicable to whom, and by whose authority? Moreover, it would be fitting to limit invoking one's own authority with regard to what new solution would be in the client's best interest, for to which client circumstances would the norms supporting the solution be applicable, and according to whom? Of course there are those, as Heinz says, who wish to acquiesce to an hierarchic organization which, while compromising their own freedom, also precludes their having to

make decisions – and where there is no decision to be made, there is no responsibility. One may encounter such leanings in oneself as well as in one's clients. But if there is to be freedom, the question now arises as to who is to take on what responsibility in this therapy, this dance. Letting one's client take complete charge precludes our being of help, and for the therapist to assume total responsibility seems equally foolish, as implied above. We would have to ask whether truly viable resolutions to problems are even achievable without an implicit freedom conferred to all the participants in this dance, a freedom that calls for responsibility for one's own actions.

It is then understood, that the rules to be danced by are not universal and don't imply moral or even normative codes to be followed, that they are adopted freely in an effort to find a more effective way of dealing with a problem, and that they are entirely the responsibility of those who dance. The therapist or consultant might tend to work with and suggest rules that his model of change indicates to him or her, and the client might tend to work with their own rules, or with those he or she associates with a therapeutic or consultative session. Yet both are free in how they manage themselves, or dance, subjecting themselves to the rules of the game they have both invented, and only in place for as long as they wish.

A case example

A client comes to therapy asking for help for her adolescent daughter, having discovered that her daughter made cuts in her arms with a knife (which, according to her daughter, occurred when she felt very angry, very frustrated), which greatly worried the client. Mother wanted the therapeutic team, which I was a part of, to fix her 15-year-old daughter. In accordance with our brief therapy model³, and relevant for the discussion in this paper, we try to work with the person who freely chooses to get help for the problem, which in this case, as in many others, clearly is the mother. And yet, upon being asked to come in, the daughter also expressed some interest in coming to therapy. She loved her

³ as developed at the Brief Therapy Center (cf. Fisch et al, 1982) and implemented in the Latino Brief Therapy Center, both independent projects at the Mental Research Institute in Palo Alto, California

mother, generally getting along well with her, but felt that mother imposed too many restrictions on her by virtue of working long hours and leaving her in charge of rather strict relatives. She had already tried to escape on some occasions, and at others she had invited boys of her age to her house when she had instructions of not letting anyone in, events that resulted in greater restrictions, which she was very unhappy about.

We agreed to work with both mother and daughter. Mother's most salient preoccupation was that her daughter cut herself, but there were others. Her daughter, on the other hand, wanted to regain mother's trust, and for mother to demonstrate this trust by giving her a bit more freedom, by being less restrictive. The therapists pointed out that from her working perspective, in order to achieve the most desired goal, others might have to be sacrificed. And so mother, although she had other things she had wanted to be fixed in her daughter, confined herself to trying to help her daughter feel better about herself, which she thought would help her to no longer cut herself. Her daughter, yearning for a freer space, out of the reach of her strict relatives, but recognizing as well that cutting herself could become dangerous and thus affect her mother gravely – an idea which in turn saddened her - indicated that she could make a greater effort to talk to her mother before acting in ways that had not turned out to be effective in getting what she wished for. And while she would try to negotiate a bit more freedom for herself, she also agreed that any arrangement needed to be acceptable to both herself and her mother.

The fact that both mother and daughter had a true desire to get along better was of great help. The rules of the game, or the steps with which we attempted to dance – freely agreed to in this therapy - dealt first with identifying behaviors (or steps), which, although in themselves not subject to criticism, had resulted in an ineffective management of the problem by both participants (e.g., mother's

arranging for very close supervision, and daughter's attempts to break away). The next steps were about changing what did not work, and about finding those steps that would promote a different dance. There was no need to play with concepts of mental illness, or with social or familial norms of conduct. The game had to do with finding a more effective and efficient way of resolving the problem as defined by the clients, with how to reduce it to something workable, with a delimited goal, and with ideas as to how to reach it within the parameters negotiated and established by the mother, who, after all, bore the entire responsibility associated with raising children who are still minors. While respecting these parameters, we tried to play with the possibility of adjusting our clients' frames of reference a bit, hoping that if they could soften their expectations, a new dance could evolve, both acceptable to the mother and manageable for both. In such an effort, we tried to "normalize", or offer an alternative, more positive meaning to those behaviors that each condemned in the other. We suggested that in our experience, adolescents often wish for more liberty in order to seek opportunities for developing themselves, albeit that they were not always aware of the consequences of their actions in this search. We suggested that mothers, on the other hand, worry about the safety and physical well-being of their developing offspring, sometimes losing sight of the adolescent's need to find a place in which to show and develop their special talents. We hoped that these reframes, only examples of many possible reframes, would help our clients with some of their worries and their desires, and, with the possibility of a different view of each other's intentions, perhaps manage their relationship more effectively. It seemed to work, for mother began to look for an alternative for her daughter's care while she worked. Fortunately they were able to find an after-school program where mother felt comfortable in letting her daughter participate, and which was also to the latter's liking. The daughter stopped cutting herself.

There were any number of initiatives undertaken by the therapist in this dance (such as narrowing the focus to one problem, and to a problem deemed to be workable; offering reframes of the problem situation; asking for attempts to solve the problem that had failed and, sometimes implicitly, sometimes explicitly, pointing out such failure; deciding who so see and when, etc.), and one might jump to the conclusion that it is an uneven dance, with an uneven distribution of responsibility. The counterclaim would be, that the client freely sought to dance and freely chose to stay in the dance, and that it was merely a matter of therapists having the possibility of offering a greater variety of dance steps, both for their own interactive dance with their clients and for the dance to be danced between the clients, a possibility made likely by their generally not being themselves stuck in the very problem described by the client. Coming from outside sometimes permits a more unencumbered look at options.

To further amplify the question of ethics, we need to ask where else they enter the stage on which the so-called therapeutic dance is to take place. It is not an easy question. We might attribute ethics to the stance that we take when we aspire to respect the world inhabited by our client implicitly, defining ourselves as and restricting ourselves to merely being facilitators of a change solicited by the client: entering and restricting ourselves to the dance we have been invited to.

There are other characteristics of this therapy that I consider to be related to a position involving ethics. We work towards focusing on *one* problem, which not only helps make therapy briefer, and therefore less intrusive, but implicitly contains the idea that while the client is seeking help because he or she or they are stuck somehow, the client him- or herself is not defective, or the system they integrate is not defective, and therefore does not warrant our becoming involved in massive changes. A small change in the management of the problem, or a modification in the perception of the problematic situation, is often all that is needed to turn it into a situation such as one can live with. In our experience, even clients who have felt stuck for years, can get moving once they manage to define their problem clearly and concretely. Limiting ourselves to working on *one* problem is to our own advantage as well, for we not only *don't* have to attempt to change a lot in our client's world, but we *don't* have to be responsible for it either. We can choose to dance or not, and at least this freedom makes ethical action possible.

For Heinz, the ethical imperative he poses for himself is: "*Heinz, act always so as to increase the number of options!*" (2002, p. 335). Heinz also said that he could impose upon himself to act according to certain principles that he has accepted for himself, but could not expect the other to adopt them. At the very moment of imposing a way of acting upon the other, one becomes an autocrat, a moralist, and ceases to be ethical. But he also saw himself as part of the world and agreed with what he attributed to the philosopher Martin Buber (p. 334): that we are through the other; that we become through the other. For him the ethical question resided in how one behaves towards the other. Ethics resides in acting towards the other as one wishes to be acted upon.

For me, then, ethics in psychotherapy has to do with acting in a manner facilitative of an increase in one's own options as well as in those of one's client(s). Heinz's ethical imperative could well be adopted as the main axiom of a therapy that does not pretend to give definitive solutions to a client seeking help. For Heinz, the role of mediators, negotiators was precisely that of presenting to the different parties of a conflict new visions, new solutions, new options and new possibilities. If we adopted that role, we would have to ask ourselves of what use the increase in the number of options would be, and how we would go about achieving it. If we managed to find new solutions, different possibilities, thus increasing the number of options, we could contribute to the client finding a way out of his or her problem, without subjecting him or her to ways specified by us. If we understand our task to be that of helping our clients find possible options, when we don't infringe upon our client's freedom to choose their actions, we are freed from having to obey our clients' call for us to resolve their problems. On the uptake of Heinz's idea that one possesses the freedom to invent for oneself the framework within which one wishes to decide: this liberty is the one we can try to facilitate in our client, so that he or she may choose or invent the frame or context within which he or she may wish to act and decide. With our reframes we offer some possible constructions, but there are always so many more frames of reference imaginable, and an infinite number of valid decisions for which the client could opt. The challenge lies in how to mediate this notion.

As for the nature of psychotherapy, Heinz thought that there could be no theory – only a *school*, a *stance*. Citing the philosopher of science Karl Popper (p. 301), he maintains that a theory is only a theory if it is falsifiable. And we would have to ask ourselves, as he

would, how would a therapist try to falsify his theory, how would he or she *experiment* with clients, clients already coming to him or her under the weight of suffering? We must conclude then, that a therapist is limited to operating within his or her beliefs and his or her own *position* or *stance*. It is clear that his or her understandings would not always coincide with those of the client, and this could result in an interruption of the mutually chosen dance. To reach out and come closer to the client, the therapist would have to be willing to listen for and accept what the client reports as having happened or as having experienced, and intend to dance again. According to Heinz von Foerster, the intention is what matters, and one can always start to dance anew.

The idea that it is more about a position, a stance (perhaps within the frame of reference of a school, as *the School of Palo Alto* is in my case) that we bring to our therapy, rather than about a theory, makes much sense to me. I find that my position, my stance, my attitude, is basic to the way I approach therapy. Only in the free interchange of our positions, in the dance during which and through which we construct new alternatives, new options, new realities can be created beyond those that keep us stuck. Much of what is ethical in this approach, and beyond the scope of this paper, remains implicit.

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COMBINING STRATEGIC FAMILY THERAPY AND BRIEF STRATEGIC THERAPY

Marilyn Wedge, Ph.D., MFT

Abstract: *This article is a case study of a fourteen-year-old girl who came to therapy following a week of hospitalization for suicidal depression and cutting. The patient also had a diagnosis of Obsessive-Compulsive Disorder. The author used a combination of strategic family therapy and brief strategic therapy with a very successful outcome. The author first used strategic family therapy was to treat the more dangerous symptoms of cutting and depression. Once these symptoms were resolved, the author used the brief strategic therapy protocol for resolving the symptoms of obsessive-compulsive disorder.*

Following her discharge from a psychiatric hospital, Anna, age 14, came to therapy with her mother and father. Anna had been seeing therapists since she was eleven years old for cutting, depression, and obsessive-compulsive disorder. Her symptoms had grown progressively worse until finally her psychiatrist hospitalized her. She was in the hospital for a week, and upon discharge was referred to the author. Anna's family consisted of her father, a university professor, her mother, a homemaker and musician, her nineteen-year-old sister (who attended university in another town), her sixteen-year-old brother David, and herself. The family was upper class and extremely talented: each member of the family composed music and each played at least three musical instruments. The older daughter was training to become a professional musician. Anna also planned a future career as a professional musician. At the time Anna came to therapy, Child Protective Services was investigating allegations that Anna's father was physically abusing her.

In the first family session with Anna and her parents, the family expressed pain and rage about the many years that Anna had gone to therapists with very little improvement of her condition.

She had seen two different therapists for depression and one for OCD. None had helped. She had been taking anti-depressant medication for over a year with only short periods of improvement. The parents were very frightened because Anna now cut her arms and wrists, and talked about the suicidal ideas that she could not get out of her mind. Her compulsive behavior involved wiping her fingerprints off anything she touched. She also had other compulsions such as foot-tapping and intermittent blinking.

Anna's brother David was also a problem for the family. Despite his intelligence he was getting D's and F's in his classes. He was angry most of the time and refused to do his homework or study. He had hit Anna and had kicked his mother. The household was chaos of door-slamming and angry outbursts between children and parents.

Therapeutic Plan

I decided to focus first on Anna's depression, since that was the most dangerous symptom. When her depression was resolved and she was no longer cutting, I would then treat Anna's OCD symptoms. I would also explore the issue of physical abuse to determine if Anna's father was harming her. I shared this plan with Anna's parents and they agreed. Dealing with their daughter's depression, cutting, and OCD was overwhelming and confusing to them. They felt beaten and worn down. I asked the parents to wait in the waiting room while I talked with Anna for the remaining minutes of the first session. My opening move with Anna was a closed-ended question that I invariably utilize to discover which parent the identified patient is protecting or helping by having symptoms. (Wedge, 2007). This invariant question takes the form: "Are you more worried about your mother or about your father." A central principle of strategic family therapy is that a child's symptom helps one of the child's parents by deflecting attention from the parent's own troubles (Haley, 1976; Madanes, 1981; Wedge, 1996, 2002, 2007). Anna's response to my question was "I am worried for my mother because she can't defend herself against my father or my brother. She is weak." Anna also told me that her parents argued all the time. I arranged to see Anna and her brother David in the second session, with the intent of gathering more information about the family problems and to discover whether any abuse was occurring.

Session two with the brother and sister revealed that they both were desperately worried about their mother, who was depressed and did not discipline them. It also became clear that this was a very loving family, and that there was no physical abuse going on. Father had only once grabbed Anna's arm in frustration because she would not obey her mother. The brother and sister had many helpful suggestions about how I could help their parents, and they said the parents needed therapy more than they did. They especially thought that their mother needed to get out of the house and get a job. They felt that she was always helping other people and did not do enough for herself. I assured them that I was going to be their parent's "helper" now, and they could get on with their own lives and focus on school, friends, music, and other important things that were important to teenagers. This replacement of the therapist as the overt family helper takes the burden off the child who is covertly helping a parent by having symptoms (Wedge, 1996).

The session concluded with my giving Anna a tedious, detailed lecture on the proper way to disinfect and bandage her cuts should she be tempted to cut her wrists or arms again. I had brought disinfectant and bandages to the session and showed them to Anna, demonstrating how to keep her cuts clean if she felt like she had to cut. Her brother exclaimed quizzically: "You're telling her how to cut!" I nodded agreement. I was, of course, paradoxically prescribing the symptom, or putting out the fire by adding more wood. Since Anna rebelled against control, I hoped she would rebel against my prescription by ceasing to cut herself. This is in fact what happened.

Marital Therapy

The next four sessions involved only the parents. By the time of my first meeting with the parents, Anna had not made any suicide threats and had not cut herself. David's anger had decreased and there was less fighting in the household. The marital therapy consisted of resolving the deep grudges and resentments that had created walls between the couple during the twenty-two years of their marriage.

The second important aspect of therapy with the couple was to help them come to agreement about discipline and limit setting for the children, and to agree to back one another up in matters

of discipline. I also instructed the mother to be less controlling of the children so they wouldn't have to rebel. The parents trusted me, since they had seen such rapid improvement in their daughter, and were willing to carry out my directions. They were self-reflective enough to admit to me "we are very controlling." We discussed ways of letting go of their children. The mother became very sad at this, but she said that she understood letting go was necessary. At the end of the session I predicted a relapse of Anna's cutting, so the parents would not slip back into their patterns of controlling behavior.

