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Full Length Research

The Role of the therapist Family and Families therapy Relationship

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Systemic family therapy also known as the Milan family therapy is focused on how family members are connected and it is of the view that therapy will take a systemic of problem maintenance and a strategic orientation to change. The Milan group believed in the concept of neutrality which keeps the Therapist from been drawn into family conflicts. Milan family therapy uses several techniques which are; hypothesizing, circular questioning, positive connotation and invariant prescription. The role of the therapist is both an expert and a co-creator of the constantly evolving family system, neutral and non-blaming stance, gives directives, does not try and overtly change families but uses a paradoxical approach to argue against change, extensive use of circular questions and other indirect interventions, stresses the positive connotations of behavior and defines troublesome symptoms as "ultimately in the service of family harmony. The process and outcome of the theory is; short treatment period, family dynamics are changed, one member (the scapegoat) stops being the focus of the family's problems and nonproductive interactions and 'games' change. Some unique aspect of the therapy is; therapists work in teams, either present with the family or behind a one-way mirror and it is expensive but effective. One critique of the therapy is the view of boundaries; this view is not universally shared, especially outside of Europe.

Key words: Systematic, Therapy, Family and treatment techniques.

INTRODUCTION

The primary goal of every therapy session or counselling session is to help family members see their choices and to ashes them in exercising. Therefore, to achieve this goal and objections the therapist must use techniques that will help members understand their relationship and problems in alternation ways, which allows them to work together to make new choices and identify new solutions, for the therapist to achieve its goal, it makes use of different methods and tachism among other this paper focuses the rolag of systematic family therapy.

Systemic Family therapy

Systematic Family therapy stresses the interconnectedness of family members while also emphasizing the importance of second order change in families.

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Major theorists

Mara Selvini Palazzoli

- trained as a psychoanalyst
- specialized in eating disorders but frustrated with results
- pioneer in applying psychoanalytic ideas to working with families
- blended psychoanalytical approach with approaches of Bateson, Haley, and Watzlawick
- formed the Center for the Study of the Family in Milan, Italy in 1971
- formed a new group to work with schizophrenics and anorectics in **1982**developed the concept of 'games,' which occur when children **and** parents stabilize around disturbed behaviors in an attempt to benefit from them
- Palazzoli died in 1999

Premises of the theory

- based on a systemic (circular) view of problem maintenance and a strategic (planned) orientation to change
- focus on the consequences of family communication patterns and conflict between competing hierarchies
- neutrality' is essential to keep the therapist from being drawn into family coalitions and disputes and gives the therapist time for assessing family dynamics
- long brief therapy' refers to the length of time between sessions (usually a month) and the duration of treatment **(**up to a year)

Treatment techniques

Hypothesizing' involves a meeting of the treatment team before the family arrives to formulate and discuss what could be creating a symptom; it is a way of preparing for treating the family **Positive connotation'** is a type of reframing in which family members' behavior is labeled as benevolent and motivated by good intentions; used to decrease resistance and establish rapport **Circular questioning'** frames questions so that every question addresses differences in perception by family members; intent is to highlight information, differences, and circular processes. The process of circular questioning is a fundamental concept in the Milan model." (Becvar & Becvar 1998: 243).

Circular questioning aimed at transforming families' ways of thinking from linear, causal chains of thought into reciprocal, interdependent worldviews (Becvar & Becvar 1998: 243). Important to the concept of circular questioning is **the idea** that in any relationship, all parties concerned must co-evolve, circularity refers to the circular sequence of interactions between family members and between the therapist and the family. For example, with regard to the latter, the therapist's hypotheses about the family lead to questions that he/she asks family members, and their responses lead to revised hypotheses and new questions. Circular questions are a common type of question and are asked of each family member to introduce new information into the system by helping members recognize differences and similarities in their perceptions. There are several types of circular questions: For example, some questions are aimed at identifying differences in each family member's perceptions about relationships ("Which family member is closest to Dad?"); others at identifying degrees of difference in perceptions ("On a scale from I to 10, how bad was the arguing this week?"); and others at helping family members reflect on the consequences or implications of different situations CI I the youngest child hadn't been born, what would Mom and Dad's marriage be **like?")**

