Strategic Family Therapy

Problem Solving

With their compelling application of cybernetics and systems theory, strategic approaches once captivated family therapy. Part of their appeal was a pragmatic, problem-solving focus; but there was also a fascination with strategies to outwit resistance and provoke families into changing, with or without their cooperation. It was this manipulative aspect that eventually turned people against strategic therapy.

The dominant approaches of the twenty-first century elevated cognition over behavior and encouraged therapists to be collaborative rather than manipulative. Instead of trying to solve problems and provoke change, therapists began to reinforce solutions and inspire change. As a consequence, the once celebrated voices of strategic therapy—Jay Haley, John Weakland, Mara Selvini Palazzoli—have been virtually forgotten. Too bad, because their strategic approaches introduced two of the most powerful insights in all of family therapy: that families often perpetuate problems by their own actions, and that directives tailored to the needs of a particular family can sometimes bring about sudden and decisive change.

Sketches of Leading Figures

Strategic therapy grew out of the **communications theory** developed in Bateson's schizophrenia project, which evolved into three distinct models: *MRI's brief therapy*, *Haley and Madanes's strategic therapy*, and the *Milan systemic model*. The birthplace of all three was the Mental Research Institute (MRI), where strategic therapy was inspired by Gregory Bateson and Milton Erickson, the anthropologist and the alienist.

In 1952, funded by a Rockefeller Foundation grant to study paradox in communication, Bateson invited Jay Haley, John Weakland, Don Jackson,

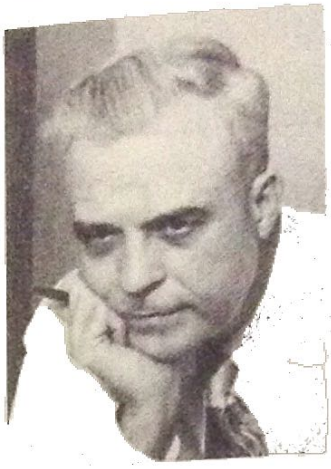
and William Fry to join him in Palo Alto. Their seminal project, which can be considered the intellectual birthplace of family therapy, led to the conclusion that the exchange of multilayered messages between people defined their relationships.

Under Bateson's influence the orientation was anthropological. Their goal was to observe families; they stumbled into family therapy more or less by accident. Given Bateson's disinclination to manipulate people, it's ironic that it was he who introduced project members to Erickson. At a time when therapy was considered a laborious, long-term proposition, Erickson's experience as a hypnotherapist convinced him that people could change suddenly, and he made therapy as brief as possible.

Many of what have been called *paradoxical interventions* came out of Erickson's application of hypnotherapeutic principles to turn resistance to advantage (Haley, 1981). For example, to induce trance a hypnotist learns not to point out that a person is fighting going under but instead to tell the person to keep his or her eyes open, "until they become unbearably heavy."

Jackson founded the Mental Research Institute in 1959 and assembled an energetic and creative staff, including Jules Riskin, Virginia Satir, Jay Haley, John Weakland, Paul Watzlawick, Arthur Bodin, and Janet Beavin. After a few years, several of the staff members became fascinated with the pragmatic, problem-solving approach of Erickson. This led Jackson to establish the Brief Therapy Project under the direction of Richard Fisch. The original group included Bodin, Haley, Watzlawick, and Weakland. What emerged was an elegantly brief approach based on interrupting vicious cycles that occur when attempts to solve problems only make them worse. Unlike today's therapies, which are brief by default, the Palo Alto approach was brief by design. This approach, known as the MRI model, was described by Watzlawick, Weakland, and Fisch (1974) in *Change: Principles of Problem Formation and Problem Resolution*, and in a follow-up volume *The Tactics of Change: Doing Therapy Briefly* (Fisch, Weakland, & Segal, 1982), which remains the most comprehensive statement of the MRI model.

When Jackson died in 1968 at the age of forty-eight, he left a legacy of seminal papers, the leading journal in the field, *Family Process* (cofounded with Nathan Ackerman in 1962), and a great sadness at the passing of such a creative talent. The MRI group suffered another painful loss in 1995 when Weakland died of Lou Gehrig's disease.



Milton Erickson was the guiding genius behind the strategic approach to therapy.

Haley was always something of an outsider. He entered the field without clinical credentials and established his reputation as a gadfly and critic. His initial impact came from his writing, in which he infused sarcasm with incisive analysis. In "The Art of Psychoanalysis" (Haley, 1963), Haley redefined psychoanalysis as a game of one-upmanship:

> By placing the patient on a couch, the analyst gives the patient the feeling of having his feet up in the air and the knowledge that the analyst has both feet on the ground. Not only is the patient disconcerted by having to lie down while talking, but he finds himself literally below the analyst and so his one-down position is geographically emphasized. In addition, the analyst seats himself behind the couch where he can watch the patient but the patient cannot watch him. This gives the patient the kind of disconcerted feeling a person has when sparring with an opponent while blindfolded. Unable to see what response his ploys provoke, he is unsure when he is one-up and when one-down. Some patients try to solve this problem by saying something like, "I slept with my sister last night," and then whirling around to see how the analyst is responding. These "shocker" ploys usually fail in their effect. The analyst may twitch, but he has time to recover before the patient can whirl fully around and see him. Most analysts have developed ways

> of handling the whirling patient. As the patient turns, they are gazing off into space, or doodling with a pencil, or braiding belts, or staring at tropical fish. It is essential that the rare patient who gets an opportunity to observe the analyst see only an impassive demeanor. (pp. 193–194)

After the Bateson project disbanded in 1962, Haley moved to MRI until 1967, when he joined Salvador Minuchin at the Philadelphia Child Guidance Clinic. It was there that he became interested in training and supervision, areas in which he made his greatest contribution (Haley, 1996). In 1976 Haley moved to Washington, D.C., where with Cloe Madanes he founded the Family Therapy Institute. Madanes, known as one of the most creative therapists in the field, had previously worked at MRI and the Philadelphia Child Guidance Clinic. In 1995 Haley moved back to California. He died on February 13, 2007.

Haley and Madanes are such towering figures that their names often overshadow those who followed in their footsteps. James Keim in California, who developed an innovative way of working with oppositional children, is ably carrying on the Haley–Madanes tradition. Other prominent practitioners of this model include Neil Schiff in Washington, D.C., Scott Sells at the Savannah Family Institute, and Jerome Price in Michigan, who specializes in difficult adolescents.

The MRI model had a major impact on the Milan Associates, Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata. Selvini Palazzoli was a prominent Italian psychoanalyst, specializing in eating disorders, when, out of frustration with the psychoanalytic model (Selvini Palazzoli, 1981), she began to develop her own approach to families. In 1967 she led a group of eight psychiatrists who turned to the ideas of Bateson, Haley, and Watzlawick and formed the Center for the Study of the Family in Milan, where they developed the *Milan systemic model.*

The Ackerman Institute has promulgated both the strategic and Milan models. Prominent contributors from the Ackerman faculty include Peggy Papp (1980, 1983), a creative force in the strategic school; Joel Bergman (1985), who developed original strategies for dealing with difficult families; Peggy Penn (1982, 1985), who elaborated on the Milan innovation of circular questioning; and Olga Silverstein, known for her clinical artistry.

Karl Tomm (1984a, 1984b, 1987a, 1987b), a Canadian psychiatrist in Calgary, Alberta, was a prominent interpreter of the Milan model, but recently, with the influence of Michael White's work (see Chapter 12), Tomm has been developing his own ideas about the impact of the therapist on families. Joseph Eron and Thomas Lund (1993, 1996), in Kingston, New York, have tried to bring strategic therapy up to date by integrating it with narrative approaches, based on constructionist principles. Finally, Richard Rabkin (1977), a literate and eclectic social psychiatrist practicing in New York City, was influenced by all the developers of strategic therapy and in turn influenced them.

Theoretical Formulations

In *Pragmatics of Human Communication*, Watzlawick, Beavin, and Jackson (1967) sought to develop a calculus of human communication, which they stated in a series of axioms. The first of these axioms is that *people are always communicating.* Since all behavior is communicative and since one cannot *not* behave, then it follows that one cannot *not* communicate. Consider the following example.