Treating Anna's Obsessive-Compulsive Disorder

Nine weeks after the initial family session, Anna's parents reported that she had no symptoms of depression and had not cut herself again. With the parents' agreement, the focus of the therapy then shifted to Anna's OCD symptoms. I did, however, continue to have brief biweekly phone conversations with the mother to support and encourage her in her efforts to become less controlling of her children and pursue interests of her own.

In the first session of the OCD treatment Anna said she compulsively rubbed surfaces that she had touched to wipe away her fingerprints, and sometimes rubbed her thigh or other parts of her body. She also tapped with her foot, and intermittently closed one eye then the other, but the rubbing was the most bothersome to her. She also had fears of windows.

Using Nardone's protocol (1996), I suggested that there might be some positive role that these symptoms had in her life. Anna could not think of what this could be. She then started to talk about getting a puppy and asked for my support with this, since her parents seemed to listen to me. I went over with Anna all the things she needed to do to take care of a dog, and she insisted that she would do them all. I agreed to call her mother and support her wish for a dog, as a dog would provide something outside herself to focus on and take care of. In the last few minutes of the session, I prescribed to Anna the repetition of the symptom ten times (Nardone, 1996). I told her that she didn't have to rub or tap at all, but if she did either thing once, she had to repeat it ten times. Anna seemed intrigued by this prescription and looked very thoughtful. She

asked, "Can I do it five times?" I replied that it had to be ten times, not five. She agreed to do this.

In the second session Anna said that she was rubbing and tapping less because she didn't want to have to repeat them ten times. The prescription "helped a little bit." She reported that her OCD was "not as much of a problem as used to be." She also told me that the rubbing used to make her feel less anxious, but she was feeling less anxiety lately so she didn't have to rub. She also announced that she had a new puppy, and was taking care of it by herself without help from her parents. The puppy seemed to serve the purpose of a friend and companion, so that Anna would not have to be dependent on closeness with her controlling mother.

I then told Anna the parable of Yu the great. (Nardone, 1996). She seemed to grasp the point of digging small channels for the water, rather than trying to dam it up all at once. Even more interesting, she seemed to understand the metaphorical connection of the water and her anxiety. At this point in the session, however, she became visibly anxious and asked if she could see if her mother was in the waiting room. She said she had nothing more to talk about with me. I agreed that she could leave, but again I prescribed the repetition of the rubbing for ten times if she did it once during the week. I also prescribed the half-hour with the alarm clock in which she was to think about her worst fears and make herself anxious.

Because Anna was ill with stomach flu, I did not see her for three weeks. Anna then reported that the OCD symptoms were much better. She repeated the wiping, tapping or blinking ten times if she felt compelled to do these things, but that hadn't happened very often, in fact much less often than they used to occur. Anna also spent half an hour near the windows trying to summon her worst fears. She said she felt better about her fear of windows. We talked briefly about what positive role the symptoms had in her life. She said the positive role of the symptoms was that they made her feel less anxious. But the main issue that she wanted to discuss was her parents' being controlling of her, especially around her music. She did not want her mother to supervise her practice times. She asked my help in persuading her parents to put a piano in her room so she could practice in private. I made this suggestion to Anna's mother when she came to pick her up.

In my last session with Anna, she said she felt much better, and after twenty minutes told me that she didn't have anything else to discuss with me. I gave her permission to call her mother to ask to be picked up early from the session. Since she was feeling so much better, we did not make another appointment, but I assured her that she could come back whenever she needed.

Anna has had no recurrence of depression or cutting. While there was not 100% improvement in all of her OCD symptoms—Anna occasionally finds herself blinking intermittently—there was enough improvement for her psychiatrist to take her off medication. The family therapy component of Anna's treatment helped with the OCD symptoms in that her mother became less controlling and her father became "much nicer" to her. Combining strategic family therapy and brief strategic therapy techniques led to an exceptionally good outcome for this patient.

I continued biweekly telephone contact with Anna's mother to answer parenting questions. After two months, she asked if she could come in to consult with me about her own life. At the session, she told me that she finally realized that she had to give up her hopes of being a full-time professional musician, and pursue another career that would keep her busy and help her let go of Anna. After much soul-searching, she had decided on a career in speech pathology. For several weeks we discussed ways in which she could go about finding a university program. She found one close to her home, enrolled, and is presently pursuing a new career. In her latest session, the mother reported that Anna has had no symptoms of depression or OCD for several months. Mother's classes were going well, and her husband was supportive of her new career. At present, the parents see me every few months for parenting issues. The focus of these sessions is for them to learn the difference between being caring and being controlling. These sessions serve to stabilize Anna's improvement. From a family therapy perspective, Anna no longer needs to help her mother because her mother's life is much happier both in her marriage and her career.

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Wedge

INTERACTION FOCUSED THERAPY TO ADDRESS DOUBLE BINDING OF DISTURBED ADOLESCENTS

Wendel A. Ray, William Saxon, and Matthew Borer¹

Abstract: *This paper presents a model for working with young adult males who are unable to develop toward independence because of the double binding communication within the family system. Originally developed and implemented two decades ago with a pilot group of 6 young adult males, the basic model, which is generalizable to female populations by making modifications in terms of age and sex appropriate outcome goals, continues to serve as the theoretical and pragmatic framework used by the first and third authors in teaching and practice of Interaction Focused Brief Therapy at the University of Louisiana at Monroe (ULM) Family Therapy Clinic, and in private practice. Fundamental axioms of an Interactional approach to the treatment of troubled young adult males and their family will be set forth. Specific focus will be given to clinical techniques and practices basic to working with this population from a Communication / Interactional theory perspective.*

The communication theorist at the Mental Research Institute at Palo Alto, California demonstrated that some Schizophrenia, and other forms of “severe mental illness” resulted from double binding patterns of family communication and interactions (Bateson, Jackson, Haley, & Weakland, 1956, 1963; Jackson, 1957a). A process for working with the young adult male sibling who is unable to develop toward independence, at least in part due to double binding communication within the family system, will be described. Developed while working with 6 young, Communication/Interactional Theory and double-bind concepts provide the underlying theory (Jackson, 1957b, 1958, 1959).

¹ Wendel A. Ray, Ph.D., is a Senior Research Fellow and former Director of the Mental Research Institute (MRI), in Palo Alto, CA, and Professor of Family System Theory at the University of Louisiana at Monroe Marriage and Family Therapy Program. William Saxon, Ed.D., is Professor of Social Work, School of Social Work, The University of Southern Mississippi, Hattiesburg, M.S. Matthew F. Borer, M.A. is a Doctoral student at the University of Louisiana at Monroe Marriage and Family Therapy Program.

Originally developed and implemented two decades ago with a pilot group of 6 young adult males (Ray, Saxon, & Woodham, 1991), which is generalizable to female populations by making modifications in terms of age and sex appropriate outcome goals, the practice model continues to serve as the basic theoretical and pragmatic framework used by the authors in teaching and practice at the University of Louisiana at Monroe (ULM) Family Therapy Clinic, and in the first author's private practice. The model was initially developed for adaptations to the procedures of a mental health clinic where the identified patient, who may or may not have been hospitalized, was seen for the intake and treatment without family involvement. In the process of working with these cases it became evident that the young adult male was caught in a net of double-bind communication and that the most efficient intervention was to get the family involved in the elimination of the double binding within the system.

Summarization of the Double Bind Theory

The families seen during this developmental stage were all characterized by a feeling of hopelessness and helplessness. They were all emotionally exhausted, anxious, and confused. These characteristics made them good candidates for treatment, because of their pain motivation. They exhibited the symptoms of a family system that was caught up in a redundant cycle of interaction based on the double binding communication. The family members were not aware of the incongruent messages, nor the redundant cycle of behavior produced by these interactions.

The essential ingredients of double bind communication are the following:

- a. Two or more persons involved in an intense relationship that has a high degree of survival value for one or more participants. The family is involved in the sending of incongruent messages, usually within the boundary of a complimentary relationship, where two people are of unequal status and one appears to be in a superior position;
- b. In this context messages are given which assert opposing commands. The assertions are

mutually exclusive because neither one can be obeyed without disobeying the other;

- c. The recipient of the message is prevented from commenting on it or walking away from it;
- d. The double binding process is not unidirectional, in that it binds the sender as well as the recipient. The family is in a no-win position (Bateson, et al, 1963; Jackson, 1965, 1967).

Characteristically, the young adult sibling in the cases discussed had begun to overtly display the effects of having grown up in a double binding family context in early adolescence or earlier. Stated simply, the most explicit and restrictive message constraining the young person was structured as follows:

- 1. The young person continuously received the verbal message, "You are now grown up; you must be responsible for your own life."
- 2. On the non-verbal level, however, the family communicated that the person was irresponsible and incapable of managing his own life.

The individual was not allowed to set goals and to perform the behaviors that were necessary to complete them (Jackson & Weakland, 1961; Jackson & Watzlawick, 1963). Someone in the family was always taking control of the young person's life. The double bind was also sometimes meta-communicated by tone of voice, facial expressions, or body posture. These behaviors were typically of a questioning, critical, or condemning nature. The young adult members who were treated were usually significant to their families in that they served to promote communication and interaction between the parents. In some cases the young person was so important that their presence within the families seemed to actually keep the parents together. The nuances of the double binding communication differ slightly in families with adolescents exhibiting other behavioral difficulties such as acting out, substance abuse, and other delinquent behaviors. However, the essence of the developmental dilemma experienced by families resulting in aberrant behavior on the part of the adolescent is fundamentally as has been described above. The authors have applied the double bind model to

be described successfully with presenting problems other than schizophrenia.

Phase One: Session with the Young Adult Male

The goal of this phase was to assist the young persons to state verbally that they wanted to become independent and that they needed for their family to disengage from them so that they could become responsible for their own lives. The initial focus of therapy was to enable the persons to ventilate their frustrations about his position in the family and dissatisfactions with the behavioral exchanges between them and the other family members.

The objective was to support them in the acceptability of separating from their family of origin and becoming an autonomously functioning individual. The therapist encouraged the client to examine his attitudes and thoughts about the family interaction as well as attitudes about himself. The emotions most prevalent during this stage were guilt about wanting to leave the family of origin, anxiety, and fear about moving toward independence. These persons could be described as having developed a sense of themselves as being a failure which was manifested by their negative thinking about themselves and their ability to succeed on their own. Yet, their awareness of their self-acceptance depended upon this growth toward independence. The cognition underlying these feelings was itself a cognitive double bind; "I have to grow up, but I can't." This view in itself was not only double binding but the "I can't" was experienced as an indication of a defect in the personality structure.

Keeping the concept of homeostasis in mind, it is advantageous to consider both the literal and metaphorical nature of such statements as "I have to grow up but I can't." Literally the statement can be understood to reflect feelings of helplessness experienced by the individual. Metaphorically it can be understood as a cogent utterance about the nature of the developmental dilemma of the whole family, which has been highlighted in the behavior of the troubled young person.

In this initial phase it was necessary to encourage the persons to begin setting small goals and providing reassurance that they could accomplish goals that were necessary for movement toward independent functioning. It was also important to help them begin to evaluate the self-defeating aspects of some of their present coping patterns. For example, a 24-year-old male had been placed in jail

and committed to the state hospital after he had taken a gun and threatened his father and brother. A prior commitment had resulted from his destruction of furniture and breaking of windows in the family home. Following the second commitment, the therapist helped the young man make a connection between his destructive behavior and his being involuntarily committed to the state hospital. It was suggested by the therapist that he call the telephone help line when he began to feel so upset that he wanted to become destructive. This suggestion provided him with something constructive to do in the place of becoming violent.

In phase one, the major therapeutic techniques used were the demonstration of empathy, respect, and genuineness. There was minimal confrontation during this stage – no head-on collisions. The only confrontation to be used in this phase should be conveyed in terms of statements of genuineness. For example, “I am concerned about the consequences of your violent behavior to you. Let’s look at some ways to deal with your feelings other than what you have been doing.” At this point, it became important to the treatment to emphasize that the therapist had faith that the young adult who had been labeled schizophrenic was capable of change and growth. Expression of this faith was a necessary prerequisite to being genuine and demonstrating respect. The therapist’s actual behaviors were characterized by encouragement, reassurance, logical discussion, giving of information, and attentive listening. Universalization was used to encourage the expression of feelings and thoughts that were not acceptable to the person.

Phase Two: Conjoint Session with the Parental Sub-System

Goals during this phase were interrelated. First, the therapist should elicit the couple to tell their story about the pressures the “sick” person had put on the family and to verbalize a desire for him to leave the nest. Secondly, the therapist should enable each spouse to begin to verbalize their differences about the solution to the current problem. Exploring what was happening between the parents as they tried to cope with this person during the adolescent period, the therapist gently moved into the area of family history centering around the interaction within the triad. An important objective was to encourage the clients to verbalize some of their differences and disagreements about dealing with the problem in prior stages of family development.

In the first marital therapy session, the therapist attempted to get the couple to express their feelings of hopelessness about changing their situation. It was hoped that the parents would express their ambivalence and guilt. A cognitive attitude frequently revealed was "We want to give up but we should not; we would be bad parents and it would be terrible to fail." By the end of the first session the parents had usually expressed their total emotional exhaustion in the supportive, accepting therapeutic environment. During this session, it was necessary that the therapist use many empathic responses to let the couple know he understood the dilemma and where they were coming from. Use of such responses enabled the clients to reveal more of the innermost feelings about the experiences they had with the sick family member. Empathy allowed the parents to begin to regain some of their feelings of worth. It was also necessary that the therapist convey respect for the parents by emphasizing their strengths, especially the strength they exhibited by coming for help.

A problem that sometimes arose in this phase of therapy was the tendency of some workers to blame parents for the young person's illness. If this is the epistemological stance of the therapist, it is probable that subtle non-verbal criticism may be communicated early in the first therapy session, thus reinforcing anxiety and feelings of hopelessness and worthlessness. It was best to view the problem as an interactional one, which involved all family members. The action-reaction concept from family systems theory was used to interpret the interactional dilemma. It was sometimes helpful to reframe the relationship cycle as, "You all loved each other so much it was difficult for you to separate from the relationship."

The next step in this phase was to get the parents to consider alternatives for solving their dilemma and the potential consequences of each choice. In this context it was sometimes useful to re-emphasize that what they had been doing had not been getting the desired results and to recognize that they must try something else. In discussing alternatives, a dialogue about some of the past and present differences in the behaviors and attitudes of the parents was encouraged. The purpose was for the therapist to gather a few facts to be used in future sessions. It was not the appropriate time, however, to begin to focus on these conflicts for the purpose of problem resolution because of the danger of premature termination of therapy by the parents.