Invariant prescriptions are a specific type of ritual given to parents of psychotic or anorexic children to break up power struggles

- requires parents to unite so that children cannot manipulate them
- parents tell their children they have a secret but don't reveal the secret_
- parents record the children's react parents then go out together for varying periods of time but don't tell children where they are going or for how long this mysterious behavior allies parents in a new way
- constructive changes in the family and the parents are preserved

Prescription Of Rituals

Rituals are assigned to break up dysfunctional rules and serve to dramatize positive. The Milan Group put themselves into the position of not being outsiders (Becvar & Becvar 1998: 244) of the family in therapy. This is epistemologically consistent with the paradigm of family and therapist constituting one system [3-2]**.** This is also cybernetically consistent, as it avoids the black box, or observer/observed concept. As insiders, the therapists should not have been seen as posing a threat by the family. Being inside the system and being accepted as non-threatening can be seen as natural outcomes of the Milan Group's dedication to neutrality and support [4,41]**.** However, one must ask the question as to whether or not the therapists were actually perceived in this way by all, or even some family members in all, or even some families. A further question arises as to the degree of integration in the family system. However, cybernetically speaking, these questions do provide answers themselves: no matter how much or how little the system was perturbed by being punctuated by the presence of the therapist, some degree of re- **organisation and adaptation must have taken place within the family in order to accommodate that perturbation.**

Working from the base of being part of the family system, the Milan Group used to prescribe rituals that paradoxically appeared not to lead to change (Becvar & Becvar 1998: 244). Further, the Milan Group worked according to the principle of meta-therapy — prescriptions at multiple levels (Palazzoli et al 1989: 17). This is consistent with their multi-positional approach and therefore also consistent with a cybernetic paradigm.

Prescription of rituals had to be carried out very exactly and carefully (Becvar & Becvar 1998: 244). It is important to note at that this stage that prescribing rituals that apparently enforce the status quo in the

family system is a paradoxical action. It is therefore also important to note again the problematic aspects of paradoxical interventions discovered by the Milan Group [4'3]. Rituals were not intended as a permanent part of family life, but rather framed in terms of experiments (Becvar & Becvar 1998: 244). Consistent with the neutral support that the Group believed was crucial to the therapeutic process, if a ritual failed, or even if the family failed to carry it out, responsibility for failure was framed in terms of the therapist, rather than the family (Becvar & Becvar 1998: 244).

The main purpose of the prescription of ritual was to point the family game in a different direction to its current course (Pals.zzoli et al 1989: 17). Further, the Group believed that by prescribing rituals, they could "cut through the knots of a game even when [they] had not yet deciphered and reframed it" (Palazzoli et al 1989: 17). A point of confusion arises at this stage for this writer, in that the Milan Group also stated clearly that they needed to understand the history of families [312]. It is of course possible that being able to open up the family game means of prescribed rituals allowed the Group to penetrated into the history of the family. Not onlywere rituals prescribed to be carried out away from the therapy room, but the whole process of therapy was in fact a ritual prescription in the ordered (ritualistic) way in which it was structured (Becvar & Becvar 1998: 242) (Palazzoli et al 1989: 17 ft). Rituals needed to be tailored to specific circumstances, but included the following general outlines: secrecy, isolation, family talks or the reading of statements, keeping of notebooks, or parental outings framed as disappearances (Becvar & Becvar 1998: 245) (Palazzoli et al 1989).

The Milan Group placed great emphasis on the idea that prescriptions functioned at multiple levels (Palazzoli et al 1989: 17, 31). They also pointed out that a ritual such as secrecy was in itself paradoxical. if parents were told to attend a session or sessions without their children and without telling the children or anybody else what had happened in therapy, the family was all aware of the directive to secrecy.