> Mrs. Rodriguez began by saying, "I don't know what to do with Ramon. He's not doing well in school and he doesn't help out around the house. All he wants to do is hang with those awful friends of his. But the worst thing is that he refuses to communicate with us."
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> The therapist turned to Ramon and said, "What do you have to say about all of this?" Ramon said nothing. He just sat there slouched in the corner with a sullen look on his face.
>
> Ramon isn't *not* communicating. He's communicating that he's angry and refuses to talk about it. Communication also takes place when it isn't intentional, conscious, or successful—that is, in the absence of mutual understanding.

The second axiom is that all messages have *report* and *command* functions (Ruesch & Bateson, 1951). The report (or content) of a message conveys information, while the command is a statement about the definition of the relationship. For example, the message "Mommy, Sandy hit me!" conveys information but also implies a command—*Do something about it.* Notice, however, that the implicit command is ambiguous. The reason for this is that the printed word omits contextual clues. This statement shrieked by a child in tears would have very different implications than if it were uttered by a giggling child.

In families, command messages are patterned as *rules* (Jackson, 1965), which can be deduced from observed redundancies in interaction. Jackson used the term **family rules** as a description of regularity, not regulation. Nobody lays down the rules. In fact, families are generally unaware of them.

The rules, or regularities, of family interaction operate to preserve family homeostasis (Jackson, 1965, 1967). Homeostatic mechanisms bring families back to equilibrium in the face of disruption and thus serve to resist change. Jackson's notion of **family homeostasis** describes the conservative aspect of family systems and is similar to the cybernetic concept of **negative feedback.** According to communications analysis, families operate as goal-directed, rule-governed systems.

Communications theorists didn't look for underlying motives; instead, they assumed circular causality and analyzed patterns of communications linked together in additive chains of stimulus and response as *feedback loops.* When the response to a family member's problematic behavior exacerbates the problem, that chain is seen as a *positive feedback loop.* The advantage of this formulation is that it focuses on interactions that perpetuate problems, which can be changed, instead of inferring underlying causes, which are often not subject to change.

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Strategic therapists made the concept of the positive feedback loop the centerpiece of their model. For the MRI group, this translated into a simple yet powerful principle of problem formation: Families encounter many difficulties over the course of their lives, but whether a difficulty becomes a problem depends on how family members respond to it (Watzlawick, Weakland, & Fisch, 1974). That is, families often make misguided attempts to solve their difficulties and, on finding that the problem persists, apply more of the same attempted solutions. This only produces an escalation of the problem, which provokes more of the same and so on—in a vicious cycle.

> For example, if Jamal feels threatened by the arrival of a baby sister, he may become temperamental. If so, his father might think he's being defiant and try to get him to act his age by punishing him. But his father's harshness only confirms Jamal's belief that his parents love his sister more than him, and so he acts even younger. Father, in turn, becomes more critical and punitive, and Jamal becomes increasingly alienated. This is an escalating positive feedback loop: The family system is reacting to a deviation in the behavior of one of its members with feedback designed to dampen that deviation (*negative feedback*), but it has the effect of amplifying the deviation (*positive feedback*).
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> What's needed is for Father to reverse his solution. If he could comfort rather than criticize Jamal and help him see that he isn't being displaced, then Jamal might calm down. The system is governed, however, by unspoken rules that allow only one interpretation of Jamal's behavior—as disrespectful. For Father to alter his solution, this rule would have to be revised.

In most families, unspoken rules govern all sorts of behavior. Where a rule promotes the kind of rigid attempted solution described previously, it isn't just the behavior but the rule that needs to change. When only a specific behavior within a system changes, this is **first-order change**, as opposed to **second-order change**, which occurs when the rules of the system change (Watzlawick et al., 1974). How does one change the rules? One way is by **reframing**—that is, changing Father's interpretation of Jamal's behavior from disrespect to fear of displacement, from bad to sad.

Thus, the MRI approach to problems is elegantly simple: (1) identify the positive feedback loops that maintain problems; (2) determine the rules that support those interactions; and (3) find a way to change the rules in order to interrupt the problem-maintaining behavior.

Haley added a functionalist emphasis to the cybernetic interpretation with his interest in the interpersonal payoff of behavior. Later, he incorporated structural concepts developed during the years he spent with Minuchin. For example, Haley might notice that whenever Jamal and Father quarrel, Jamal's mother protects him by criticizing Father for being so harsh. Haley might also see Jamal becoming more agitated when Mother criticizes Father, trying to get his parents' attention off their conflicts and onto him.

Haley believed that the rules around the **hierarchical structure** of a family are crucial and found inadequate parental hierarchies lurking behind most problems. Indeed, Haley (1976) suggested that "an individual is more disturbed in direct proportion to the number of malfunctioning hierarchies in which he is embedded" (p. 117).

To counter a problem's payoff, Haley borrowed Erickson's technique of prescribing ordeals, so that the price for keeping a symptom outweighed that of giving it up. To illustrate, consider Erickson's famous maneuver of prescribing that an insomniac set his alarm every night to wake up and wax the kitchen floor. Haley tried to explain all therapy as based on ordeals, suggesting that people will change to avoid the ordeals inherent in being a client (Haley, 1984).

Madanes (1981, 1984) also emphasized the functional aspect of problems, particularly the rescuing operations involved when children use their symptoms to engage their parents. For example, when a daughter sees her mother looking depressed, the daughter can provoke a fight which prods the mother into taking charge. Much of Madanes's approach involves finding ways for symptomatic children to help their parents openly, so that they won't have to resort to symptoms as sacrificial offerings.

Like Haley, Selvini Palazzoli and her associates (1978b) focused on the power games in the family and on the protective function symptoms served for the whole family. They explored families' histories over several generations, searching for evidence to confirm their hypotheses about how the children's symptoms came to be necessary. These hypotheses often involved elaborate networks of family alliances and coalitions. They frequently concluded that the patient developed symptoms to protect one or more other family members so as to maintain the delicate network of extended family alliances.

Normal Family Development

According to **general systems theory**, normal families, like all living systems, depend on two vital processes (Maruyama, 1968). First, they maintain integrity in the face of environmental challenges through *negative feedback*. No living system can survive without a coherent structure. On the other hand, too rigid a structure leaves a system ill-equipped to adapt to changing circumstances. That's why normal families also have mechanisms of *positive feedback*. Negative feedback resists disruptions to maintain a steady state; positive feedback amplifies innovations to accommodate to changed circumstances. Recognizing that the channel for positive feedback is communication makes it possible to state the case more plainly: Healthy families are able to adapt because they communicate clearly and are flexible.

The MRI group resolutely opposed standards of normality: "As therapists, we do not regard any particular way of functioning, relating, or living as a problem if the client is not expressing discontent with it" (Fisch, 1978). Thus, by limiting their task to eliminating problems presented to them, the MRI group avoided taking any position regarding how families should behave.

The Milan Associates strove to maintain an attitude of *neutrality* (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). They didn't apply preconceived notions or normative models to their client families. Instead, by raising questions that helped families examine themselves and that exposed hidden power games, they trusted that families would reorganize on their own.

In contrast to the relativism of these two approaches, Haley's assessments *were* based on assumptions about sound family functioning. His therapy was designed to help families reorganize into more functional structures, with clear boundaries and generational hierarchies (Haley, 1976).

Development of Behavior Disorders

According to communications theory, the essential function of symptoms is to maintain the homeostatic equilibrium of family systems.[1] Symptomatic families

[1]The notion of symptoms as functional—implying that families *need* their problems—was to become controversial.

were seen as trapped in dysfunctional, homeostatic patterns of communication (Jackson & Weakland, 1961). These families cling to their rigid ways and respond to signs of change as negative feedback. That is, change is treated not as an opportunity for growth but as a threat, as the following example illustrates.

CASE STUDY

Laban was a quiet boy, the only child of Orthodox Jewish parents from Eastern Europe. His parents left their small farming community to come to the United States where they both found factory work in a large city. Although they were now safe from religious persecution, the couple felt alien and out of synch with their new neighbors. They kept to themselves and took pleasure in raising Laban.

Laban was a frail child with a number of peculiar mannerisms, but to his parents he was perfect. Then he started school. Laban began to make friends with other children and, eager to be accepted, picked up a number of American habits. He chewed gum, watched cartoons, and rode his bicycle all over the neighborhood. His parents were annoyed by the gum chewing and by Laban's fondness for television, but they were genuinely distressed by his eagerness to play with gentile children. They may have come to the United States to escape persecution but not to embrace pluralism, much less assimilation. As far as they were concerned, Laban was rejecting their values—"Something must be wrong with him." By the time they called the child guidance clinic, they were convinced that Laban was disturbed, and they asked for help to "make Laban normal again."