In most of these families there was the immediate emergency of violence on the part of the identified patient toward himself or a family member or other types of acting out in the community. It was at this point that the parents often expressed differences and disagreements on handling the immediate problem. Occasionally the therapist would suggest alternatives, but only after the parents had had the opportunity to explore their own ideas. It was not unusual that the two parents expressed opposing alternatives. Usually the father was ready to have the young person thrown out of the house. The mother wanted some action to be taken, often not knowing what or how, but was not ready for him to leave the home. It was helpful for the therapist to suggest, as an alternative to neutralize the struggle, for the parents to have the police apprehend the young person in the event of violence toward himself or others. It was often helpful to assure them that they were good parents and did not want to see anything adverse happen to their child or to allow him to hurt someone else. The parents were assured that the therapist knew they would make certain that he would not be allowed to engage in additional self-defeating behaviors because of their love for him.

It was necessary to get closure on phase two before moving to the next phase. Closure was accomplished when the therapist had elicited strong affirmation about “freeing the young person to develop toward independence.” Once this commitment was made, it was useful for the therapist to reassure the family that this alternative was not a perfect one, but considering the longevity of the problem, this alternative was the best one.

In this phase some differences and disagreements were elicited and it was necessary to bring closure to this aspect by verbally recognizing that the couple had unresolved feelings related to the relationship, but these could be dealt with at a later time if the parents desired. Resolution of these issues was reserved for the conjoint sessions in the final phase of treatment. The second phase took three to six sessions with the number of sessions needed, depending upon the resistance of the couple and the skill of the therapist. Some conjoint sessions were conducted concurrently with Phase I while others began after the young person had been seen for several sessions.

Phase Three: Sessions with the Family Triad

The goal for this phase was to get each family member to attain a strong commitment to change, with each member expressing in

concrete terms his/her desires toward this end. Typically, the parents would state their desire for their son to begin preparing for independent functioning and the young adult would state a strong intent to begin developing goals that would lead to self-sufficiency. It was important that the parents take a strong united stand to convince the young adult that they were really serious. This commitment on the part of the parents in effect released the young person from the double bind situation. The objective of this session then became to synthesize and bring into the larger system the activities and accomplishments from the prior two phases.

Ventilation of dissatisfaction about interactions within the family was common during this phase. Each person was provided an opportunity to express his/her views of the problem, what had been done about it, and what solutions they saw. It was necessary for the therapist to be cognizant of the communication processes and to establish a structure for the family to practice open, honest, clear communication. In the past one of the problems these families had was an inability to metacommunicate (i.e. communicate about their communication). Each family member had an opportunity to comment on anything said by another member and to check out what was said for clarification purposes. Encouraging each person to explain how he or she heard what was said by each family member was important. Cross-checking of interpretations about what was said was necessary to help the triad learn to respond to what the other person said, rather than what they thought the other person meant.

Another important aspect of this phase of therapy was the exploration of the advantages and disadvantages of both stability (things staying as they are) and change (movement toward greater independence on the part of the young adult) for all members of the family (Jackson & Yalom, 1965). In cases where the young person's behavior is particularly aberrant, there are usually advantages to be found for things staying the way they are. Often spouses are anxious about facing life together as a couple after the young person leaves. In turn, the young adult is anxious about the parental discomfort. Perpetually reacting to one another the family becomes fixed in time. This is the essence of the developmental difficulty faced by the family. Fear of separation and issues of intimacy between the parents frequently emerge and must be addressed.

It was important for the therapist to make sure that there had been closure on phase three once the parents had taken a definitive stand on their desire for the young person to become independent and young adult had made it clear that he intended to pursue his goals; the purpose had been accomplished. To be sure the double bind was broken; the therapist would check on how the patient heard what the parents said and get him to restate what he had heard. The same process was followed with the parents.

At this point in the process the therapist directly clarified what was to be the focus in phase four. It was essential that the parents understand that the therapist and the identified patient would work together in setting and implementing goals. It was emphasized that the parents would stay out of the patient's planning for his independent functioning. In some cases the family could give financial help for training or educational pursuits. In some instances such aid was acceptable, but in others it was necessary for the therapist to help the young person to find other means of financial assistance such as vocational rehabilitation, grants, etc.

When the therapist detected residuals of resistance on the part of the parents, it was helpful to emphasize that their tasks would be difficult for them to accomplish, but was the only way to solve their conflict. This statement can be concluded with a comment, "You love your son very much and I know you will make this work." If the goals in the first three phases had been thoroughly accomplished, the family was free enough at this point from the double bind communication to allow for further movement toward independence on the part of this particular young adult. A common ploy used by family members to resist change was to attempt to get the therapist into a power struggle. In some instances the therapist needed to insure success by making it more difficult for the parents to resist their part of the agreement. An extra incentive was provided by making such comments as, "You really can't follow through on our agreement. I do not expect you to be able to accomplish this change even though I know how bad you want a happy family. I have tried this with many families like you and have found that the parents cannot keep their agreement." The paradoxical interactions between therapist and the couple were based on the idea that some families who come for help are resistant to the help offered. Such communications work at resistances to change enabling the family to change even though they fear the unknown (Jackson, 1959; Ray, 2005; Watzlawick, Weakland, & Fisch, 1974).

Phase Four: Individual Therapy with the Young Adult and Concurrent Marital Therapy Sessions

In this final phase the goal with the identified patients was to begin to help them to explore alternatives, establish and implement small goals. The therapist assumed some responsibility in helping them implement these goals. For example, if financial aid was needed, the therapist arranged a referral to an agency such as vocational rehabilitation. In one instance a 24-year-old male wanted to attend a college within the state. The first goal that was set was for him was to request applications and information about a particular program and school. This goal was undertaken in the therapist's office. The young person wrote the letter with the assistance of the therapist and it was mailed from the office. Since larger goals were broken into small steps or sub-goals, it was most effective to have two thirty-minute weekly sessions rather than the usual single one-hour session. This arrangement gave the therapist and the young adult the opportunity to work toward the accomplishments of the sub-goals at a more rapid pace.

A supportive relationship with the therapist was extremely important; however, it was necessary that the young person be pushed to work toward their goals on their own. No excuses were accepted by the therapist for the persons' failure to follow through on their contracts. Where such failure occurred, the plan was renegotiated and new contracts developed. It was also necessary for the therapist to deal with attitudes that inhibited the persons from accomplishing or undertaking assigned tasks. These attitudes were attacked in two ways: either directly on a didactic cognitive basis, and/or by getting the person to perform the necessary behaviors that would lead to attitudinal changes and feelings of worth.

Couples Therapy

The focus of this phase was to assist the couple to reorient their family life style and re-structure their patterns of communication. It was often difficult for them to begin communicating directly since, in the past, so many of their messages had been sent through the third party. So much of each family member's goal orientations and problem solving had been focused on dealing with the problems of the young adult, resulting in being forced to reorient their life styles to the new interactional patterns. Some couples had initiated observable changes in their relationship as a result of going through

the other phases and felt able to manage without additional sessions. It was usually "required" that they come to at least one session in this phase to reinforce and reaffirm their decision. Advantages and disadvantages of the changes were assessed and the strength of their decision reinforced. In some instances it was useful to reemphasize the difficulty of following through while simultaneously reminding the couple that this was the only way to solve the problem, and that their love for each other would make them want to try as they had never tried before on any other problem (Jackson & Bodin, 1968).

If the parents did desire to come for a specified number of marital sessions, some of the issues that had been brought up in conjoint sessions were re-opened during this phase. Some of the most common areas of dissatisfaction for the couple had been communicational, affectional, and sexual exchanges. It was not unusual that both of the marital partners felt cheated and unloved. They had a strong desire to get more of their emotional needs met through the marital relationship. The therapist was helpful to the couples by aiding them in achieving reciprocity in terms of behavioral exchanges in these areas. When role conflicts needed to be resolved so that the couple could maximize their satisfactions from the relationship, the therapist served as a mediator as they renegotiated the division of labor.

Where there were other children in the family it was often revealing to get the couple to talk about their relationship with the younger siblings. The goal here was to see if another child would be selected to form a new triad to stabilize the spouse subsystem. In one family with a 12-year old son, it became evident to the therapist and the couple that interaction between the mother, father, and the child was similar to that with the initial young adult patient. In this case it was necessary to work with the family in generalizing what they had learned in therapy with the young adult to the relationship with this other child. This was not a difficult task since the parental or marital sub-system had been strengthened during the prior treatment process. However, where these sub-systems have not been restructured, resolution of this problem could be more difficult.

It is not uncommon that families of this type will have developed a pseudo-mutual atmosphere in which they tend to withdraw and avoid conflictual situations. Such withdrawal includes denial and non-acceptance of negative emotions such as anger. In these cases, it

was necessary to reframe expressions of negative feelings so that they are seen as positive and acceptable to the family. The therapist offered emotional support as family members began to admit and express feelings openly. One possible reframe is to state, "If you are going to have a healthy family life, it is absolutely necessary that you begin to express your anger and dissatisfactions about what is going on within the group."

In some instances one of the marital partners might decide that they did not want to come for additional sessions, while the other partner had some unresolved concerns and wanted individual help in the resolution of certain feelings or personal problems. In these instances, the individual has the right to get such assistance and it is important to emphasize that the person will be able to resolve individual concerns and issues. However, the therapist has an ethical responsibility to explain to the couple the possibility that a disequilibrium in the family may occur as a result of individual treatment. For example, if a more passive partner wants additional sessions, successful therapy will result in this person's becoming more assertive. Such self-assured behavior will then have an effect upon the spouse and other family members which require the other members to learn to respond to a changed individual. Such adjustments can be extremely upsetting to some families who strongly resist change.

Conclusions

This model of Interaction Focused Therapy was initially developed with six young adult males and their families. Follow-up with the initial group revealed that four of the young adults gradually attained independent functioning through education, training, or employment. The other two were less successful in total separation but their family relationships are congenial and double binding that brought them into therapy had been alleviated. Experience with this process indicates that it was effective in freeing all six families from the double-bind situation. During the years since the model was developed the presuppositions of Communication or Interactional Theory continue to provide the foundation for training and clinical practice conducted by the authors here at the ULM Family Therapy Center and in private practice. Outcome with families with an offspring exhibiting behavior diagnosed as severe remain comparable or superior to the results attained the original study. Perhaps the most vital factor in successful or unsuccessful application of Interaction Focused Therapy relates to an observation made by the creator of the orientation, Don Jackson: The extent to

which the therapist “believes” in family therapy will determine his emphasis on techniques that convey this orientation to the patient,” (1961, p. 30) and the authors would add the success or lack of it.

Once the young person was freed of the double bind, the most difficult part of therapy became helping him catch up in terms of emotional, education, or occupational endeavors. This process was often slow and took patience and persistence on the part of the therapist. As was true with the six persons in the original study all of whom were on heavy regimes of medication, it remains necessary that the therapist work closely with the psychiatrist in terms of gradual reduction of medication, as it was very difficult for the young person to maintain motivation and accomplish goals because of heavy doses of drugs. Gradual reduction of dosage becomes feasible as family pressures on the young person were reduced and the young adult developed a therapeutic relationship with the therapist.

While this model was developed while working with young adult males, it is easily generalizable to working with young adult females experiencing difficulty making the transition from adolescence to young adulthood by making modifications in terms of age and sex appropriate outcome goals. The double binding nature of communication and the necessity for redefining the nature of relationships between the young female and her parents is fundamentally the same, as is the process of treatment. As a result of treatment, the young persons came to know that they had the support of their families and further interference with their life goals was not likely. Perhaps the real key to treatment in these difficult cases is the old philosophy of “Don’t give up on the client’s ability to change”

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FORMER CLIENTS AS A RESOURCE IN PSYCHOTHERAPY: “MY SYMPTOMS SPOKEN OUT BY SOMEBODY ELSE”

Stefan Geyerhofer¹ and Carmen Unterholzer²

Abstract: *The article describes the practice of using former clients as consultants in therapy. This temporary extension of the therapeutic setting can decrease clients' subjective isolation, help reach a better and more direct understanding and opens up opportunities for experiencing and learning about new solutions from a “positive example”. Theoretical considerations to this method of intervention are combined with reports from participating clients (from follow up interviews to these sessions). Two concrete case examples illustrate the benefits for clients and possible effects on the participating consultants and the therapeutic process. Risks and guidelines for the use of this intervention method are presented and discussed in comparison with methods of similar intentions (such as video interviews, written client reports, former clients on reflecting teams...).*

“I used to have a client who had quite a similar problem...”

With words like these Milton Erickson used to start his already legendary trance inducing stories about his former clients. Hereby he shifted the attention for finding solutions to the problems away from him and his clients, and towards others not present in the room. He let his clients seize the former clients' experiences in a modeled form.

1 Stefan Geyerhofer is a clinical psychologist, health psychologist, psychotherapist (systemic family therapy), instructing therapist and supervising therapist in the ÖAS, co-founder of the Institute for Systemic Therapy (IST) in Vienna and adj. professor for psychology at Webster University. He is a founding member and member of the board of the European Networks for Systemic and Strategic Therapy

2 Carmen Unterholzer is a doctor of German language and literature studies and educator, visiting lecturer at the University of Innsbruck, technology writer, instructor for poetry- and biblio-therapy (Fritz-Perls Institute, Düsseldorf) and psychotherapist (systemic family therapy) at the Institute for Systemic Therapy (IST) in Vienna, Austria

Jeffrey K. Zeig, hypnotherapist and publisher of Erickson's work, is another one to show how it's possible to utilize stories about completed successful therapies in the current therapeutic setting.

For example, Zeig tells to a woman that has been suffering from phobia for 13 years and comes to ask Zeig for hypnosis, several stories about women who had been able to overcome their phobias in different lengths of time. "This particular patient had a habit (that probably lay beyond her conscious perception) of nodding in a validating manner – especially during those parts of the anecdotes centering around the slow solution of the problems at hand." (Zeig 1999, p. 33). So he gave her appointments with long lapses between the sessions. "Applying shorter lapses between the sessions was not indicated, because the client had already indicated that it's only a slow recovery that could possibly be achieved." (Zeig 1999, p. 34) Zeig thus makes use of anecdotes in order to provoke diagnostically sizable reactions. Yet these anecdotes are also utilized with the intention to:

- establish contact with the clients
- suggest solutions to the clients' problems
- facilitate insight
- improve clients' motivation
- change rigid patterns of relationship
- reduce clients' resistance
- plant stratagems
- Redefine problems or define them anew (Zeig 1999, p. 34ff.)

The preservation of therapeutic success stories has gained a great number of new variations with the formation of the narrative approaches within systemic therapy.

While Erickson and Zeig used to talk for their former clients, narrative therapists let their clients speak up by themselves.

Therapists end therapies with a final interview in which they look back jointly on the fight against symptoms of a disorder or a problem, putting special emphasis on all those discoveries that have helped to cope with the symptoms of a disorder or a problem. (White & Epston 2002; Epston, White & Ben 1995).

The interviews at the end of the course of therapy give the clients the chance to once again and in a concise way narrate their own success story to themselves and an audience (formed by the therapist and other clients whom the narrations may serve).

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Yet also therapists are given the opportunity to go beyond the initially stated problem and defined aim of therapy, in order to mold in the alternative narrations together with the clients. (Geyerhofer & Komori 1993).