In strategic models there are three explanations of how problems develop. The first is *cybernetic*: Difficulties are turned into chronic problems by misguided solutions, forming positive-feedback escalations. The second is *structural*: Problems are the result of incongruous hierarchies. The third is *functional*: Problems result when people try to protect or control one another covertly, so that their symptoms serve *a* function for the system. The MRI group limited itself to the first explanation, while Haley and the Milan Associates embraced all three.

To clarify these differences, consider the following example: Sixteen-year-old Juwan recently began refusing to leave the house. An MRI therapist might ask his parents how they had tried to get him to venture out. The focus would be on the parents' attempted solution, on the assumption that this was likely to be maintaining Juwan's refusal, and on their explanation, or *frame*, for Juwan's behavior, believing that their framing of the problem might be driving their false solution.

A Haley-style therapist might be interested in the parents' attempted solutions but would also inquire about their marriage, the ways in which Juwan was involved in struggles between them or other family members, and the possible protective nature of Juwan's problem. This therapist would be acting on the assumption that Juwan's behavior might be part of a dysfunctional triangle. The therapist might further assume that this triangular pattern was fueled by unresolved conflicts between the parents. Madanes would also be interested in this triangle but, in addition, would be curious about how Juwan's behavior might be protecting his parents from having to face some threatening issue.

A Milan systemic therapist wouldn't focus so much on attempted solutions but instead would ask about past and present relationships in the family. In so doing, the therapist would be trying to uncover a network of power alliances, often continuing across generations, that constituted the family's "game." Some such game left Juwan in the position of having to use his symptoms to protect other family members. The family might reveal, for example, that if Juwan were to grow up and leave home, his mother would be drawn back into a power struggle between her parents, which she had avoided by having a symptomatic child. Also, by not succeeding in life, Juwan might be protecting his father from the shame of having a child who exceeded him in accomplishment.

Goals of Therapy

The MRI group is proudly minimalistic. Once the presenting problem is resolved, therapy is concluded. Even when other problems are apparent, if the family doesn't ask for help with those problems, they aren't targeted. Because they view people who have problems as stuck rather than sick, MRI therapists see their job as simply to help them get moving again.

MRI therapists help families define clear and reachable goals so that everyone knows when treatment has been successful. They often find that much

of the therapy takes place simply in the process of pushing clients to set concrete goals, because in doing so clients are forced to clarify vague dissatisfactions. Also, in getting clients to define achievable goals, MRI therapists help people let go of utopian aspirations, which are likely to lead to disappointment.

In trying to achieve problem resolution, the immediate aim is to change the behavioral responses of people to their problems. More specifically, as described earlier, MRI therapists try to interrupt (often to reverse) vicious feedback loops. To achieve this behavioral change they may reframe the problem and, in that sense, introduce a cognitive element. But any cognitive consideration is only in the service of the primary goal of behavior change.

Haley's approach is also behavioral and, even more than the MRI group, downplays the importance of insight. He was scornful of therapists who helped clients understand why they did things but failed to get them to do something different. Haley's ultimate goal is often a structural reorganization of the family, particularly its hierarchy and generational boundaries. Unlike in structural family therapy, however, these structural goals are always directly related to the presenting problem. For example, to improve the relationship between the polarized parents of a rebellious teenager, a structural therapist might get the parents to talk about their marital problems, where Haley would have them talk only about their difficulty working together to deal with their son.

The early work of the Milan group (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978b) was heavily influenced by the MRI and Haley models. The Milan Associates expanded the network of people involved in maintaining the problem but were still primarily interested in interrupting destructive family games. The techniques they developed differed from other strategic schools in that they were less behavioral and instead were designed to expose covert collusions and reframe motives for strange behavior. While less problem focused and more interested in changing families' beliefs than other strategic therapists, the original Milan approach was no less manipulative: The responsibility for change rested on the therapist whose job it was to outwit resistance.

When the Milan Associates split into two groups in the early 1980s, this strategic emphasis remained with Selvini Palazzoli and the groups she subsequently formed. Later, she abandoned brief, strategic models altogether in favor or long-term therapy with more focus on insight for the individual patient (Selvini, 1993).

After the breakup of the Milan group, Boscolo and Cecchin moved away from strategically manipulating families and toward collaborating with them to form systemic hypotheses about their problems. Therapy became more of a research expedition that the therapist entered without specific goals or strategies, trusting that the process of self-examination would allow families to choose to change their unproductive patterns. The therapist was released from responsibility for any certain outcome and adopted an attitude of curiosity (Cecchin, 1987) toward families, rather than the interventive attitude of strategic therapists.

By moving in this direction, Boscolo and Cecchin took a position opposite to that of their strategic predecessors. This collaborative philosophy became the bridge for many strategic therapists to the narrative approaches of the 1990s.

Conditions for Behavior Change

In the early days of family therapy the goal was simply to improve communication. Later the goal was refined to altering specific patterns of communication that maintained problems. A therapist can either point out problematic sequences or simply block them to effect therapeutic change. The first strategy relies on insight and depends on a willingness to change. The second does not; it's an attempt to beat families at their own games.

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For the MRI school, the way to resolve problems is to change the behavior that's been maintaining them. It's believed that through seeing the results of altering rigid behavioral responses, clients will become more flexible in their problem-solving strategies. When this happens, clients achieve second-order change—a change in the rules governing their response to problems.

For example, Maria argues with her father about her curfew and her father grounds her. She then runs away and stays with a friend. A first-order

intervention might be to help Maria's father find a more effective punishment to tame his out-of-control child. A second-order strategic intervention might be to direct the father to act disappointed and sad around his daughter, implying that he has given up trying to control her. This shifts Maria from feeling trapped by her father to feeling concerned about him, and she becomes more reasonable. Her father learns that when attempted solutions aren't working, he needs to try something different. This change is second order in that it alters the rules governing the way father and daughter interact.

Haley (1976) believed that telling people what they're doing wrong only mobilizes resistance. He was convinced that changes in behavior alter perceptions, rather than the other way around. The Milan group turned this behaviorism on its head. They were more interested in getting families to see things differently (through a reframing technique called *positive connotation* to be discussed later) than in getting family members to behave differently. This shift from behavior to cognition set the stage for the constructivist and narrative movements (see Chapters 3 and 12).

Therapy

Assessment

The goals of an MRI assessment are to (1) define a resolvable complaint, (2) identify attempted solutions that maintain the complaint, and (3) understand the clients' unique language for describing the problem. The first two goals show where to intervene; the third suggests how.

The first step is to get a very specific, behavioral picture of the complaint, who sees it as a problem, and why it's a problem now. When a therapist asks, "What is the problem that brings you here today," many clients reply ambiguously, "We don't communicate," "We think our fourteen-year-old is depressed," or "Clarence seems to be hyperactive." The MRI therapist inquires about exactly what these complaints mean. "We don't communicate" might mean "My son argues with everything I say" or "My husband never talks to me." "Depressed" might mean sad and withdrawn or sullen and disagreeable; "hyperactive" might mean disobedient or unable to concentrate. A useful device is to ask, "If we had a videotape of this, what would it look like?"

Once the problem has been defined, the therapist tries to determine who has tried to solve it and how. Sometimes the attempted solution seems obviously to have made things worse. For example, the wife who nags her husband to spend more time with her is likely to succeed only in driving him away. Likewise the parents who punish their son for fighting with his sister might convince him that they favor her. Or the husband who does everything his wife asks in order to keep the peace may become so resentful that he starts to hate her.

From this inquiry emerges a formulation of the problem-solution loop and the specific behavior that will be the focus of intervention. Typically, the strategic objective will be a 180-degree reversal of what the clients have been doing. Although interventions typically involve prescribing some alternative behavior, the key is to stop the performance of the problem-maintaining solution (Weakland & Fisch, 1992).

Grasping the clients' unique language and ways of seeing their dilemmas is important to framing suggestions in ways they will accept. For example, a devoutly religious wife might be amenable to the suggestion that she pray for her husband to become more involved with the family rather than continue to criticize his failings. In another case, cited by Shoham and Rohrbaugh (2002), a young woman was seen as perpetuating her boyfriend's jealous accusations by trying to reassure him. Unfortunately, these efforts to reason with the boyfriend only ended up in arguments, which were painful enough to threaten the relationship. Because the woman was a devotee of "mindfulness meditation," the therapist suggested that the next time the boyfriend asked a jealous question and she felt like defending herself, she should tell him that she was feeling stressed and needed to meditate.

Haley's assessment begins with a careful definition of the problem, expressed from the point of view of every member of the family. But unlike the MRI group, Haley also explores the possibility that structural arrangements in the family may be contributing to their problems—especially pathological triangles, or

cross-generational coalitions. As Haley said, "Problem children tend to determine what happens in families, which makes for hierarchical difficulties" (Haley, 1996, p. 96).

In addition to structural problems, Haley and Madanes also consider the interpersonal payoff of problem behavior. According to Haley, the apparent helplessness of a patient often turns out to be a source of power in relation to others whose lives are dominated by the demands and fears of the symptomatic person. A schizophrenic who refuses to take his medication might, for example, avoid having to go to work. While it isn't necessary to decide what is or isn't a real illness, Haley tends to assume that all symptomatic behavior is voluntary. Sometimes this is a crucial distinction—as, for example, in cases of drug addiction or losing one's temper.

In the Milan model, assessment begins with a preliminary hypothesis, which is confirmed or disconfirmed in the initial session. These hypotheses are generally based on the assumption that the identified patient's problems serve a protective function for the family. Therefore, assessment of the presenting problem and the family's response to it is based on questions designed to explore the family as a set of interconnected relationships. For example, the reply to a question like "Who has been more worried about this problem, you or your wife?" will suggest a hypothesis about the closeness and distance of family members. The ultimate goal of assessment is to achieve a systemic perspective on the problem.

Therapeutic Techniques

Although strategic therapists share a belief in the need for indirect methods to induce change in families, they developed distinctly different techniques for doing so.

The MRI Approach

The MRI model follows a six-step treatment procedure:

1. Introduction to the treatment setup
2. Inquiry and definition of the problem
3. Estimation of the behavior maintaining the problem
4. Setting goals for treatment
5. Selecting and making behavioral interventions
6. Termination

Once the preliminaries have been concluded, the therapist asks for a clear definition of the major problem. If a problem is stated in vague terms, such as "We just don't seem to get along," or in terms of presumptive causes, such as "Dad's job is making him depressed," the therapist helps translate it into a clear and concrete goal, asking questions like "What will be the first small sign that things are getting better?"

After the problem and goals are defined, MRI therapists inquire about attempted solutions, which might be maintaining the problem. In general, the solutions that perpetuate problems fall into one of three categories:

1. The solution is to deny that a problem exists; action is necessary but not taken. For instance, parents do nothing despite growing evidence that their teenage son is using drugs.
2. The solution is an effort to solve something that isn't really a problem; action is taken when it shouldn't be. For example, parents punish a child for masturbating.
3. The solution is an effort to solve a problem within a framework that makes a solution impossible; action is taken but at the wrong level. For instance, a husband buys increasingly expensive gifts for his wife, when what she wants is affection.

Once the therapist conceives a strategy for changing the problem-maintaining sequence, clients must be convinced to follow this strategy. To sell their directives, MRI therapists reframe problems to increase the likelihood of compliance. Thus a therapist might tell an angry teenager that when his father punishes him, it's the only way his father knows how to show his love.

To interrupt problem-maintaining sequences, strategic therapists may try to get family members to do something that runs counter to common sense. Such counterintuitive techniques have been called *paradoxical interventions* (Haley, 1973; Watzlawick, Weakland, & Fisch, 1974).

CASE STUDY

Watzlawick and his colleagues (1974) described a young couple who were bothered by their parents' tendency to treat them like children by doing everything for them. Despite the husband's adequate salary, the parents continued to send money and lavish gifts on them, refused to let them pay even part of a restaurant check, and so on. The strategic team helped the couple solve their difficulty with their doting parents by having them become *less* rather than more competent. Instead of trying to show the parents that they didn't need help, the couple was told to act helpless and dependent, so much so that the parents got disgusted and finally backed off.

The techniques most commonly thought of as paradoxical are symptom prescriptions in which a family is told to continue or embellish the behavior they complain about. In some contexts, such a prescription might be made with the hope that the family will try to comply with it and thereby be forced to reverse their attempted solution. If Jorge, who is sad, is told to try to become depressed several times a day and his family is asked to encourage him to be sad, then they will no longer try ineffectively to cheer him up, and he won't feel guilty for not being happy.

At other times, a therapist might prescribe the symptom while secretly hoping the clients will rebel against this directive. The therapist might encourage Jorge to continue to be depressed because, in doing so, he's helping his brother (with whom Jorge is competitive) feel superior.

Sometimes a therapist might prescribe the symptom with the hope that in doing so the network of relationships that maintain the problem will be exposed. The therapist says that Jorge should remain depressed because that way he can continue to occupy his mother's attention, which will keep her from looking to his father for affection, since his father is still overinvolved with his own mother, and so on.

To prevent power struggles, MRI therapists avoid taking a directive posture. Their *one-down stance* implies equality and helps anxiety and resistance. Although some strategists adopt a one-down position disingenuously, a modest approach was consistent with the late Weakland's own unassuming character. While sitting clouded in the smoke of his pipe, Weakland discouraged families from trying to change too fast, warning them to go slow and worrying out loud about the possibility of relapse when improvements did occur. This **restraining** technique reinforced the therapist's one-down position.

The Haley and Madanes Approach

Haley's approach is harder to describe because it's tailored to address the unique requirements of each case. If *strategic* implies *systematic*, as in the MRI approach, it also implies *artful*, which is especially true of Haley's therapy. As with other strategic approaches, the definitive technique is the use of *directives*. But Haley's directives aren't simply ploys to outwit families or reverse what they're doing. Rather, they are thoughtful suggestions targeted to the specific requirements of each case.

Jay Haley tailored directives to fit the needs of specific clients and their problems.

Haley (1976) believed that if therapy is to end well, it must begin properly. Therefore, he devoted a good deal of attention to the opening moves of treatment. Regardless of who is presented as the official patient, Haley began by interviewing the entire family. His approach to this initial interview followed four stages: a *social stage*, a *problem stage*, an *interaction stage*, and finally a *goal-setting stage*.

Haley used the initial minutes of a first session to help everyone relax. He made a point of greeting each family member and making sure they were comfortable. Like a good host, he wanted his guests to feel welcome. After the *social stage*, Haley got down to business in the *problem stage*, asking each person for his or her perspective. Because mothers are usually more central than fathers, Haley recommended speaking first to the father to increase

his involvement. This suggestion illustrates Haley's strategic maneuvering, which characterized his whole approach to families.

Haley listened carefully to the way each family member described the problem, making sure that no one interrupted until each had a turn. During this phase, Haley looked for clues about triangles and hierarchy, but he avoided making any comments about these observations because that might make the family defensive.

Once everyone had a chance to speak, Haley encouraged them to discuss their points of view among themselves. In this, the *interactional stage*, the therapist can observe, rather than just hear about, the interchanges that surround the problem. As they talk, Haley looked for *coalitions* between family members against others. How functional is the *hierarchy*? Do the parents work well together, or do they undercut each other?

Sometimes Haley ended the first session by giving the family a task. In subsequent sessions, directives played a central role. Effective directives don't usually take the form of simple advice, which is rarely helpful because problems usually persist for a reason.

The following two tasks are taken from Haley's (1976) *Problem-Solving Therapy*. One couple, who were out of the habit of being affectionate with each other, were told to behave affectionately "to teach their child how to show affection." In another case, a mother who was unable to control her twelve-year-old son had decided to send him away to military school. Haley suggested that since the boy had no idea how tough life would be at military school, it would be a good idea for the mother to help prepare him. They both agreed. Haley directed her to teach the boy how to stand at attention, be polite, and wake up early every morning to make his bed. The two of them followed these instructions as if playing a game, with the mother as sergeant and the son as private. After two weeks the son was behaving so well that his mother no longer felt it necessary to send him away.

One thing unique about Haley's approach was his focus on the interpersonal payoff of psychiatric symptoms. The idea that people get something out of their symptoms has been rejected by most schools of family therapy because they see it as a version of blaming the victim. Haley's point wasn't that people become anxious or depressed in order to manipulate others, but that such problems, once they develop, may come to play a role in interpersonal struggles in the family. It is this covert function of symptoms that Haley explored.