With the help of audio and video recordings from these interviews it is possible to later utilize this material as a resource in the sessions with new clients.

Those clients who had been in a similarly difficult situation, yet managed to master this challenge, thus become positive coping models.

Written final summaries are being worked with in a similar manner as audio and video recordings. With the clients' permission, these are forwarded to other clients encountering similar difficulties, thus rendering some very few yet significant lines the carriers of hope in situations of prevailing despair.

A step out of isolation: "I don't know of anyone who could overcome this disorder "

During one session with Julia* I once was confronted with the entire despair of this 12-year old girl in her fight against anorexia**. It all started out seemingly harmless. One day in July in a public pool a friend of hers had told her: "You should pay attention! You are getting fatter and fatter! "Due to this incident, Julia prescribed herself a "summer diet", refraining from sweets. In August, most thoughts and conversations already centered on the problems of "being fat", "gaining weight", and "eating". From September on, she started counting calories, beginning in the fall she started eating only few elected foods. She felt her own will was "fading away", something else had taken control of her. In November she was being hospitalized in the General Hospital of Vienna, weighing only 35kg, the diagnosis being: "anorexia".

The first three sessions of therapy at my institute took place in January together with her parents, overlapping with her being treated as an inpatient. We discussed the history of the problem (her mother had been anorectic in her youth as well), the momentary situation (pressure exerted by the clinic due to her threshold weight of 36 kg), as well as possible causes (difficult family situation since her parents' divorce, fear of growing up, etc.) as well as the effects of her disorder on the other family members (feelings of guilt, fear, change of the course of life due to care obligations ...).

During the second session at first I discussed the parents' history as a couple, their divorce, current conflicts and her unsuccessful and desperate attempts to help Julia, alone with the parents. I then talked to Julia alone. We discussed her fear of growing old, her perfectionism and her strengths. I continued asking questions about what I should know about her and her problem. When I asked her how she is calling her disorder by herself she started telling me the story of "Fritzchen" (German for 'little Fritz'). She told me how in such a short period of time she, "Fritzchen", had been able to steel away her free will and take over control of her life, erase all the fun she used to have in life, and finally make her end up in a psychiatric hospital.

Since her parents knew of "Fritzchen", we had been able in a later session with Julia and her parents to externalize the anorexia as "Fritzchen". (Regarding the externalization of problems view: White 1988; White & Epston 2002; Freeman, Epston & Lobovits 2000). By this means it was further possible to unite the family in the fight against the "G'frast" (as Julia called it). Julia had decided to take up the fight against "Fritzchen" and discovered her very own will as her prime ally in this fight ("I want to live!") "I want to recover!").

She had already given a demonstration of her newly arisen willpower during her last week in the clinic. She could persuade the other girls to switch the TV-channel as soon as commercials would show one those super-slim models. First battles against "Fritzchen" were won, and in collaboration with me she was able to brief her parents how to support her in her fight in the best way possible.

In the fourth session Julia was talking about her first big retracement, her motivation was about to melt away. "Fritzchen" had won several battles, yet the fight against anorexia seemed to be a lot harder than expected. After her release from hospital Julia was again confronted with the outside world, which included: supermarkets ("Fritzchen's" favorite battlefield), fashion magazines, billboards, mirrors, friends that were lacking empathy, teachers and schoolmates – a whole lot of fellows with little understanding, and at the same time allies of the anorexia or in Julia's words: "Fritzchen's spies". With tears in her eyes she expressed her despair: "Where on earth am I supposed to get support from, not knowing of anybody who had been able to overcome this disorder. In the clinic I've only met people who had already been there twice before." It was this very session, when I

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first suggested inviting one of my former clients to join one of the running sessions.

Former clients as “positive models“: *“Without chances? No way!”*

The therapy with Carla* had been finished already several years ago. The then 14-year old had been facing discharge as an inpatient in the General Hospital of Vienna when she was referred to me. Her therapy had been one of those where the therapist doesn't really get the chance to ask about the problem because the family is so busy talking about what had changed and what would be regarded as possible solutions. This is the clearest signal for not trying to take a problem-oriented path but rather start off right away with a solution-oriented approach. (Geyerhofer & Komori 1995; 1999) We spent two sessions with affirming, extension and internalization of solutions and agreed upon an appointment for a “check-up” session three months from then. The mother later on cancelled that appointment as everything had gone well. Carla sent me her personal “final report“, I thanked her in a letter once again stressing Carla's and the other family members' accomplishments.

“While being an inpatient, my attitude toward eating had changed” the young woman writes in her report, which she titled: “anorexia - without chance? No way!” “I had stopped associating eating with gaining weight and ideal weight. It became a daily duty in order to stay healthy and above all to stay powerful. Here I'm not thinking of competitive sports but of work and tasks in everyday life. The regular meals are also of major importance for the entire condition of the mind. One is able again to participate in school activities, have fun, and engage in various hobbies. Oftentimes I'm telling to myself, especially in moments of doubt, that it would be mean toward myself, if I wouldn't enjoy my youth the way my friends can do it.“ Carla gave me permission to forward her written down thoughts to other clients struggling with anorexia. It was exactly what came to my mind sitting face to face with Julia in a room filled up with hopelessness.

I handed a copy of Carla's report to Julia, and promised her, as she had wished, to try to arrange a joint session together with Carla. I could get a hold of Carla's mom on the phone and explained to her my idea of inviting Carla to participate in a running session as an expert. She told me her daughter didn't live there any more, that she had moved into an apartment in which she lived by herself and that

she was studying eagerly. She also told me about her concerns that inviting Carla to join a current session might re-evolve "old stories". She suggested talking to Carla in the first place and that she would respect her decision whatever it might be. Carla agreed to participate on the following day.

Knowing about the suffering of others: "I'm not alone"

Similar to the success stories of Erickson and Zeig as well as audio and video recordings of the closing sessions of successful therapies, writing down the "reports of success" of former clients can play a supporting role in therapy. Madigan and Epston (1995) describe how these "therapeutic archives" can help clients facing similar problems and be a source of new motivation to overcome isolation. Madigan and Epston define the Anti-Anorexia and Anti-Bulimia-League as a public community of support providing material that helps clients to overcome their solitariness and isolation.

Clients thus feel that they are not alone with their suffering and problems. Epston, Morris and Maisel (1995) stress that the meaning of these archived material cannot be overestimated. According to them, these stories mark the "beginning of an alternative vocabulary that is the precondition for realizing the suppression exerted by a problem and for every form of resistance." (Epston, Morris und Maisel, 1995, pp. 69-96) Epston defines his role as a mediator by the expression of a "therapeutic archivist" (Epston et al. 1995) forwarding collected knowledge and the experience of former to current clients, based on the former clients' consent and rules of discretion.

Jim Sparks (1997) describes, based on a case carried out at the Mental Research Institute (MRI) in Palo Alto, how to integrate former clients into a current session directly and "live". For Karuna Cayton, therapist practicing at the MRI, it was her client's feeling of being without confidence and left alone in his suffering that lead her to inviting a former client to join the current session. As mentioned by Cayton's client, his persistent hopelessness also stemmed from the fact that he had never met anyone able to successfully overcome panic attacks. (Sparks, 1997) Jim Sparks shows how the dialogue between client and consultant can at least momentarily displace the feeling of solitariness.

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Something similar is told by Tobias* about a therapy session with a former client as consultant. "It had simply been good to hear that others are suffering from the same problem as I am. It had been interesting for me to hear "my" symptoms spoken out by a different person" he tells in a follow-up interview***. He had been suffering from panic attacks, anxiety and depression for three years. He already had dropped out of therapy twice and came to my institute with great expectations toward brief therapy after heaving read one of Paul Watzlawick's books. During this therapy, the interrelations between his anxiety and his difficult family and personal situation became clearer to him. Besides treating his panic attacks and depression, the realignment of his life and the strengthening of his personality had been aims of therapy from the beginning on. In a moment when he had the feeling of "never ever being able to get out of this", and doubted that anyone sharing his symptoms would ever be able to live without suffering again, I suggested to him to invite a former client into the next session, who actually managed to overcome her panic attacks.

I had thought about Gudrun*, a former client suffering from burnout symptomatic and panic attacks. By the end of her therapy she had allowed me to record her personal success story in a video interview. Gudrun didn't hesitate to join us in a therapy session with Tobias. I introduce them with their first names. At first, Gudrun tells her story, Tobias listens carefully. She's talking about her disposition toward anxiety, and her experience that she was able to exert an influence on the course of her fears. She explains how and with the use of "what tricks" that she had been able to "tame the monster", that once made her suffer, and that she had been free of any relapses for an entire five years now. She closes by listing the positive side effects of her disorder and the therapy: She has started to go jogging, stopped smoking, changed her job; reduced being so demanding with herself, takes a closer look at enjoying the fruits of everyday life, and knows about the side effects of analyzing and chewing things over excessively. Tobias keeps asking about details of her symptoms, yet he shows special interest for the "tricks" that Gudrun had mentioned. The vivid conversation between the two lets me sit back and relax in the role of listener and moderator. In the follow-up interview Tobias mentioned how important it had been for him to have somebody else confirm what he had lived through himself. "It was good, to hear in a very concrete manner, how others perceive this. On an abstract level one knows that there are others with the same disorder. But it causes such a huge difference actually having

another person in front of you speaking about her experiences." Without having asked her, Gudrun tells me something similar in her follow-up interview: that it had been of great importance for her to experience that others deal with similar problems as she does. "If someone would have come into my session back then who understands me, who has made similar experiences, that definitely would have been beneficial – especially because it was so important for me to realize that others suffer from the very same problem as I do."

Integrating former clients as consultants into therapy sessions can in the short, but also in the long run, outweigh the oftentimes prevailing feeling of isolation and being alone with a disorder or problem. This assumption falls in line with Lobovits, Maisel and Freeman's (1995) hypothesis that traditional approaches toward individual therapy oftentimes, without intending to do so, foster a climate of solitariness. Like with self-help groups and group therapies, clients can take from a session with former clients as consultants not just the relieving certainty of not being alone, but can also discover that they are being well understood by others. In the best of all cases they get an affirmation of their own attempts to solve their problems or even other possible solutions. Furthermore, some other possible effects of this method of intervention can be identified.

A model for problems and solutions with similarities and differences: *"Similar suffering, yet different perspectives"*

To invite people facing similar challenges like the clients into the "Reflecting Team" (Neil, 1996) is yet another possibility to make use of their knowledge and experience. Epston and Madigan (1995) write, that if they had an open position in a "Reflecting Team" they would rather fill it with a member of their Anti-Anorexia / Anti-Bulimia-League instead of a therapist. According to their experience, clients are always fascinated with the direct and empathetic reflections of members of the League.

Matthew Selekman (1991, 1995), psychotherapist from Chicago, is talking about similar experiences from his work with delinquent youth. Peers in Reflecting Teams oftentimes render themselves more useful regarding therapeutic outcome than therapists. (Selekman, 1995)

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The creative ideas that young men and women get from their peers are easier to embrace than those from therapists, and due to this they are better suited to foster the finding of new solutions. The peers present can already after few words become respectable "positive models". If this identification process is successful they can become in the course of therapy a source for a direct and empathetic understanding of the problem, yet also for possible solutions. In his work with the well placed title „With a little help from my friends“, Selekman (1991) describes several different ways of integrating peers into a family therapy setting. He also mentions that peers can help retrieve clients' trust in their parents and that they can be helpful in preventing relapses.

Selekman's therapeutic creativity becomes apparent in a case he describes in his book about solution-focused therapy with children (Selekman 1997, pp. 171ff.)

Finding himself stuck in the course of the sessions with a young client and his parents, he chooses to include a friend of the clients' as a consultant into the setting, who was regarded by both the client and his parents to be part of an "exceptional relationship". In the course of the following sessions this friend proves to be a great consultant for the client, his parents, and the therapist as well.

Eugene K. Epstein works as a youth psychiatrist at the Clinic for Youth Psychiatry and Psychotherapy in Wilhelmshaven, Germany, and decided to work with the ideas of Selekman. He says that he and his colleagues had agreed upon engaging inpatient youth in reflective processes. "The to-be-treated can become active supporters for the therapies of other clients when they are integrated into the course of therapy. The rather passive position of the client is overcome by an alternative role comprehension. Young men and women can view themselves as highly recognized and demanded consultants in the context of therapy, even though they are being clients themselves." (Epstein 1998, p. 42)

Something similar is being told by the clients we are presenting here. Gudrun had tried to give Tobias an idea of the fact that getting in charge of your own life can be fun, too. Toward the end of the session, Tobias said that it had been good to hear this from Gudrun. His dad had told him the very same thing, but from him, you couldn't take it.

Inviting peers or former clients into Reflective Teams can broaden the scope of therapy, yet it also bereaves clients of the chance to actively interact with a new resource. In a Reflective Team clients

don't get the chance to ask actively, while during the "live-hours of consultation" with former clients it is even mandatory to actively ask questions. For Tobias this opportunity to ask questions revealed itself to be very helpful, as he mentions in a follow-up interview. "I wanted to know from her how exactly she knew what her sticking points were. I asked her how exactly she could tell that her panic attacks had been overcome, when she could frankly say: I'm done with it. And then I wanted to know if her attacks were totally gone now or if she was still feeling the onset of them from time to time."

The direct communication allows for the gauging of similarities and differences regarding problems, living circumstances and attempted solutions by the clients. And this can very well lead to a paradigm shift. For the narrations of former clients oftentimes entangle possibilities to perceive the own problem in a different way, sometimes they even include extraordinary metaphors, reframing and externalizations. Tobias summarizes this effect based on the joint session with Gudrun, in the following way: "It had been so important for me to realize that it's possible to view the very same things from a totally different angle. That has helped me a lot."

Speaking of Hope: *"It's not going to be part of my life forever"*

"Today, for the very first time, I felt something that might be called hope"; Karuna Cayton's client spoke out at the end of the session that had been accompanied by a former client. (Sparks, 1997) "I can't even tell you how much I've been touched by what you've told me today. I wish we had many more hours to talk." This client Jim Sparks (1997) is telling us about gives us a hint to one of the most precious enrichments that comes with these joint therapy sessions. Clients can really feel that they have been understood departing from a common ground of suffering. Despite all the differences in the personal tale of woe, this empathetic and oftentimes solitary understanding can be a great relieve that sparks new hope. In the same line Tobias is thinking after having met with Gudrun. He stresses two things: To him, the invitation to a former client had been a lucid moment. "I had thought if I'm really such a hopeless case, my therapist wouldn't make such an effort." And further, he found it quite relieving to realize that others had been able to overcome panic attacks. "It's been important for me to understand that these things can go away, that it won't accompany me until the end of my days, because at that point in time I had almost lost faith in that." His newly acquired hope stemmed from the fact that Gudrun

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had fully overcome the symptoms of panic attack. "When she told me her panic attacks had faded away completely, that had been such a relieve."