Although MRI therapists speculate about what may be maintaining symptoms, they emphasize other people's misguided solutions and don't consider the interpersonal payoff of the symptoms themselves. The primary goal of hypothesizing in Haley's approach is to understand the heart of the family drama that the symptoms revolve around. Haley focused on the meaning behind people's problems and therefore believed that problems should have reasonable solutions. The answer is to help families find new ways to solve their problems.

CASE STUDY

In a case treated by Jerome Price, a thirteen-year-old girl was referred to juvenile court because of chronic truancy. She had repeatedly failed to show up at school, and both her parents and school officials had tried a range of threats and punishments—all to no avail. The judge referred the girl to therapy. Price began by asking questions designed to find out why the girl was skipping school. The most obvious question was "Where do you go when you don't go to school?" To the therapist's surprise, the girl said that she went to the home of her ninety-two-year-old grandmother. The girl's parents assumed that she was taking advantage of her grandmother. However, when Price asked, "Why there?" he learned that the grandmother lived alone and was in constant fear of falling. Her children rarely visited and didn't address her concerns directly, so the granddaughter had taken it upon herself to see that her grandmother was safe.

Price's directives addressed both the purpose of the girl's truancy and the hierarchical imbalance that it reflected in the family. He encouraged the parents to visit the grandmother more often, hire a caregiver to be there during the day, and arrange activities at a local senior center. Knowing that her grandmother was safe—and that her parents were now taking charge—the girl returned to school.

Unlike many contemporary family therapists, practioners in the Haley/Madanes tradition openly address the issue of interpersonal power in families. Early in his career, Haley (1963) recognized that communication always affects how family members relate to one another in a way that either increases or decreases their influence. This was not meant as a judgment but merely a description of the way things seem to work. Haley devoted much of his early effort to observing how power was used and misused in families, with the idea that therapists can either ignore power struggles or recognize and help families resolve them.

CASE STUDY

When a man beats a woman, people have no trouble seeing this as an issue of power and its misuse. But when sixteen-year-old Brad (Price, 1996) verbally harassed his mother to get the use of her car, his individual therapist didn't see this as Brad's misuse of power. When Brad proceeded to push his mother to the ground and rip the keys out of her hand, the therapist still insisted on exploring Brad's reasons for being angry at his mother.

When Brad's mother got fed up with this approach and sought treatment from a strategic practitioner, the new therapy focused on how Brad had become so powerful and what it would take for his mother to regain leadership. Most of the sessions included the mother and Brad's uncle, who cared very much about him and was therefore more than willing to help discuss and carry out decisions. When Brad was faced with a united front of two adults, who met with him and a therapist and also held meetings at his school, the reformulation of the power balance began calming him down and simplifying his life to the point where he could return to acting like a sixteen-year-old, rather than an abusive husband.

As is often the case, the underlying dynamics in this family didn't emerge until after the presenting problem improved. Once Brad started behaving respectfully and performing better in school, his mother's depression became more apparent. In a way, Brad had kept his mother emotionally occupied by reenacting her struggles with his father, which made it unnecessary for her to make new friends, date, and move forward in her life. With Brad improving and no crises to deal with, his mother became conscious of what was missing in her life, and the therapist was able to help her address her own future. Haley would see Brad as trying to help his mother by giving her a problem that distracted her from her own. In some cases this "helpfulness" is conscious; it other cases it isn't.

Metaphor is another theme in Haley's approach. In the previous case, Brad's misbehavior, which mimicked that of his parents' previous abusive relationship, could be seen as a metaphor for his mother not having resolved her emotional struggle over past abuse. In this approach, a symptom is often seen as a metaphor for an underlying problem. Thus, a school problem in a child may mirror a work problem of a parent. An underachieving child might be a reflection of an underfunctioning parent. An addicted child may be a clue that someone else in the family is secretly acting in self-destructive ways.

Such was the case in which thirty-seven-year-old Margery asked for help with her three-year-old daughter. Whenever the two entered a store, the little girl would steal something, such as a pack of gum or candy. Upon further exploration, the therapist learned that Margery was having an affair with her best friend's husband. The metaphor of stealing thus proved apt.

Madanes (1981) describes how one relationship may metaphorically replicate another. As was the case with Brad and his mother, parents can fight with their children about things they should be addressing between themselves. Two children can fight with each other in the same way their parents would be fighting if they weren't distracted by the children. One child can struggle with parents in a way that deflects the scrutiny that otherwise might be directed at a sibling. This is often the case when there is a young adult at home who is not working or going to school, and is basically stuck on the launching pad. A younger sibling may become symptomatic and start failing at school in a way that serves as metaphor to force the parents to deal with the issue of needing to be productive.

Madanes (1984) also addresses power imbalances in couples and how they play a role in a wide range of symptoms. She looks at the areas of couples' lives in which power is regulated, including money, education, control of children, coalitions with in-laws, religion, and sex. It often turns out that the partner

Cloe Madanes's "pretend techniques" are a clever way to help break control-and-rebel cycles.

with the least power develops the most emotional problems. Symptoms such as depression, headaches, substance abuse, eating disorders, phobias, and so on certainly burden the person who suffers them, but they also burden other family members. Others in the family often try desperately to do something about such symptoms, but the symptomatic person may refuse to accept help, thereby maintaining a perverse sort of power by holding onto troublesome symptoms. Again, this process is typically not conscious, and this way of thinking about it is not offered as some objective truth but rather as one possibly useful clinical hypothesis.

Looking at such struggles in the light of power balancing, a therapist is able to have a more flexible view of the drama a couple is embroiled in. Is the abuser someone who actually needs more of a role in his children's lives? Does a partner need an avocation that can help him or her feel more successful?

CASE STUDY

This dynamic was the case with Mark and Brianna. Mark became more and more depressed and refused to seek a job after being laid off. Six months had passed, and he had done little. He spent money as if his income were still coming in, while Brianna stayed home with the children despite being in demand as a registered nurse. Brianna berated Mark about his lack of action, shouting at him at times and generally exacerbating his general sense of failure. *She* was the expert on the children. *She* took them to church. *She* had a master's degree, while he had only two years of college.

As Mark became more depressed and did increasingly less, Brianna was forced to go back to work and give up staying home with the children. By what he didn't do—"because he was depressed"—Mark dominated the family that had previously dominated him. He now took care of the children (albeit not to Brianna's satisfaction) and stayed home while she worked, and no one went to church because Brianna had to work the graveyard shift on Saturday nights. Mark's depression had equalized the power imbalance that developed when he lost his job and began to feel like a failure. Brianna's emotional control over their lives had previously been offset by the fact that Mark was the breadwinner. When he lost that role, the couple went into imbalance and Mark had to find another form of power to replace his income. Ironically, the helplessness of depression provided that power.

The artful commonsense component of Haley's strategic therapy can be understood by looking at high-conflict divorce. Rather than think of a high-conflict couple as pathological, Haley would look at them developmentally and in terms of the family life cycle (Haley, 1973; Haley & Richeport-Haley, 2007). This approach attempts to come up with benevolent hypotheses that describe clients in the best possible light. Rather than see the ex-spouses as personality disordered, a Haley-style therapist would more likely see them as still in need of an emotional divorce (Gaulier, Margerum, Price, & Windell, 2007). Such a conceptualization offers a therapist ideas about what needs to be done to resolve problems.

CASE STUDY

Even after they were divorced, Rob and Melissa continued to argue over every aspect of their seventeen-year-old daughter Marta's existence. When the therapist asked Marta if these arguments looked like the arguments her parents had when they were married, she sighed and said that the arguments "were identical." The therapist asked the parents whether they were really willing to let go of each other, once and for all. Both resisted the idea that they were still emotionally married, but the therapist challenged them to prove that they were not.

The therapist asked both parents to collect memorabilia and write accounts of events from their marriage that they would like to leave behind. The therapist led them through a ritual over about a month, in which they brought in the items and accounts, described them to each other and said why they no longer wanted the effects of these things in their lives, and then ritually burned them in the therapist's presence. Rob and Melissa were directed to collect the ashes in a jar and sent on a weekend trip to northern Michigan, where they stopped in a virgin pine forest and ritually buried the ashes. At the therapist's suggestion, they took a boat trip and, at a specific time and in a specific way, threw their wedding rings (which they had kept) into the depths of Lake Superior.