Also Carla mentioned that she would have wished to have received this form of intervention during her own therapy. "I thought it would surely have been beneficial, if a "cured client" would have been invited to join my therapy. That enables courage and confidence."

Courage and confidence are two factors that play a tremendously important role in therapy. Snyder, Michael and Cheavens (2001), examining the "theory of hope" differential themselves from older, emotion-focused models of hope, and instead focus on thinking - the rather cognitive part of this factor. "Hope can be understood in the way people think of their goals." Michael J. Lambert (1992), outcome researcher and professor of psychology at Brigham Young University defined "placebo, hope and expectation" as one category of the four common therapeutic factors, working beyond the boundaries of single schools. Research evidence shows that hope and expectation account for 15% of positive therapy outcome. "This class of therapeutic factors refers to that part of amelioration that results from the clients' knowing of being treated and of the evaluation of the basic ideas behind the therapy and the techniques that accompany it. (Hubble et al. 2001, p. 28).

At this point, and close to the heritage of Frank and Frank, (1991), Snyder, Michael and Cheavens (2001) believe four points to be of major importance:

- An emotionally co notated relationship to the therapist who is committed to help the client and who trusts in the client's capacity to change. It seems to be exactly what Tobias' therapist had achieved to convey to him when he decided to invite a former client into the session.
- A therapeutic setting that nourishes the client's perception of the therapist to foster positive change and strengthen his trust in being able to leap forward. The client needs to feel that the therapist working in this very special setting had been able to help others reach their goals before. And it's here that the "positive models" come into play, because

clients can perceive by themselves that there are people alive who had been helped by the therapist.

- A therapeutic myth or a rationale that can account for the symptoms of the client and that can explain how the symptoms are going to change in the course of therapy. Therapeutic rituals or methods of treatment that the therapist trusts in. Effective therapists convey both knowledge about solutions as well as acting by demonstrating faith in their techniques and the sufficient skills to carry them out. (Snyder et al. 2001, p. 198).
- The reawakening of hope is both a characteristic of psychotherapy as a whole, as well as of the intervention strategy discussed here.

Problem-focus and solution-focus: *“I would have loved to present to her that one single solution”*

Geyerhofer and Komori (1999) describe the broadening of the therapeutic scope through the integration of systemic models of therapy (problem-focused, solution-focused, and narrative approaches). Therapists are being guided by their clients, by the therapeutic process and by their experience concerning the shift of the therapeutic focus on the following two axes: “acting vs. cognition” and “problem- vs. solution-focus“. Let’s try to view the broadening of the therapeutic scope discussed here in the light of this shift on the axis of problem- vs. solution-focus. As a matter of fact, this could be of special importance in those cases where concentrating on solutions and resources may not work well. We’re thinking of the following situations:

The solution to the problem and a life without suffering seem out of reach to the client due to the lack of practical examples that could demonstrate such a solution.

A life without suffering and problems seems out of reach because clients realize that the fight for a life free from suffering may take longer than expected and require more resources than the client thinks he can come up with.

The motivation for enacting already established solutions is being boycotted by the severity and endurance of the relapses.

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Motivation for therapeutic change exists, yet there are simply no practical ideas how to enact meaningful change, and, furthermore, the ideas of the helper cannot be perceived (which to Milton Erickson would probably have been the typical situation for "I once used to have a client ...").

Carla mentions that to her being the positive model it had been very important to come up with possible solutions during the session. "Both of us were noticing the same ways of acting. We weren't loud or screaming. No, we were starving. We had always wanted to do it all right. We had always taken everything personal. We had always bared the blame on ourselves. I could recognize me in all that." And it was exactly due to these parallels, that she was able to stress possible solutions. "I had wanted to convey that there is no such thing as the one single possible solution, but rather that it's many small steps that render change possible." At the same time Carla mentioned that it had caused a problem to her that she could not just come up with that one single solution. "But anyways, it surely was important for her to witness somebody who had been able to make it."

Also Gudrun mentioned in a de-briefing interview after the session with Tobias, that it had been hard for her to tell if her solutions had been of any use for Tobias. "I saw quite clearly where exactly he was stuck and I also felt I had filled my role in a decent way. Yet I simply couldn't tell how it was for him."

We believe it to be possible to put the focus on solutions while performing joint sessions with former clients as consultants, or having them participate in the Reflecting Team.

Yet, we also think that a main aspect of this method doesn't have to do with solution-focus. It rather is to be found at the very end of the continuum, namely the exact understanding of the problem situation and the suffering. Several years ago I used to hand over to a client and mother of a child suffering from ADHS, a video cassette in which parents and children were talking about their life and battle against this syndrome. When this woman came back into the practice the next time, she expressed: "You can't imagine how I've cried watching the tape. I had the impression of another person telling the story of my life!"

Sometimes it's exactly this deep understanding of one's suffering from the very inside of another person that's necessary to put into action solutions that one had already pondered upon before.

Tobias describes this aspect in the following way: "In the course of the session it's simply been nice to realize that others can feel the same, and that there is a life after the suffering, that one might even be better off than ever before once it's all over. This thought seemed very sage to me and I used to really believe it back then! Anyways, I had decided after that not to put so much pressure onto myself."

Karuna Cayton and her client (Sparks 1997) had been surprised that many of the ideas that arisen during the course of the session, had not been new. "But being able to listen to somebody else out of his very own experience had caused a significant difference to me", Cayton's client explains. (Sparks, 1997)

Also for Tobias Gudrun's ideas had not been sensationally new ones, yet moreover a confirmation of the already initiated possible solutions. "I haven't learned anything entirely new. Gudrun stressed the importance of going step by step. I know that – yet putting it into action is the big problem", he remembers months later during a follow-up interview.

Former clients as experts: "I know so much"

Jim Sparks mentions in his article the benefits of the extended setting to the client. Almost in a casual way he writes toward the end of the opening chapter about possible great effects for those clients who offer their expertise and their experiences as consultants to other clients. We had expected this, yet we were surprised by the extent.

Carla mentions twice during the follow-up interview, what a good feeling it had been to be a "positive model". I had been proud, so proud – I really felt that. It had made me happy to see that my therapist still remembered me even though I had already recovered. And I felt that I could bring about to the client some important ideas. (...) It had been a totally satisfying feeling. (...) I had the impression of really knowing a lot about anorexia. I felt I could convey something, and that was very good. Besides, it had been fascinating for me to feel how I could empathize with the client."

Similarly, Gudrun expresses that during the session with Tobias she realized how much she knew about panic attacks. "I noticed how much I knew – as well about the disorder as about myself. That once again became so clear to me during the session with Tobias. I

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then thought that it was a little sad not having done more with this knowledge, I could have written a book. (...) After the session there had been a feeling of strength and my success in this entire thing had become clear once again." Even for clients in current therapies taking the role of the "positive model" seems to be attractive. For instance, Tobias mentioned many times without being asked, that whenever he's ready, he would love to volunteer for such an intervention. "I want to hand on my knowledge about how it's actually possible to overcome this. I'd wish to put my energy into this, others should benefit from this. So I don't have the feeling of just having wasted my time with these panic attacks." We assume this idea of becoming a "positive model" to even strengthen the motivation to ameliorate in therapy.

Similar to the invitation to the "Reflecting Teams" (Selekman 1995), similar to the video interviews (Madigan u. Epston 1995), or with the use of final reports, former clients can actually grow out of their role of being clients after receiving the invitation to join a session. They assume a different role: the one of being the expert for problem solving. They become consultants for possible paths out of the disorder, and positive models for the fight against states of suffering.

The fear of relapse and the pride of what's been mastered:

"Looking back without fear – the final cut"

We later on want to discuss in detail the risks that may be entailed by the above mentioned kind of sessions, both for clients and for the therapeutic relationship. Yet also former clients that are being invited by their therapist to join a session as a consultant, are facing a risk that shouldn't be underestimated: For having to go through all the details of the fight, the suffering, and the conflicts that one used to draw others in after all these years can be quite a challenge. Because these memories have the potential of re-awakening the once tamed monsters, reactivate old patterns, and let those already forgotten feelings of helplessness take over again.

Gudrun points out her doubts in a very clear way: "The day before I didn't feel very good. I hadn't thought about the panic attacks for such a long time. And then, all of a sudden, I'm being told of somebody who just had a severe relapse. Something like that is always shaking and instantly it came to my mind: what if... And suddenly these old thoughts and feelings were back, in a rudimentary way. Yet I was able to dissolve them quite well right

away." In this way she describes her initial reaction toward the invitation to join the session with Tobias in a de-briefing interview. In the follow-up interview she talks about something similar: "Going over my notes I realized how much I had already forgotten. Yet at the same time I realized what I had done in order to get where I am at today. I hadn't thought about that for a long while. Being confronted with that again was probably quite helpful for me. By the end of the day, I don't want to entirely forget that time. (...) About two or three days before I had quite clear memories of my panic attacks, also accompanied by fear. These feelings had been very intense – it was not only pleasing. For a short while I was worried to relapse, but I was able to manage that quite well – fear from fear!" As she was invited to this session she "mentally had already distanced herself quite a bit from the panic attacks. I once again had to think about my fears and the burn-out, which was good for me. And one other thing was good for me as well: It was a healing experience to be asked as a positive case example. That to me had been the real punch line – both of therapy and of the disorder. The invitation was yet another strengthening."

Also Carla stresses that after the session there had been "the perception of strength, which once more underlined my success in this matter." Back then, during the conversation with the client, the anorexia had not been an important theme to her any more, still it had been beneficial to her to talk about it for one more time. "That session really made me think carefully again about those anorectic years. In the meantime I had tended to belittle a bit: In my case it hadn't been that bad by the end of the day, and all in all I was all right. But talking about it again in the session I suddenly realized: no, it actually had been quite severe. That session made me take myself and the anorexia seriously. The belittlement didn't work anymore; by talking about it I could magnify my perception of the meaning of it all." She didn't fear to relapse any more. "By being able to talk about it in such a free and relaxed way I felt that it was finally over. I thought to myself: being able to talk in such a way about it, the difficult years sure must be over."

The excerpts from the interview with the "consultants" show yet another post-therapeutic chance: Consultants can codify their story of problem solution in a new way. After recalling the old symptoms and the emotions entangled with them they are being confronted with the question: "How exactly could I manage all this?" To present in an exemplary way solutions and ideas to other persons concerned,

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activates the former client's own resources, his recall of solution strategies discovered, and the very own strength in the battle against those states of suffering. Already the invitation to such a session provides the opportunity to internalize for a second time the solution strategies utilized back then as a client.

Like Michael White's "re-description questions", his questions for possibilities in a life without problem ("possibility questions") (White 1988; White & Epston 2002) and other question techniques and interventions for the internalization of solutions (Epston 1993), and similar to the here stated interviews, the final reports, victory celebrations or certificates (White u. Epston 2002) there is the opportunity opening up with the invitation as a consultant into a current therapy, to return to one's mind the very own accomplishments and to hand them on to someone else, in the presence of the former therapist. That session can thus become an opening performance of the "history of solutions" in front of a partly known (therapist) and a partly unknown audience (client).

The therapists' role in sessions with former clients as consultants

Snyder, Michael and Cheavens (2001) investigated what kind of interventions actually reduced clients' hope. They conclude that it's not beneficial when therapists work more than their clients. Because in this case it might occur that the goals and ideas that might emerge in the sessions are more the therapists' than the clients'. They stress that the therapists' role is to merely mold the components of hope. Clients' confidence actually tended to diminish as therapists devoted themselves to any single paradigm. "The theory of hope suggests that there are various different approaches to help clients reach their goals. By being able to flexibly apply their interventions, therapists can enhance the power of their striving." (Snyder, Michael u. Cheavens 2001, S. 209). By integrating former clients into current therapies, therapists are utilizing a to this day unconventional technique, at least in the sphere of individual therapy. This way they enlarge their repertory of methods. They should pay attention to stay in the background during the course of this type of joint sessions, and point out connections, parallels and differences if necessary. They should moderate the entire process. The therapeutic dialogue itself should be left to client and consultant.

A beautiful metaphor for the therapist's role in this kind of sessions comes from Gudrun, who studies music: "It's been like a jam

session. There was this kind of implicit interlocking. Everyone was able to take his role, play his part well. The therapist was the conductor, yet he was playing an instrument at the same time. That's been very nice to witness. The sensitivity, the tactfulness that was present in the room – I really liked that."

The therapist's cautious way of acting seems to have suited as well Carla's needs: „It's been good that he intervened here and there, asked questions, and moderated the dialogue. It's simply been important that he tried to conciliate between two people who barely knew each other. The atmosphere has been very relaxed and comfortable, and I instantly felt that I can be quite frank here." In special cases and with exceptionally sensitive and empathetic consultants it can happen that these find themselves in the role of co-therapist. In this case, it should be the therapist's duty, departing from a meta-level, to carefully gauge the development of the consultant's role. Because at the end of the day, the therapist always carries the main responsibility for the congregation.

Possible effects on the relationship level: *"I was pleased to see that the therapist was so highly committed with me"*

Besides the factor "hope and expectations", Miller, Duncan and Hubble (2000, 2001) discuss "client-therapist relationship" as the second of the four areas of common factors, that significantly facilitate change. Scientific findings suggest that the factor "relationship" may actually account for 30% of positive therapy outcome. Care, empathy, warmth, acceptance, mutual reinforcement and encouragement to take risks are some of these. Besides all the resources clients bring into therapy these variables may turn out to be responsible for the biggest share of the benefit resulting from therapeutic interventions." (Asay & Lambert 2001, p. 41).

Integrating former clients as consultants into current therapies seem to have resulted in an improvement of the client-therapist relationship, at least as the individuals interviewed by us are concerned. Tobias puts it this way: "I thought it had been a good idea and I was pleased to see that he was so committed with me. As far as I know, it's not really common to do that. (...) I was thankful he had made that extra effort."

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Yet also with former clients returning to the therapeutic scene in their new role as consultants, the relationship toward their former therapist changes. Gudrun points out that: "In the course of therapy what had occurred to me as a problem from time to time was the hierarchical gap. I was needy, little and weak. The longer the therapy went on, and the better I felt, the more this gap actually bothered me. It was hard for me to deal with that. The invitation to join the session with Tobias brought me into the expert position. Now I could help somebody who was needy. And that also changed the authority gap to my former therapist." Something similar was mentioned by Carla twice: "When the therapist was calling me, I was really happy. It's rather uncommon for a therapist to get into contact with a client after the end of therapy and remember her." She says that she had been very proud to pass on her knowledge: "I was glad my therapist still remembered me, even though I was already cured. (...) I was glad and felt strongly valued."

Risks and guidelines for practice

Possible advantages of this temporary extension of the therapeutic setting have been discussed thoroughly. We finally want to focus on possible risks of this intervention technique and summarize the most important guidelines for practice.

Sparks (1997) already commented on the risk of negative comparison with the "positive model". Clients whose hope for recovery is at a low level could find themselves in an inferior position compared to the "expert" that managed to master this great leap successfully, maybe even with apparent ease, or they might even tend to devalue themselves. It should therefore be the therapist's responsibility to anticipate this tendency and direct the focus more upon the consultant's difficulties in overcoming problems.

"What was it that helped you the most, back then, when it was still difficult?"

"How did you face relapses back then, and what helped you deal with them?"

"Before things changed for the better, how did you manage to deal with the moments of suffering?"

Something similar holds true in case the client is not able to listen to possible solutions presented by the consultant, due to his current

situation. In most cases it can then help for the therapist to focus more on the problem than the solution by directing questions to the consultant about his former problem and the symptoms back then. (Geyerhofer u. Komori 1999). The goal of the session then shifts from finding solutions to overcoming isolation. In a similar way, Sparks (1997) mentions that in such a situation it seems more helpful to the client to have somebody there who had gone through something similar and still remembers the difficulties encountered, than to hear about all the various ways someone has found to overcome a specific problem.

In case clients are facing problems to direct questions to the consultant after having listened to their story, the therapist can help out with the following questions:

"What's been striking you as interesting looking at Mr. / Mrs. X's story?"

"What aspects of the story would you like to know more about?"

In case clients feel uncomfortable in the presence of people "not belonging to therapy", or if they encounter difficulties formulating questions, which can be the case with younger clients, the therapist should assume a more active role. They can utilize their knowledge about the client's problems addressing detailed questions to the consultant.

"How did your environment react to your problems back then?"

"What did not help you at all back then?"

"Looking back, what has been especially incriminating?"

"What eventually opened up the path toward change?"

"How do you explain to yourself your problem back then? And what explanations did you have back then, when you approached me?"

The best case provided, there will be a vivid conversation unfolding between the client and the consultant, leaving the therapist with the role of listener and moderator. In this case the strengths of self-help

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groups become apparent within the framework of individual therapy, at least temporarily.

Quite a problem, though not an unsolvable one, is how to preserve discretion in this kind of sessions. Already at the very onset of such a joint session something is revealed: both client and consultant know they are being or have been treated for a similar problem. Our practical experience shows it's beneficial to call both client and consultant by their first names, and to also introduce the one to the other in this way. The therapist's questions are more of a general nature, and do not refer to details from the former and current therapies, unless it is the client or consultant himself who refers to any details. Both client and consultant should be informed beforehand, that the legal discretion does hold for the therapist but not for the client and consultant, in such an extended session.

We already have mentioned the risk of relapse for clients. This should be taken into account when choosing suitable consultants. And we want to mention yet another ethical implication: Even after many years, therapists should take into account the unequal distribution of authority and hierarchies between client and therapist. Keeping this in mind, one should try to formulate the invitation to the consultant in a way that even a rather shy person would manage to decline the offer in case it doesn't suit him well. To preserve the therapist's responsibility, a short briefing before and de-briefing after the session should be included.

In the session following the congregation with the consultant, clients are given the opportunity to reflect their experiences from the joint session. Yet consultants may feel left alone with feelings of doubt and insecurity. To us, therapist's responsibility also includes to give the consultants a chance for a brief reflection after the joint session, be it in a phone call or a short dialogue. For instance, Gudrun told us about her doubts after the session with Tobias. She was unsure if she had been able to convey exactly what she had wanted to. In the de-briefing interview a few days later, we managed to clear away these doubts.

In the briefing, consultants should be familiarized with the idea behind the joint session, not including therapy contents, though. The general course of action, their role and the legal matters should be addressed as well. Possible risks may be addressed at this point,

and the de-briefing interview after the joint session should also be mentioned.

In order to make sure this intervention strategy is successful we again want to stress the factor “expectations“. Especially efficient would be the fact that the client himself comes up with the idea of a joint session, be it in an explicit or, like in our cases, as well as those described by Jim Sparks (1997), in a rather indirect way. In this case, positive expectations are most likely to be prevalent both before the session as well as at the very beginning of it.

Yet the therapist's expectations toward this sessions matter as well. Because of that we suggest a therapist to only propose such a joint session if he himself believes it makes sense. Only then the therapist can credibly demonstrate his hope and positive expectations to the client and to the consultant.³⁴⁵

³ All names have been altered for privacy protection.

⁴ All cases were treated by Stefan Geyerhofer at the Institute for Systemic Therapy (IST) in Vienna, Austria.

⁵ Follow-up Interviews have been carried out and evaluated by Carmen Unterholzer.

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Contact:

Adj. Prof. Mag. Stefan Geyerhofer
Institut fuer Systemische Therapie
Am Heumarkt 9/2/22
A – 1030 Wien
Austria
geyerhofer@geyerhofer.com
www.geyerhofer.com

Dr. Carmen Unterholzer
Institut fuer Systemische Therapie
Am Heumarkt 9/2/22
A – 1030 Wien
Austria
carmen.unterholzer@aon.at

MAINTAINING THE INTEGRITY OF STRATEGIC THERAPY IN AN AGENCY SETTING

*Eileen Bobrow, MA, LMFT¹
Jolynne Batchelor, MSW, LCSW²
Judy Harris, MSW, LCSW*

Abstract: *Any dedicated practitioner of strategic therapy has persuaded the frightened and hopeless parents of a symptomatic child that they are capable of solving the problem, only to encounter more rigid symptom-maintaining systems in the form of well-intended child welfare departments, institutions of juvenile justice, schools, behavioral and medical health care agencies, and funding sources. The problem becomes even more complicated in a publicly funded mental health setting, where, to succeed, the director must effectively implement the strategic approach not only within the agency but with relevant community partners as well. This article will examine the how-to's of effectively implementing strategic therapy in a community mental health agency. Three cases will be utilized to demonstrate the ideas presented.*

Strategic therapy is a humane approach to effectively treating human dilemmas. This approach to therapy, which was given to the therapy field by Jay Haley and Cloe Madanes, is not merely a method or a “model” but an entirely unique means of understanding problems and their solutions. Because strategic therapy is not simply a set of interventions but rather a paradigm for change, it cannot be practiced in a piecemeal fashion and also maintain its integrity. Moreover, to view this approach as a set of techniques while failing to comprehend the intention of this therapy not only leads to ineffective intervention but can be harmful as well. It seems not unlikely that criticism of the approach for being “tricky” or manipulative came from a lack of broader understanding regarding the use of particular interventions.

¹ Mental Research Institute,

² Youth Contact, Inc.

In a community mental health setting, therapists most typically treat clients with difficult problems that have brought them to the attention of other public systems. Therapists in a publicly funded agency must interact with other systems that may view the problem and its solution quite differently. Within this context, even therapists who are trained in strategic therapy may become seduced into assuming a medical model approach to treatment, and this will likely lead to failure. Agencies that do not meticulously maintain the focus on strategic therapy will not support therapists in a way that allows them to practice the approach in any meaningful way. Effectively practicing strategic therapy in a publicly funded agency, therefore, requires directors and supervisors who are dedicated to scrupulous and comprehensive implementation of the approach.

The strategic family therapist begins with the idea that symptomatic behavior serves a protective function within the family. Whether or not this premise is “true” or not is less important than its usefulness in defining problems in such a way that maintains the optimism of families, therapists, and their supervisors. The concept of a protective function leads the strategic therapist to believe that even the most difficult symptoms make sense within their context and are ultimately both an act of love and solvable. The strategic therapist expects that that even conflicted, troubled, addicted, abusive, or even seemingly “pathological” families are motivated or can be motivated to love and protect one another.

Practitioners in a publicly funded agency are presented on a daily basis with challenging, multi-problem family situations that are most often complicated further by the involvement of the state and other institutions. The strategic therapist practicing in a community mental health setting must recognize that he/she is practicing within a larger, powerful system or network of powerful systems that most often understand and treat problems with the medical model approach. It is critical that the strategic therapist effectively engages and negotiates with other systems much as he/she does with a family. That is, the therapist must effectively join with child welfare caseworkers, juvenile justice counselors, teachers, school counselors, psychiatrists, pediatricians, and funding managers in order for the outcome of treatment to be positive. It is up to the director of any publicly funded agency committed to implementing this approach to consistently train and supervise staff in strategic therapy and also to set the stage for effective intersystem collaboration within the community.

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The key variables that a strategic therapist utilizes to understand and change a family system are the same as those that the agency director must apply in order to successfully implement this approach. These variables include the following: 1) hierarchy—which refers to the organization of power in a system; 2) unit—which refers to the number of people with whom the therapist will intervene; 3) sequence—which refers to the order of interactions; and 4) protectiveness—which refers to the idea that humans are motivated to help others. Practicing strategic therapy in a community mental health setting requires that these four concepts be applied to the internal administration of the agency and also to partnerships with referral and funding sources. Maintaining the integrity of this approach is critical for successful resolution of client problems.

The agency hierarchy should be arranged to support the organization's intention to practice strategic therapy. First and foremost, the agency director must be knowledgeable and skilled in strategic therapy so that decisions that relate to funding and program development will sustain the effective practice of this approach. The director must also organize the agency so that those individuals with demonstrated ability and commitment to strategic therapy are placed in other positions of authority. Those with the most power in the agency should have clear communication with one another with the goal of strengthening the organization's mission. That the agency practices strategic therapy should be overtly expressed to employees and potential employees, and the director must be willing to reinforce that message with appropriate training and support to clinicians. The director must provide clinicians with a training regimen that includes the opportunity to routinely practice with a supervisor behind a one-way mirror, to videotape therapy sessions, to have access to videotapes of master clinicians as well as research and practice literature, and to have ongoing supervision. Clinicians must be trained specifically to organize not only the hierarchy of family systems but also the hierarchy of the therapeutic relationship and partnerships with other systems so that therapy is successful.

The units with which the director must have influence include both the agency staff members, as just described, and relevant community partners as well. The director must develop positive, effective relationships with funding sources just as the strategic therapist must affect the family in treatment. This occurs when the director actively participates in community planning groups and offers concise strategies that address the problems identified in ways

that support parents and families being empowered to raise their children. For example, it is not uncommon to hear reports from service providers about the difficulty of engaging “unmotivated” parents in treatment. The authors of this paper understand that parental engagement rates in public agencies are typically very low. Moreover, the authors know, from their own experience, that agencies practicing effective strategic therapy can expect to have active parental participation in ninety per cent or more of cases. The agency director should demonstrate that these and other positive outcomes can be achieved by collecting reliable data within the organization. It is also helpful for the director to have the ability to discuss with community partners the recent research regarding the effectiveness of family-based treatment.

The director must understand the usual sequence of funding and program development patterns, which often favor individually-oriented, medical model treatment practices. It is the director’s job to dedicate energy to aspects of the funding system that will promote the effective practice of family therapy. The director must also decide when not to participate in projects that are inconsistent with the mission of the organization and may even do harm to families as opposed to promoting their success. Of course, once one views problems and their solutions from the strategic therapy approach, it is difficult to imagine any program succeeding if it is not designed to attend to the needs of families in a positive way.

Protectiveness not only applies to the strategic therapist’s fundamental premise that the function of the symptom is to help the family or a family member. The external systems within which families participate, which include schools, child welfare, juvenile justice, and others, also serve to protect children, families, and the community. The director must understand the problem from the standpoint of the systems he/she must influence, just as the strategic therapist must recognize and acknowledge the particular perspective of each family. For example, if the objective is to persuade the juvenile justice system, the director must first realize that one of the primary interests of that system is to safeguard the community. The director must persuade those with power in the juvenile justice system with that the inclusion of families in youth treatment enhances community safety.

The actions taken by the director within the community to promote the agency’s goals create the context for the practice and

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supervision of strategic therapy within the organization. In order to demonstrate the complexity of implementing this approach in a community mental health agency, three cases will be described below. Each case example explains the strategies that the therapist and supervisor developed to intervene with both the family and the external systems involved with the client. Also examined are the actions that supervisors must take to help therapists adhere to the tenets of the approach. The cases presented were treated in a variety of publicly funded mental health settings.

Megan* was a seven year-old Caucasian girl brought to the agency for treatment by her grandparents for her angry outbursts and for refusing to defecate. Megan was in the custody of the state and in the care of her maternal grandparents after being removed from her parents' care two years ago. This had occurred because of the domestic violence between Megan's mother and father, which Megan had witnessed, and one incident of physical abuse of Megan by her father. Both parents had a history of methamphetamine addiction, and they had been unable to provide adequate care for Megan. At the time Megan began treatment, her parents lived approximately two hours away in a rural community, and she visited them on the weekends under the grandparent's supervision. Megan's parents had the opportunity to regain custody of their daughter if they continued to meet the requirements of child welfare, including completion of drug and alcohol treatment, a parenting course, and domestic violence classes. The girl was aware of the possibility of returning to her parent's care.

The therapist in this case recognized that one of the first tasks in the treatment was to develop and maintain a positive relationship with the child welfare caseworker. It was understood by the therapist that, for the problem to be solved, the context must be changed. Thus, the issue of the child's relationship with her parents needed to be resolved whether she returned to their care or remained with her grandparents. The caseworker was contacted by the therapist to obtain her consent to involve the parents in the therapy, explaining that if the child were to be safely returned home, the parents must be afforded the opportunity to learn more positive ways to interact with the child and that the child needed to regain trust in her parents' ability to care for her. Often in cases such as these, parents and children are provided minimal interaction, or interactions are observed but not altered in a way that the parents and child experience as helpful, which is likely to result in an unfortunate

outcome. Parents may become detached from their children and consequently feel hopeless about their ability to ever effectively provide and protect. Thus, their motivation to fulfill the expectations of the child welfare system dwindles. Children remain anxious about their parents' ability to care for them and act out when returned to the care of disillusioned parents, ultimately setting up a cycle of child placement and parents who become even more disempowered and distanced from their children.

Strategic therapists must be trained to join with other service providers utilizing the same methodology employed to engage families. For example, the therapist knows that the child welfare worker's first priority is keeping children safe. Therefore, the strategic therapist must convey to the worker that his/her goal is also to protect children from harm and that the best way to do so is to change the family system. The task is for the therapist to make the worker's job easier. The child welfare system does not necessarily recognize family therapy as the preferred mode of treatment. Thus, the therapist must be prepared to help the worker substantiate the treatment to his/her supervisors and to the court, in many cases by providing documentation regarding the progress of the case and information regarding the effectiveness of this approach to treatment. If the therapist clearly assumes responsibility for the case and effectively collaborates with other systems, it is more likely that the treatment will be effective. In this situation, the caseworker had previous positive experience with the agency and had specifically referred the case because of the organization's inclusion of families in treatment. Her eagerness to refer families to the agency was the result of the efforts of another therapist within the agency, who had demonstrated effectiveness of the approach with other cases.

In this particular case, Megan's grandparents did not overtly ask the therapist for help with the family problems, which were too painful. This is most common. Instead, the grandparents brought Megan to treatment due to their concern regarding her anger and expression of angry feelings. When Megan became angry, she would tantrum and scream that she hated her grandparents. The grandparents were also worried that Megan refused to defecate, often holding her bowel for days, which led to messy accidents. Several weeks into the therapy, the grandparents disclosed to the therapist that Megan's dad was not her biological father and that the girl was unaware of this. Megan had recently begun asking questions about why her last name was different from her dad's.