James Keim and Jay Lappin (2002) describe a strategic approach to a case with a nagging wife and withdrawing husband. First they reframe the problem as a "breakdown in the negotiation process." A *negotiation*, the couple is told, is a conversation in which one party makes a request and the other names a price. This reframing allows the wife to make requests without thinking of herself as a nag—and the husband to see himself as having something to gain in negotiations, rather than as a brow-beaten husband who is forced to give in to his wife.

Keim and Lappin recommend introducing couples to the negotiation process as a "fun exercise" designed to get them back on track in reaching agreements. Then the couple is given a handout with elaborate instructions for negotiating in a constructive fashion and asked to progress from negotiating easy issues in the session to doing so at home and then tackling more difficult issues, first in the session and then at home. Finally, the couple is cautioned that even after negotiating some exchanges, they may choose not to accept the quid pro quo terms. Sometimes it's preferable to endure certain problems rather than pay the price of trying to change them.

Madanes used the observation that people will often do something they wouldn't ordinarily do if it's framed as play to develop a whole range of **pretend techniques**. One such strategy is to ask a symptomatic child to pretend to have the symptom and encourage the parents to pretend to help. The child can give up the actual symptom now that pretending to have it is serving the same family function. The following two cases, summarized from Madanes (1981), illustrate the pretend technique.

CASE STUDY

A mother sought therapy because her ten-year-old son had night terrors. Madanes suspected that the boy was concerned about his mother, who was poor, spoke little English, and had lost two husbands. Since the boy had night terrors, the therapist asked all the members of the family to describe their dreams. Only the mother and the son had nightmares. In the mother's nightmare someone was breaking into the house. In the boy's, he was being attacked by a witch. When Madanes asked what the mother did when the boy had nightmares, she said that she took him into her bed and told him to pray to God. She explained that she thought his nightmares were the work of the devil.

Madanes's conjecture was that the boy's night terrors were both a metaphorical expression of the mother's fears and an attempt to help her. As long as the boy was afraid, his mother had to be strong. Unfortunately, while trying to protect him, she frightened him further by talking about God and the devil. Thus, both mother and child were helping each other in unproductive ways.

The family members were told to pretend that they were home and mother was afraid that someone might break in. The son was asked to protect his mother. In this way the mother had to pretend to need the child's help instead of really needing it. At first the family had difficulty playing the scene because the mother would attack the make-believe thief before the son could help. Thus she communicated that she was capable of taking care of herself and didn't need the son's protection. After the scene was performed correctly, with the son attacking the thief, they all discussed the performance. The mother explained that it was difficult to play her part because she was a competent person who could defend herself.

Madanes sent the family home with the task of repeating this dramatization every evening for a week. If the son started screaming during his sleep, his mother was to wake him up and replay the scene. They were told that this was important to do no matter how late it was or how tired they were. The son's night terrors soon disappeared.

CASE STUDY

A mother sought treatment for her five-year-old because he had uncontrollable temper tantrums. After talking with the family for a few minutes Madanes asked the boy to show her what his tantrums were like by pretending to have one. "Okay," he said, "I'm the Incredible Hulk!" He puffed out his chest, flexed his muscles, made a monster face, and started screaming and kicking the furniture. Madanes asked the mother to do what she usually did in such circumstances. The mother responded by telling her son, in a weak and ineffective way, to calm down. She pretended to send him to another room as she tried to do at home. Next, Madanes asked the mother if the boy was doing a good job of pretending. She said he was.

Madanes asked the boy to repeat the scene. This time he was Frankenstein's monster and his tantrum was performed with a rigid posture and a grimacing face. Then Madanes talked with the boy about the Incredible Hulk and Frankenstein's monster and congratulated the mother for raising such an imaginative child.

Following this discussion, mother and son were told to pretend that he was having a tantrum while she was walking him to his room. The boy was told to act like the Incredible Hulk and to make lots of noise. Then they were told to pretend to close the door and hug and kiss. Next Madanes instructed the mother to pretend that *she* was having a tantrum, and the boy was to hug and kiss her. Madanes instructed mother and son to perform both scenes every morning before school and every afternoon when the boy came home. After every performance the mother was to give the boy milk and cookies, if he did a good job. Thus the mother was moved from a helpless position to one of authority, in which she was in charge of rewarding her son's make-believe performance. The next week the mother called to say that they didn't need to come for therapy because the boy was behaving very well and his tantrums had ceased.

Haley (1984) returned to his Ericksonian roots in a book called *Ordeal Therapy*, a collection of case studies in which ordeals were prescribed to make symptoms more trouble than they're worth. "If one makes it more difficult for a person to have a symptom than to give it up, the person will give up the symptom" (p. 5). A standard ordeal is for a client to have to get up in the middle of the night and exercise strenuously whenever he or she had symptoms during that day. Another example might be for the client to have to give a present to someone with whom he or she has a poor relationship—for example, a mother-in-law or ex-spouse—each time the symptoms occur.

Haley also used ordeals to restructure families. For example, a sixteen-year-old boy put a variety of items up his behind and then expelled them, leaving his stepmother to clean up the mess. Haley (1984) arranged that after each such episode, the father had to take his son to their backyard and have the boy dig a hole three feet deep and three feet wide, in which he was to bury all the things he was putting up his rear end. After a few weeks of this, Haley reported that the symptom stopped, the father became more involved with his son, and the stepmother became closer to the father.

The current form of Haley/Madanes therapy, called *strategic humanism*, still involves giving directives, but the directives are now more oriented toward increasing family members' abilities to soothe and love than to gain control over one another. This represents a major shift and is in synch with family therapy's movement away from the power aspects of hierarchy and toward finding ways to increase harmony.

An excellent example of strategic humanism's blend of compassion and cleverness is Keim's work with oppositional children (Keim, 1998). Keim begins by reassuring anxious parents that they aren't to blame for their children's oppositionalism. Next he explains that there are two sides of parental authority—discipline and nurture. To reinforce the parents' authority while avoiding power struggles, Keim encourages them to concentrate on being sympathetic and supportive for a while. The parent who soothes a child with the forgotten language of understanding is every bit as much in charge as one who tries to tell the child what to do. After progress has been made in calming the child down—especially in breaking the pattern by which oppositional children control the mood in the family by arguing with everything their parents say—Keim coaches the parents to post rules and enforce consequences. This strategy puts parents back in charge of unruly children without the high-intensity melodrama that usually attends work with this population.

The Milan Model

The original Milan model was highly scripted. Families were treated by male-female cotherapists and observed by other members of the team. The standard format had five parts: *presession*, *session*, *intersession*, *intervention*, and *postsession* discussion. As Boscolo, Cecchin, Hoffman, and Penn (1987) describe:

> During the presession the team came up with an initial hypothesis about the family's presenting problem. . . . During the session itself, the team members would validate, modify, or change the hypothesis. After about forty minutes, the entire team would meet alone to discuss the hypothesis and arrive at an intervention. The treating therapists would then go back to deliver the intervention to the family, either by positively connoting the problem situation or by a ritual to be done by the family that commented on the problem situation and was designed to introduce change. . . . Finally, the team would meet for a postsession discussion to analyze the family's reactions and to plan for the next session. (p. 4)

As indicated in this description, the primary intervention was either a *ritual* or a *positive connotation*.

The **positive connotation** was the most distinctive innovation to emerge from the Milan model. Derived from the MRI technique of reframing symptoms as serving a protective function—for example, Carlo needs to continue to be depressed to distract his parents from their marital issues—the positive connotation avoided the implication that family members benefited from the patient's symptoms. This implication made for resistance that the Milan team found could be circumvented if the patient's behavior was construed not as protecting specific people but as preserving the family's overall harmony. Indeed, every family member's behavior was often connoted in this system-serving way.

The treatment team would hypothesize about how the patient's symptom fit into the family system and, after a mid-session break, the therapists would deliver this hypothesis to the family, along with the injunction that they should not try to change. Carlo should continue to sacrifice himself by remaining depressed as a way to reassure the family that he will not become an abusive man like his grandfather. Mother should maintain her overinvolvement with Carlo as a way to make him feel valued while he sacrifices himself. Father should continue to criticize Mother and Carlo's relationship so that Mother will not be tempted to abandon Carlo and become a wife to her husband.