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Prior to coming to the agency, the grandparents had taken Megan to two other counselors for help with the girl's angry outbursts and her refusal to defecate. The therapist here contacted the two previous counselors to understand what had been tried before so as not to make the same mistakes. One of the former counselors had viewed Megan's negative behavior towards her grandparents as an attachment problem due to her disrupted relationship with her parents. The other of the earlier counselors had perceived Megan's refusal to defecate as a means to gain control in response to her previously disorganized living situation. (The possibility of sexual abuse had been eliminated by both of the previous counselors.) However, the problems had not been directly addressed by either of those counselors, and instead had been focused on helping Megan to identify her feelings and to develop "coping skills". The problems remained unsolved. Megan had also been evaluated by a doctor for her refusal to defecate, and there was no medical cause found. The doctor had recommended some dietary changes, which the grandparents had implemented, but still the problem remained unsolved.

The therapist and supervisor here took a strategic approach to understanding and treating the girl and her family. It was presumed by the therapist and supervisor that Megan's troublesome interactions with her grandparents were not simply an expression of anger but were instead the outcome of her loyalty bind between her parents and her grandparents. While the girl still loved her parents and hoped that they could ultimately care for her, she was also anxious that they would not be able to do so. The grandparents had for the past two years provided the girl with a stable and loving home. Inherent in situations like these are parents who feel powerless with their own children and, while perhaps grateful to the grandparents who cared for a child in their absence, might be resentful at the same time. Also innate to these circumstances are grandparents who want the parents to be able to successfully care for the child but fear they will not be able to do so. In this case, there was indeed conflict between the parents and the grandparents regarding parenting matters and obvious confusion over who was or should be in charge of caring for the girl.

The therapist and supervisor assumed that Megan was aware on some level of the family secret about her paternity. It was hypothesized that the girl's refusal to defecate was a metaphor for

the blocked communication in the family. The therapist and supervisor understood that the girl's family had told her since birth that the man she knew as her daddy was her biological father in an effort to protect and love her. The girl's biological father had been involved with her mother only briefly and had abandoned the mother after learning about her pregnancy. The family believed this would be too painful a story for the girl. The family was now uncertain as to how to address the Megan's questions about her paternity without causing her more hurt and so had maintained the secrecy.

The therapist and supervisor worked together to plan a strategy for helping the girl and her family with the presenting problems about which they were most concerned. Focusing on the presenting problem is different than encouraging the family to have insight regarding the origins of a symptom. Insight-oriented therapy had been tried previously and had not been successful.

Here, the therapist joined with the grandparents by indicating she would help them solve the presenting problems of the girl's refusal to have a bowel movement and her negative behavior towards the grandparents. She complimented them on protecting their grandchild and for being wise enough to understand how important it was for Megan to continue her relationship with her mother and father by supporting her visitation with them. The therapist knew that she also needed to engage the biological parents in the therapy in order to successfully resolve the conflict between the adults, address the secret about the girl's paternity, help the parents ease the child's anxiety about their ability to care for her, and ultimately return the child to the custody of her parents. The therapist expressed her belief to the grandparents that they were in the best position to help the parents successfully learn to care for the girl and that she believed their ongoing support would help the girl have a safe and loving relationship with her parents. This helped to soothe the grandparents' anxiety regarding the inclusion of the parents in the therapy, which mimicked their anxiety about the girl returning to her parent's custody. The therapist told the grandparents that the best way to help the girl would be to help her parents, and the grandparents indicated that they were committed to doing whatever was necessary to help their granddaughter and agreed to help the parents.

Undeterred by the two-hour distance between the parents and the agency, the therapist contacted the mother and father to invite their

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participation in the therapy along with Megan and the grandparents. The therapist assumed that the mere invitation to participate in Megan's treatment might cause the parents to believe they would be blamed for the problem and dissuade them from participating. Thus, the parents were approached by the therapist in a manner that overtly demonstrated to them that the therapist believed that they were people who were motivated to help their daughter and knew their child like only a mother and father could. The mother and father agreed to come to meet with the therapist, who spent time alone with the parents gaining an understanding of their specific goals for participating in therapy. The mother and father indicated that they were eager to have their daughter returned to them and to work on developing a more positive relationship with the grandparents. They agreed to continue to make the two-hour drive to be involved in the therapy, and the therapist began sessions with the entire family together to identify ways they could work together to solve the presenting problems.

Both the parents and grandparents were most concerned about Megan's refusal to defecate. The grandparents in particular were frustrated that no cause or solution for the problem had been identified by the doctor or by the previous therapists. Because the ultimate goal of the case was for the girl to return to the care of her parents, it made sense to place the father and mother in charge of solving the problem. By doing this, the therapist began reorganize the family hierarchy so that the parents were in charge of caring for Megan. The therapist intentionally chose to ask the father for help in solving the problem. Because the father had previously been abusive to Megan and her mother, he needed a way to interact positively with the child and to restore his power in the relationship so that he could become an effective parent. The father suggested that he would pay Megan twenty dollars if she succeeded in having thirty accident-free days. The mother readily agreed to the plan, and the therapist convinced the grandparents to try the father's suggestion, not because they had failed to solve it, but because it gave the father the opportunity to develop a loving parental relationship with the girl. The mother and the grandparents were assigned the task of helping the father monitor the girl's progress.

The therapist and supervisor understood that Megan and her family needed a means to address the abuse and neglect that had occurred and to do so in a manner that would ultimately allow them to develop a safe and healthy relationship. One of the interventions that were

planned to create this opportunity included a session during which apologies to the girl were made by the parents, following the steps outlined by Cloe Madanes (1995) in "The Violence of Men". These steps for reparation are performed in a ritualized fashion that increases the power of repentance in a manner that is exceedingly different than the "pseudo-regret" often offered by abusers that becomes part of the pattern of violence. The father apologized to Megan for his violence towards her and her mother, and the mother apologized to Megan for not protecting her. The father also apologized to the mother for the abuse towards her. Both parents apologized for not being available to parent the girl because of their substance abuse. The grandparents were present and apologized for not protecting the girl since they had been aware of the problems prior to the state's involvement in the case. The girl was able to express her bad memories and fears to her family, and the therapist helped the adults respond to her lovingly.

The therapist who is new to this approach must be helped by the supervisor to create a context in which the steps described above occur in such a way that is supportive of the family and also leads to change. Families who are violent most often feel ashamed and are consequently defensive about their behavior. The therapist may feel negatively towards the family, and subtly or otherwise blame them. The family will notice, and the therapy will fail. The supervisor must help the therapist develop empathy for the family. Conversely, the therapist may only see the actions the family has already taken, such as attending parenting classes and substance abuse treatment, and neglect to see that what must change is the context of the relationship between the adults and the child and that the family must be given the opportunity for a positive corrective experience. In this case, the therapist acknowledged the efforts that the parents and grandparents had already made and expressed to them her belief that they would help the girl in any way they could. The therapist assisted the adults in understanding the girl's experience of the abuse and neglect and explained that the steps to reparation would help the girl and the family.

The therapist and supervisor also discussed how the family could talk about the secret of the girl's paternity to her in a helpful way. The therapist explained to the family that Megan could not become "unstuck" until the family was able to discuss the secret. The therapist assured the family that she understood their motivation to protect the girl and would work carefully with them to develop a

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loving and age-appropriate approach to discuss the matter with the girl. This was rehearsed in session, anticipating all of the possible ways in which Megan might react and how the parents could respond to each accordingly. The therapist helped the parents tell Megan in session that when her mommy met her daddy, she already had the little girl. The parents told the girl that when her mommy met her daddy, her mommy knew her daddy was very special because he loved the little girl so much, and that made mommy love her daddy even more. The girl was told that her mommy felt very happy because the girl and her daddy loved each other so much, and so the mommy and daddy decided they would all be a family. The only question that Megan asked in response was, "Does this mean Daddy has to leave?" Both parents assured Megan that her daddy was her daddy always, and the family gave the child hugs and reassurances to soothe her until the girl was convinced. The story was purposefully simple in order to best meet the developmental age of the child. The therapist helped the parents plan how they could answer the additional questions that the child will likely have as she grows up.

During this same period of time, the father and mother became very invested in helping solve the problem of the Megan's refusal to defecate. The parents' positive interactions with Megan helped her feel more secure about their ability to take care of her. The intervention also created a playful way for the family to connect while they were keeping track of the accident-free days. During each session, Megan would come in and excitedly tell the therapist her "record" with the parents and grandparents cheering her on. After a few unsuccessful attempts, the girl managed to have thirty accident-free days, and she collected her money. At termination, the family members indicated that they were no longer keeping track of accident-free days because the problem had been solved.

Ultimately the grandparents felt relieved that the therapist had included the parents in the treatment. When the therapist assumed the "worry" about the parents, the grandparents were freed to help the girl and her parents in a more positive way, when previously they had been critical of the mother and father. The parents eventually moved to the area, near the vicinity of the grandparents' home. This had allowed for more interaction between Megan and her parents and gave the parents the ability to be involved in solving the problem on a daily basis. It also provided the opportunity for grandparents to see that the parents were committed to recovery from substance

abuse and were re-establishing a loving and effective parenting relationship with the girl. The grandparents helped the parents develop a budget plan, and the parents were able to accept the help because they now felt confident that the grandparents were committed to helping Megan return home.

It was finally determined that Megan would be returned to the custody of her parents. This decision was facilitated by the therapist, who had contacted the caseworker on a weekly basis regarding treatment progress and case-planning. Because of the positive relationship that this therapist had carefully and intentionally developed with the caseworker, the caseworker was confident that the therapist's recommendations were sound and enthusiastically supported the treatment planning. The caseworker, as a result, agreed to advocate in court for the therapist's recommendations to return Megan to the care of her parents. The caseworker also allowed the therapist and family to develop the specific transition plan for the girl, when this is more often the function of the child welfare worker.

During the termination phase of treatment in this case, the adults continued to work together to care for Megan. The therapist helped the parents develop a plan to honor the grandparents and thank them for their contribution to raising their daughter. The parents planned to take the entire family to a special dinner and for Megan to make a special card for the grandparents. This served to create a ritual around the girl returning home to her parents, signifying that the grandparents were returning to the role of grandparents and the parents were returning to their respective roles as well. The adults had established a more trusting relationship with one another. The father was able to develop more confidence as a parent through therapy and by becoming more involved in Megan's daily activities. The parents continued to be involved in Narcotics Anonymous, and a plan was developed with the entire family in the event the girl has future worries about her parents. The mother and father thanked the therapist for not having assumed that they were bad parents, and the therapist assured the family that they deserved credit for the positive changes that had occurred.

In yet another case example, James*, a fifteen year-old African-American youth, was brought to the agency by his mother for fire-setting and running away from home. James lived with his three younger siblings and his mother, who had recently left an abusive relationship with the children's father. The father had been

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extremely physically and emotionally violent towards the mother and the children, including killing the family pets with the children present. The mother in the past had also been physically abusive towards the children but had more recently taken measures to protect them by secretly moving out-of-state away from the father and gaining professional employment. Nevertheless, the mother became overwhelmed by raising four children on her own. The children were often left with inadequate supervision. The mother was not cooking for them, nor was she making sure they were bathed or that their clothes were clean.

James was involved in the juvenile justice system due to his fire-setting and sneaking out of the home at night with peers. The fire-setting was of particular concern due to the most recent incident, in which the boy burned down the deck of the family's apartment home. The fire-setting had also brought the case to the attention of the public source funding the treatment, and the county mental health system assigned the family a case manager. At the outset of the case, the boy's probation officer had requested that the therapist assess James with a diagnosis that would qualify him to be placed out-of-the-home in residential treatment. The mother at that time was indicating to the probation counselor that she could not control James's behavior and was asking for the boy to be placed. The psychiatrist involved with the case also recommended placement.

Another therapist might have agreed to place the child in an institution. The strategic therapist and supervisor in this case, however, expected that family therapy could effectively solve the problem and allow the boy to remain at home. It was hypothesized that the boy's negative behaviors served a protective function in the family, because it activated his mother to parent and also brought the family to the attention of the community, which began to provide help. Because the therapist and supervisor believed that James's behaviors were an extreme attempt to help his family, it followed that unless the therapist helped the mother, the boy would not improve. Moreover, James would be even more concerned about his family if he were out of the home and unable to "help", and he would be unconvinced that the mother was making changes in the family unless he was able to participate. The therapist then had a complex task at hand. Not only did the mother need to be convinced that the case could be successfully resolved by allowing James to remain in her care and by placing her in charge of the boy, but the other systems involved had to be persuaded as well.

The therapist accomplished this in a number of ways. The therapist told the mother that the mother was the authority on her child and that no one knew the boy like she did or would be more able to solve the problem than she was. The therapist expressed confidence that by working together in family therapy, the problem could be solved. Knowing that the mother was ashamed that her child was in trouble and felt blamed for the boy's problems by her own family and by other service providers, the therapist approached the mother with amazement that she had been able to leave her abusive husband and find a job that would support her family. Ultimately, the therapist helped the mother feel competent as a parent so that she would be able to care for and protect her son in a way that she had not been able to do in the past. This approach does not minimize the fact that the mother was neglectful or had failed to protect her children from abuse in the past. However, by emphasizing that the mother was viewed by the therapist as capable, the therapist was able to help the mother be responsible for the protection of her children in a way that would not have been possible had the mother remained defeated and defensive. In each session, the therapist refrained from taking responsibility away from the mother for redirecting the misbehaviors of the boy and his siblings that occurred in the therapist's office. Instead, the therapist expected the mother to manage her children's behaviors and coached her to give them directives such as "sit down" and "stop interrupting". During the fifth session, the mother said to the therapist, "At first I didn't understand why you let the kids go wild in your office and never said anything. Now I know it's because you always believed I could handle them."

Simultaneously, the therapist convinced the probation counselor and the case manager that the mother was capable of managing James and that placing him in an institution was premature because the family had never participated in family therapy. The therapist explained to the other service providers that the boy had never been helped to process the abuse, and the mother had not been allowed the opportunity to make amends to the boy for not protecting him, nor had she been helped to restore her role as protector. The probation officer and case manager were reassured by the detailed safety plan that the therapist developed with the mother. The safety plan included increased supervision of James by the mother as well as detailed actions that the mother would take at any sign of elevated safety risks.

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The therapist also convinced the other service providers that she was assuming responsibility for the case and was capable of doing so, which helped minimize their anxiety about James's behaviors. The therapist and supervisor recognized that both the probation officer and the case manager had power in the case. Gaining the confidence of these individuals was crucial so that they would be less likely to believe it necessary to make decisions regarding the case without the therapist's consult. The therapist took charge of the case in a number of ways. For example, as opposed to allowing the case manager to coordinate meetings between service providers as is typically the practice, the therapist assumed the responsibility for calling the meetings and for setting the agenda, for holding the meetings at the agency as opposed to an alternative location, and for bringing extensive documentation regarding treatment planning, case progress, the safety agreement, and evidence for the effectiveness of this approach to treatment.

While a strategic therapist makes every effort to empower the family to solve the problem, the therapist in this case had to strategically negotiate with the probation officer to utilize the juvenile department to help the mother enforce consequences for the boy's negative behaviors. This was done because the probation officer needed to convince the judge that the juvenile department was doing their part to support James and his family. For instance, community service was used as a consequence for the boy's running away. However, the goal of the therapy was ultimately to restore the mother to a position of power within the family, as opposed to having an institution perform the job of parenting. Therefore, the therapist helped the mother set up a consistent household routine for James and his siblings so that the mother would be the source of authority. This included helping the mother to implement appropriate rewards and consequences for the children within the home.

Despite these interventions and the mother's initial agreement to do whatever was necessary to solve the problem, she regularly became overwhelmed and unable to follow through with simple therapy directives. The mother continued to neglect the children's basic needs, and the therapist understood that the mother needed to convince the children that she would care for and protect them in order to solve the problem of the boy lighting fires and running away. When clients do not accomplish assigned tasks, therapists may become frustrated and hopeless and, consequently, may blame or pathologize the client or the family. Defining the client as incapable

of change is not helpful to the therapy. It is the supervisor's job to help the therapist feel empathetically towards the client and the family and to assure the therapist that change will occur. In this case, the therapist was hesitant to urge the mother to change for fear that the mother would feel blamed and become even less inclined to complete therapy directives.

The therapist and supervisor decided to present the case to their consultant, who had been hired to provide the agency with ongoing training in strategic therapy. The consultant helped create a strategy that would maintain the mother's motivation to solve the problem and to address the numerous concerns regarding the boy and his family. The therapist was advised by the consultant that it was critical that the therapist refuse to allow the mother to fail. Instruction was then given for the therapist to empathize with the mother, who had been abused and neglected herself as a little girl but had never been protected or cared for in the way she was being asked to with her own children. In every session, the therapist implemented the supervision plan, acknowledging the mother's anger for the abuse and neglect she herself had experienced. The therapist apologized to the mother for not being able to help her when she was a child and assured her that the therapist would help her now. The therapist knew that it was essential for the mother to make reparations to the children for not adequately protecting them (Madanes, et al., 1995). However, the consultant believed any apology by the mother at this point would be meaningless to the children and that what first needed to occur was for the mother to provide the children with basic care.

The therapist was also instructed to address in an indirect manner the mother's ambivalence to change. In order for this type of intervention to be benevolent and effective, the therapist must recognize, or be helped by a supervisor to recognize, that their client is motivated by love and is capable of change. The therapist also must understand, or be helped by a supervisor to understand, that the ability to influence one's circumstances is a basic human need and that, for some clients, the only means by which they can experience a sense of control is by refusing to comply. In this case, the therapist knew that the mother in her heart of hearts wanted to help her children but that her guilt and shame had thus far prevented her from doing so. The therapist realized that the mother's definition of herself as a helpless victim had been furthered by well-intended professionals who sympathized with the mother but did not expect

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that she was capable of helping herself or her children. The therapist also realized that the mother had been counseled as to what she should and shouldn't do by family members and other service providers and that the advice had not solicited change. The supervisor knew that finding a different approach was the responsibility of the therapist, and developed the indirect intervention with the assistance of the consultant. During each session, the therapist listed the mother's strengths and stated to her, "I think you're capable of doing these things {providing for the children's basic needs}, but it's a big job, and it's going to be hard. If you're not up to the challenge, then let me know." This was effective because the mother no longer had to communicate to the therapist, by failing to fulfill directives, that she felt helpless. By giving the mother an option, the power struggle in the therapy was removed.

The therapist was at this point in the position to insist that the mother care for her children. The mother was told that in order to solve the problem, she needed to be in charge of making certain that the children were bathed, she needed to make meals for the children, and she needed to provide them with additional supervision. The therapist said to the mother that a parent of four children does not have the luxury to collapse at six o' clock in the evening and was lucky if she was able to collapse at ten-thirty at night. The mother then began to follow through on the therapist's directives. She ensured that the children were bathed and had clean clothes. She arranged with her employer different work hours so that she could be home with the children to cook dinner and assist them with homework. With the help of the therapist, the mother developed a list of household rules and expectations regarding chores. She began to reward the children for positive behaviors and provide consequences for the negative ones. The therapist coached the mother on ways she could respond to James's defiance with playfulness, which proved to be more effective in gaining his cooperation. The mother even rearranged the home so that James was unable to sneak out at night. Eventually, the therapist was able to organize a session during which the mother apologized to the boy and his siblings for the abuse they had experienced and for her failure to protect them (as discussed in the previous case example). The boy did not light any more fires and began to comply with his mother's instructions. The mother no longer threatened to send the boy away from home. The probation officer and the case manager were satisfied that the boy did not require out-of-home placement.

In the preceding case examples, the clients' presenting problems were resolved in part because of the effective collaboration that each therapist facilitated with the other systems involved. In order to succeed in solving the problems of clients, the supervisor must recognize the power that other systems have to affect the outcome of therapy and help the therapist to develop an intervention plan accordingly. When this does not occur, therapy is likely to fail.

Consider for example the case of Arturo*, a sixteen year-old Latino boy whose parents brought him to the agency due to concern for his extreme cutting behaviors. Over the past several months, Arturo had cut with a razor on his arms and even on his face. Arturo had recently made statements and written notes to his peers, school counselors, and teachers that he thought he was "crazy" and needed to be "locked-up in a mental hospital". Arturo had been treated previously in individual counseling and with antidepressants and anti-anxiety medication. The family said there had been no change in the problem as a result of those interventions. The father reported that the school was very worried about Arturo and were considering placing the youth in a more restrictive educational setting.

In this particular case, the therapist was practiced in strategic therapy. Because of her training and experience, the therapist was confident that Arturo's problem could be effectively resolved in family therapy. However, less experienced family therapists often become anxious when clients present with serious and risky problems. It is the supervisor's job to assure the therapist that the symptoms can be resolved in family therapy. The ability of the supervisor to provide assistance via a one-way mirror and/or videotaping is essential in order to provide support to the therapist. Additionally, it is useful for the supervisor to be knowledgeable about the research regarding the effectiveness of strategic therapy so that the information can be shared with the therapist.

The therapist in this case contacted Arturo's school to gain an understanding of their view of the problem. The school counselor was alarmed about Arturo's behaviors and informed the therapist that the school intended to place Arturo in an alternative setting because they feared for his safety and felt that his behaviors were very disruptive to other students. The therapist was concerned that this was a premature decision. Although previous counseling had not solved the problem, family therapy had never been provided. Moreover, the therapist believed that the problem was occurring

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within the context of the family, and thus, changing Arturo's school setting would not lead to a solution.

The therapist hypothesized that Arturo's symptoms were an attempt to be protective of his family. Arturo had indicated to the therapist that he was homosexual, though he had not had discussed this with his parents. Because of the family's cultural and religious values, the therapist understood that overt acknowledgment of Arturo's homosexuality would be potentially distressing to them. Arturo's cutting had caused his parents concern, and so the focus of attention in the family was on his symptoms. While Arturo had so far been able to avoid the conversation with his family about his being gay, the cost of his silence came at great emotional cost to him. In order to help Arturo, the therapist and supervisor needed to develop a strategy that allowed Arturo and his family to talk about Arturo's homosexuality, and, most importantly, facilitated a loving response from his parents.

The therapist recognized that family therapy as it has been described here has significant limitations when the client has been institutionalized. Solving a problem most effectively requires that the context in which the dilemma occurs be changed. The particular sequence of interactions that contribute to the client's symptom in any given family can only be understood within the context of that family. In addition, the efficacy of the therapist's interventions can only be determined if the client functions in a normal as opposed to an artificial environment. Placing Arturo in an institution would not alter the interactions, or lack thereof, between the family members regarding Arturo's homosexuality and so would not solve the problem of the cutting. It is possible that Arturo would have discussed his being gay with peers and counselors in the alternative program, and perhaps he would have received their support. However, this would not have the same effect as his family's understanding and acceptance of his being gay.

The initial task of the therapist and supervisor was to intervene with the school to prevent Arturo from being placed in the alternative program. The supervisor advised the therapist to call a meeting with the school counselor, vice principals, and principal. The goal of the meeting was to assure the school that the therapist understood the problem to be serious and would work intensively with Arturo and his family to solve the problem. The therapist offered to schedule a meeting with the family and the school to develop a clear safety plan for Arturo. The school was given the promise by the therapist that

she would maintain frequent and consistent contact with the school in order to monitor progress. The therapist asked the school if they could grant her the opportunity to work with the family to resolve the problem since family therapy had not yet been tried. The school seemed pleased that the therapist would be helping the family. Nevertheless, they had already made the decision to place Arturo in an alternative setting and, because they believed Arturo's behaviors presented too much risk, would not reconsider at this point. Arturo was placed in a day program that he would attend during school hours.

The family asked that the therapist continue to provide family therapy although Arturo was going to be enrolled in a program that provided its own counseling services. The supervisor had to make a decision about whether or not the therapist should continue to work with the family. It was uncertain as to whether or not the therapist would be able to be in charge of Arturo's treatment within the alternative setting. The supervisor understood that if the therapist did not have a powerful influence in the case, it would not be possible to provide effective treatment since the focus would shift away from changing the family system. As it so happened, the program was unable to provide a bilingual therapist to help them communicate with Arturo's parents. Arturo's parents were first generation immigrants from Mexico. Although the father spoke English and Spanish, the mother spoke only Spanish. The alternative setting program subsequently asked the family therapist, who was bilingual and bicultural, to continue to provide the therapy. The supervisor believed that this request afforded the therapist authority over the therapy in this case and that, if the therapist could maintain this leverage, Arturo's problem could be effectively resolved.

Arturo began attending the alternative program. The therapist learned from the program's counselor that the school was worried that Arturo would not share his feelings in group counseling and also that Arturo's journal assignments lacked sufficient insight. The program's counselor believed that Arturo needed to express his feelings and understand the cause of the problem. The school recommended that Arturo be placed there for at least one year.

Since the therapist and supervisor understood that if Arturo believed that he would be embraced and not rejected by his family if his homosexuality were to become overt, the problem of the cutting and disturbed interactions with others would be solved. A lengthy

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placement seemed unnecessary and might, in fact, impede Arturo's normal development. While the alternative setting could provide Arturo with the abilities needed to adapt to abnormal circumstances, this set of skills is different than those needed outside of an institution (Haley, 1980). Moreover, learning those skills might make it even that much more difficult to succeed in life outside of an institution.

That the therapist in this case had authority over the treatment was critical. The supervisor and therapist developed a strategy to intervene with the alternative program. The therapist called a meeting with Arturo's family, the program's staff members, and the vice principal of Arturo's former publicly school. The purpose of the meeting was to clearly define what Arturo needed to achieve in the alternative program in order to satisfy the concerns of the public school. The therapist led the meeting and helped develop goals that clearly focused on Arturo's safety, which was most related to the presenting problem. A three month placement was successfully negotiated by the therapist, with the goal being that Arturo would achieve the established objectives in that amount of time and then return to his former school.

In the meantime, the supervisor helped the therapist devise a strategy to cease Arturo's cutting. The first intervention was designed to interrupt and alter the predictable interactions that the family members had established in response to Arturo's problem. The therapist learned that historically, the mother would not discover that Arturo had cut until the school counselor would call and inform her. The mother, who was very worried about the cutting, would scold Arturo, which had not been effective. The mother would not inform the father of Arturo's cutting because she did not want to cause the father too much distress. The father was very concerned about Arturo but seemed powerless to help him. The father stated many times that he did not understand the problem and did not know how he could help.

The therapist instructed the mother to examine Arturo's arms for cutting daily and to inform the father if Arturo had cut or not. The therapist directed the father to reward Arturo with positive time together when Arturo did not cut. The mother checked the Arturo's arms each day. Arturo did not cut, and the father spent time with him in the evenings playing board games, going for ice cream, and watching movies that both enjoyed. This intervention served a

number of purposes. It placed the parents in charge of managing Arturo's symptom, improved the communication between the parents, gave the father a means to help his son, and afforded Arturo the opportunity to experience his parents' nurturing.

Inevitably, the parents would have to reassure Arturo regarding his homosexuality before the problem of the cutting could be resolved, and the supervisor understood the matter as a delicate one that would require particular sensitivity on the part of the therapist. Strategic therapy assumes that parents love their children, and the therapist's task is to help parents effectively show their love. In this case, the supervisor advised the therapist to reframe the symptom to Arturo and his family as Arturo's sacrifice for those he loved. The therapist explained to the family that she believed Arturo was making an extreme attempt to communicate something to the family that he could not do without fearing he would cause them distress. The parents responded as the supervisor and therapist predicted. The mother and father said that there was nothing that their son could not tell them. The therapist stated that while she believed that this were to be true, Arturo loved his parents too much to upset them. The therapist asked the parents to convince Arturo that there was nothing he could tell them that would change their love for him. The parents were directed by the therapist to sit close to Arturo and hold his hands. The therapist instructed the mother and father to tell Arturo that they would love him and take care of him no matter what he told them and that they did not want Arturo to protect them.

The parents soothed Arturo in this way for two therapy sessions. Finally, Arturo openly discussed with his family that he was homosexual. The parents responded lovingly to him. The therapist assisted the parents with their worries that Arturo would have a difficult life should he be overtly gay. The parents were assured that, with their love and protection, Arturo would be able to have a happy and healthy life. The therapist also advised the parents on how they could help Arturo respond to negative interactions with peers should he encounter those.

Arturo did not cut again and returned to public school after three months in the alternative program. In a six month follow-up, Arturo had remained in the public school setting. He was openly gay at school and had developed several new friendships. Arturo actively sought his parents' advice about relationships, and his mother and father continued to respond supportively. Though the outcome of the

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case was ultimately positive, the therapist and supervisor failed in their effort to prevent Arturo from being placed in the alternative school program. Had the therapist not spoken Spanish and used that as leverage to maintain her authority over the therapy, it is believed that the case would have failed.

Jay Haley (Simon, 1982, p.27) stated in an interview: "Consider the master botanist who must grasp the extraordinary complexity of the flower and its growth process while not losing his appreciation of the beauty of a field of poppies. The botanist who cannot enjoy a flower is as handicapped as the one who has learned nothing about the flower's structure. The therapist must understand and appreciate the extraordinary complexity of a person and his social network. Yet, he must accept the simple process of life and know that children should mind their parents and parents respect grandparents. While appreciating complexity and maintaining an attitude of uncertainty about what is really found in human life, the clinician should be willing to be an expert and say what must be done."

To maintain the integrity of strategic therapy requires an appreciation of the great degrees of complexity to which Haley referred. Maintaining this integrity in a publicly funded agency demands an even greater degree of recognition of the complexity of systems. In order to successfully resolve the complicated human dilemmas for which clients seek help, what must occur is a change in context. Therapists from whom this help is sought must themselves be afforded a context that will allow them to promote change within the family and the community. In short, the therapy is only as good as the system in which it is practiced.

*Names and other identifying information have been changed to protect the identities of clients.

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