Rituals were used to engage families in a series of actions that ran counter to or exaggerated rigid family rules and myths. For example, one family that was enmeshed with their large extended family was told to hold family discussions behind locked doors every other night after dinner during which each family member was to speak for fifteen minutes about the family. Meanwhile they were to redouble their courtesy to the other members of the clan. By exaggerating the family's loyalty to the extended family while simultaneously breaking that loyalty's rule by meeting apart from the clan and talking about it, the family could examine and break the rule that perpetuated their dysfunctional system.

Rituals were also used to dramatize positive connotations. For example, each family member might have to express his or her gratitude each night to the patient for having the problem (Boscolo et al., 1987). The Milan group also devised a set of rituals based on an odd-and-even-days format (Selvini Palazzoli et al., 1978a). For example, a family in which the parents were deadlocked over parental control might be told that on even days of the week Father should be in charge of the patient's behavior and Mother should act as if she weren't there. On odd days, Mother is in charge and Father is to stay out of the way. Here, again, the family's rigid sequences are interrupted, and family must react differently to each other.

Positive connotations and rituals were powerful and provocative interventions. To keep families engaged while using such methods, the therapeutic relationship is crucial. Unfortunately, the Milan team originally saw therapy as a power struggle between therapists and families. Their main advice to therapists was to remain neutral in the sense of avoiding the appearance of taking sides. This **neutrality** was often manifest as distance, so that therapists delivered their dramatic pronouncements while acting aloof; not surprisingly, families often became angry and didn't return.

In the early 1980s, the original Milan team split around the nature of therapy. Selvini Palazzoli maintained the model's strategic and adversarial bent, although she stopped using paradoxical interventions.

Instead she and Prata experimented with a specific ritual called the **invariant prescription**, which they assigned to every family they treated.

Selvini Palazzoli (1986) believed that psychotic and anorexic patients are caught up in a "dirty game," a power struggle originally between their parents that these patients are pulled into and ultimately wind up using their symptoms in an attempt to defeat one parent for the sake of the other. In the invariant prescription, parents were to go out together without telling anyone else in the family of their whereabouts and to be mysterious about where they went. The goal was to strengthen the parental alliance and reinforce the boundary between generations.

In the 1990s Selvini Palazzoli reinvented her therapy once more, this time abandoning short-term, strategic therapy (invariant prescription included) for long-term therapy with patients and their families (Selvini Palazzoli, 1993). Thus, she came full circle, beginning with a psychodynamic approach, then focusing on family patterns, and finally returning to a long-term therapy that emphasizes insight and focuses again on the individual. This new therapy revolves around understanding the denial of family secrets and suffering over generations. In this way it is linked conceptually, if not technically, to her former models.

Boscolo and Cecchin also moved away from strategic intervening but toward a collaborative style of therapy. This approach grew from their conclusion that the value in the Milan model wasn't so much in the directives (positive connotations and rituals), which had been the model's centerpiece, but in the interview process itself. Their therapy came to center around **circular questioning**, a clinical translation of Bateson's notion of double description. Circular questions are designed to shift clients from thinking about individuals and linear causality and toward reciprocity and interdependence. For example, a therapist might ask: "Did she start losing weight before or after her sister went off to college?" "How might your father have characterized your mother's relationship with your sister, if he had felt free to speak with you about it?" "If she had not been born, how would your marriage be different today?" "If you were to divorce, which parent would the children live with?" Such questions are structured so that one has to give a relational description in answer.

Circular questions were further refined and cataloged by Penn (1982, 1985) and Tomm (1987a, 1987b). Boscolo (Boscolo & Bertrando, 1992) remains intrigued with their potential. As an example, let's return to Carlo's family and imagine the following conversation (adapted from Hoffman, 1983):

CASE STUDY

Q: Who is most upset by Carlo's depression?

A: Mother.

Q: How does Mother try to help Carlo?

A: She talks to him for hours and tries to do things for him.

Q: Who agrees most with Mother's way of trying to help Carlo?

A: The psychiatrist who prescribes his medication.

Q: Who disagrees?

A: Father. He thinks Carlo shouldn't be allowed to do what he wants.

Q: Who agrees with Father?

A: We all think Carlo is babied too much. And Grandma too. Grandpa would probably agree with Mother but he died.

Q: Did Carlo start to get depressed before or after Grandfather's death?

A: Not long after, I guess.

Q: If Grandfather hadn't died, how would the family be different now?

A: Well, Mother and Grandma probably wouldn't fight so much because Grandma wouldn't be living with us. And Mother wouldn't be so sad all the time.

Q: If Mother and Grandma didn't fight so much and Mother wasn't so sad, how do you think Carlo would be?

A: Well, I guess he might be happier too. But then he'd probably be fighting with Father again.

By asking circular questions, the frame for Carlo's problem gradually shifts from a psychiatric one to being symptomatic of changes in the family structure.

Boscolo and Cecchin became aware that the spirit in which these questions were asked determined their

usefulness. If a therapist maintains a strategic mindset—uses the questioning process to strive for a particular outcome—the responses of family members will be constrained by their sense that the therapist is after something. If, on the other hand, the therapist asks circular questions out of genuine curiosity (Cecchin, 1987), as if joining the family in a research expedition regarding their problem, an atmosphere can be created in which the family can arrive at new understandings of their predicament.

Other Contributions

Strategic therapists pioneered the *team approach* to therapy. Originally, the MRI group used teams behind one-way mirrors to help brainstorm strategies, as did the Milan group. Papp (1980) and her colleagues at the Ackerman Institute brought the team directly into the therapy process by turning the observers into a "Greek chorus" who reacted to events in the session. For example, the team might, for strategic purposes, disagree with the therapist. In witnessing the staged debates between the team and their therapist over what a family should do, family members might feel that both sides of their ambivalence were being represented. Having the team interact openly with the therapist or even with the family during sessions paved the way for later approaches in which the team might enter the treatment room and discuss the family while the family watched (Andersen, 1987).

Jim Alexander was a behaviorist who, out of frustration with the limits of his behavioral orientation, incorporated strategic ideas. The result was *functional family therapy* (Alexander & Parsons, 1982), which, as the name implies, is concerned with the function that family behavior is designed to achieve (see also Chapter 10). Functional family therapists assume that most family behaviors are attempts to become more or less intimate and through *relabeling* (another word for *reframing*) help family members see each other's actions in that benign light. They also help family members set up contingency management programs to help them get the kind of intimacy they want. Functional family therapy represents an interesting blend of strategic and behavioral therapies and, unlike other strategic models, retains the behaviorist ethic of basing interventions on sound research.

Evaluating Therapy Theory and Results

Communications family therapy wasn't just an application of psychotherapy to families; it was a radically new conceptualization that altered the very nature of imagination. What was new was a focus on the process and impact of communication, rather than the content. Communication was described as feedback and a tactic in interpersonal power struggles. In fact, all behavior is communicative.

When communication takes place in a closed system—an individual's fantasies or a family's private conversations—there is little opportunity for objective analysis. Only when someone outside the system provides input can correction occur. Because the rules of family functioning are largely unknown to the family, the best way to examine them is to consult an expert in communication. Today the concepts of communications theory have been absorbed into the mainstream of family therapy, and its symptom-focused interventions have become the basis of the strategic and solution-focused models.

Strategic therapies reached the height of their popularity in the 1980s. They were clever, prescriptive, and expedient—qualities appreciated by therapists who often felt overwhelmed by the emotionality of families in treatment. Then a backlash set in and people began criticizing strategic therapy's manipulative aspects. Unfortunately, when strategic therapists were confounded by the anxious inflexibility of some families, they may have exaggerated the irrational power of the family system.

In the 1990s the strategic approaches described in this chapter were replaced on family therapy's center stage by more collaborative models. But even as the field moves away from an overreliance on technique and manipulation, we shouldn't lose sight of valuable aspects of strategic therapy. These include having clear therapeutic goals, anticipating how families might react to interventions, understanding and tracking sequences of interaction, and the creative use of directives.

Historically, most of the research on the effectiveness of strategic therapy hasn't been very rigorous. More than any other model in this book, information about strategic therapy is exchanged through the case

report format. Nearly all of the articles and books on strategic therapy include at least one description of a successful treatment outcome. Thus strategic therapy appeared to have a great deal of anecdotal support for its efficacy (although people tend not to write about their failed cases). Recently, researchers have revisited these strategic ideas and have attempted to provide more rigorous empirical support.

Some early studies of the outcome of family therapies based on strategic therapy helped fuel its popularity. In their classic study, Langsley, Machotka, and Flomenhaft (1971) found that family crisis therapy, with similarities to the MRI and Haley models, drastically reduced the need for hospitalization. Alexander and Parsons found their functional family therapy to be more effective in treating a group of delinquents than a client-centered family approach, an eclectic-dynamic approach, or a no-treatment control group (Parsons & Alexander, 1973). Stanton, Todd, and associates (1982) demonstrated the effectiveness of combining structural and strategic family therapies for treating heroin addicts. The results were impressive because family therapy resulted in twice as many days of abstinence from heroin than a methadone maintenance program.

In the early 1980s the Milan Associates offered anecdotal case reports of amazing outcomes with anorexia nervosa, schizophrenia, and delinquency (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978b, 1980). Later, however, members of the original team expressed reservations about the model and implied that it wasn't as effective as they originally suggested (Boscolo, 1983; Selvini Palazzoli, 1986; Selvini Palazzoli & Viaro, 1988).

Although the original Milan model appears to have gone the way of the dinosaurs, there are currently two thriving strategic camps: the MRI group on the West Coast and the Washington School started by Haley and Madanes on the East Coast.

Some followers of the MRI model have focused their attention on accumulating empirical support for the social cybernetic ideas. Several studies of both individual problems (Shoham, Bootzin, Rohrbaugh & Ury, 1996; Shoham-Salomon, Avner & Neeman, 1989; Shoham-Salomon & Jancourt, 1985) and couples problems (Goldman & Greenberg, 1992) suggest that strategic interventions are more effective than straightforward affective or skill-oriented interventions when clients are resistant to change. For example, Shoham and Rohrbaugh adapted the MRI model of strategic therapy and developed a couples-focused intervention for change-resistant health problems, including smoking and alcoholism (e.g., Shoham, Rohrbaugh, Stickle & Jacob, 1998; Shoham, Rohrbaugh, Trost & Muramoto, 2006). To date, their studies targeting smoking cessation have shown that this approach is, at the very least, as successful as existing smoking-cessation interventions and possibly demonstrates increased effectiveness for certain higher-risk subpopulations (e.g., female smokers and dual-couple smokers) (Shoham et al., 2006). Additionally, in their study of couples with a male alcoholic they found that couples who engaged in high levels of demand-withdraw interactions (a positive feedback loop) were more likely to drop out of the CBT conditions, while the level of demand-withdraw did not affect drop out in their strategic couples-focused interventions (Shoham et al., 1998). This would seem to suggest that characteristics of the couples dynamic might be important when determining what treatment would be the most effective. Strategic therapy, which tends to be less confrontational and less directive, might fit better with couples who engage in these types of demand-withdraw interactions.

A group of researchers in Miami have spent the last several decades developing Brief Strategic Family Therapy (BSFT), an intervention for adolescent substance abuse and behavioral problems. Several of the central tenets of this model borrow from the Haley and Madanes model of strategic therapy. They claim that BSFT is (1) pragmatic (using whatever means necessary to encourage change), (2) problem focused (only targeting interactions associated with the identified problem), and (3) planful. Additionally, in line with Madanes's thinking about the function of the symptom, the developers of BSFT posit that the role of the symptom is to maintain family patterns of interaction and if the symptom is removed, the pattern of interaction is threatened. Over the years, the developers of BSFT have conducted numerous clinical trials and found that their model is successful in engaging and retaining families in treatment (Robbins et al., 2003, 2008; Szapocznik et al., 1988), decreasing adolescent substance abuse and associated problem behaviors, as well as improving family functioning (Robbins et al., 2000; Santiseban et al., 2003).

What people came to rebel against was the gimmickry of formulaic techniques. But gimmickry wasn't inherent in the strategic models. For example, the MRI's emphasis on reversing attempted solutions that don't work is a sound idea. People do stay stuck in ruts as long as they continue to pursue self-defeating strategies. If, in some hands, blocking more-of-the-same solutions resulted in a rote application of reverse psychology, that's not the fault of the cybernetic metaphor but of the way it was applied.

Strategic therapists are currently integrating new ideas and keeping up with the postmodern spirit of the twenty-first century. Haley published a book in which the evolution of his thinking is apparent (Haley, 1996), and a new book on the influence of the MRI on the field was released (Weakland & Ray, 1995). In addition, some authors have integrated MRI strategic concepts with narrative approaches (Eron & Lund, 1993, 1996). It's good to see that strategic thinking is evolving, because even in this era of the nonexpert therapist, there is still room for thoughtful problem-solving strategies and therapeutic direction.

Summary

Communications therapy was one of the first and most influential forms of family treatment. Its theoretical development was based on general systems theory, and the therapy that emerged was a systems approach *par excellence*. Communication was the detectable input and output therapists used to analyze the black box of interpersonal systems.

Another significant idea of communications therapy was that families are rule-governed systems, maintained by homeostatic feedback mechanisms. Negative feedback accounts for the stability of normal families and the inflexibility of dysfunctional ones. Because such families don't have adequate positive feedback mechanisms, they have difficulty adjusting to changing circumstances.

While there were major differences among the therapeutic strategies of Haley, Jackson, Satir, and Watzlawick, they were all committed to altering destructive patterns of communication. They pursued this goal by direct and indirect means. The direct approach, favored by Satir, sought change by coaching clear communication. This approach involved establishing ground rules, or metacommunicational principles, and included such tactics as telling people to speak for themselves and pointing out nonverbal and multilevel channels of communication.

The trouble is, as Haley noted, one of the difficulties of telling patients what to do is that "psychiatric patients are noted for their hesitation about doing what they are told." For this reason, communications therapists began to rely on more indirect strategies, designed to provoke change rather than foster awareness. Telling family members to speak for themselves, for example, may challenge a family rule and therefore meet with resistance. With this realization, communications therapy became a treatment of resistance.

Resistance was treated with a variety of paradoxical directives, known loosely as *therapeutic double binds*. Erickson's technique of prescribing resistance was used as a lever to gain control, as, for example, when a therapist tells family members not to reveal everything in the first session. The same ploy was used to prescribe symptoms, an action that made covert rules explicit, implied that such behavior was voluntary, and put the therapist in control.

Strategic therapy, derived from Ericksonian hypnotherapy and Batesonian cybernetics, developed a body of powerful procedures for treating psychological problems. Strategic approaches vary in the specifics of theory and technique but share a problem-centered, pragmatic focus on changing behavioral sequences, in which therapists take responsibility for solving problems. Insight and understanding are eschewed in favor of directives designed to change the way family members interact.

The MRI model is strictly interactional—observing and intervening into sequences of interaction surrounding a problem rather than speculating about the intentions of the interactants. Haley and Madanes, on the other hand, are interested in motives: Haley mainly in the desire to control others and Madanes in the desire to love and be loved. Unlike the MRI group, Haley and Madanes believe that successful treatment often requires structural change, with an emphasis on improving family hierarchy.

Like Haley, the Milan Associates originally saw power in the motives of family members. They tried to understand the elaborate multigenerational games

that surrounded symptoms. They designed powerful interventions—positive connotation and rituals—to expose those games and change the meaning of problems. Later the original group split, with Selvini Palazzoli going through several transformations until her current long-term approach based on family secrets. Cecchin and Boscolo moved away from formulaic interventions, became more interested in the questioning process as a way to help families to new understandings, and in so doing paved the way for family therapy's current interest in conversation and narrative.

CHAPTER 5 PRACTICE TEST

The following questions will test your application and analysis of the content found within this chapter. For additional assessment, applying, analyzing, synthesizing, and evaluating chapter content with practice, visit **MySearchLab**.

1. General systems theory depends on which two processes? How do normal families operate like general system theory?

2. What are the three explanations of how problems develop in strategic models? How would a Haley, a Milan, and an MRI therapist approach the problems?

3. How does an MRI therapist and a Haley therapist differ in their goals of therapy? How does the Milan group compare with the other models?

4. What are the six steps treatment in the MRI approach? How do paradoxical interventions factor in to the treatment?

5. What was Haley's approach to therapy? What kind of format did he follow?

6. Where do metaphors fit in to the Haley and Madanes approach? How do these approaches contrast each other?

7. What are pretend techniques? Who advocates their use, and what is the goal in using them?

8. What is Keim's approach in dealing with oppositional children? What is the goal in this approach?

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Conclude your chapter study by completing the chapter exam.

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^ = Family Therapy Asset
Δ = Case Study