The fact that the sessionis had taken place expectations will also be aroused, not only in the parents, but also in the children. Parents, even though adhering to the injunction to secrecy, and therefore while not actually saying anything about the session, would convey non-verbal messages to the family, thereby subtly introducing new patterns of communication into the family system (Palazzoli et al 1 989: 31). That the Milan Group recognized these important points as part of the injunction one cannot manipulate and thereafter deliberately continued to use the prescription method demonstrates their awareness of; and openness to, a systemic way of thinking. It is important to note the influence of communication science in the epistemology of the Milan Group. What was crucial to the efficacy of the prescription method was the "hierarchical arrangement of communications on a nonverbal level" (Palazzoli et al 1989: 31). This is not only a tenet of general systems theory, but also of the structural therapists, who interpret the hierarchy in terms of certain specific sub-systems within the family (Becvar Becvar 1998: 189). These sub-systems are as follows: the spouse subsystem, the parental subsystem and the sibling subsystem (Becvar & Becvar 1998: 189). These subsystems, according to the structural therapists, function according to hierarchical rules (Becvar & Becvar 1998: 189). Communication in the form of negotiation of roles within and between the subsystems is a crucial factor (Becvar & Becvar 1998: 189).

Therapy Goals

The primary goal of therapy is to **"help family members see their choices and to assist them in exercising their prerogative of choosing" (Gelcer, McCabe, & Smith-Resnick,** 1990, p. 22). To achieve this goal, systemic therapists use techniques that help family members understand their relationships and problems in alternative ways, which **allows them to work together to make new** choices and identify new **solutions (i.e., to "play a different game").**

Two distinguishing characteristics of Milan systemic family therapy are its use of a therapeutic team and the division of each therapy session into **five parts:**

- a pre-session team discussion
- the interview with the family
- discussion of the interview by team members
- conclusion of the interview with a prescription (task) given to the family
- A post-session team discussion of the family's reactions to the prescription and formulation of a **plan for the** next session.

During each session, one or two members of the team meet with the family, while the remaining members observe **sessions behind a one-way mirror. Team conferences are**frequent, and an observer may call a therapist out of the session for a "strategy conference" to share his/her observations and make suggestions.

Aspects of problem situations

- a type of prescription that directs the **family to change their behavior under certain circumstances**

- **directive should** state a specific time the ritual is to be carried **out, what is to be done, who is to do it, and how it is** to be done

Role of the therapist

- both an expert and a co-creator of the evolving family system
- neutral and non-blaming stance
- gives directives
- does not try and overtly change families but uses a paradoxical approach to argue against change
- extensive use of circular questions and other indirect interventions
- stresses the positive connotations of behavior
- defines troublesome symptoms as "ultimately in the service of family **harmony" Process and outcome**
- short treatment period
- family dynamics are changed
- one member (the scapegoat) stops being the focus of the family's problems
- nonproductive interactions and 'games' change
- 'old epistemology' is replaced with more productive and appropriate behaviors
- process **of growth continues beyond therapy**
- vicious cycles are replaced with virtuous cycles of interaction

Unique aspects of systemic therapy

- flexibility and application for a variety of client families
- therapists work in teams, either present with the family or behind a one-way mirror:
- expensive but effective
- 'Greek chorus' is a special type of reflecting team in which observers may debate the merits of what the therapist is doing and families are helped to acknowledge and feel their ambivalence
- concentrates on one problem over a short period of time

Comparison with other theories

- "European bias toward non-intervention" refers to a high respect for people's individual
- boundaries; this view is not universally shared, especially outside of Europe
- controversial view about schizophrenia by Palazzoli who states that "schizophrenia always begins as a child's attempt to take sides in the stalemated relationship between parents"
- like strategic family therapy, interventions are tailored to the specifics of each family.
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The Milan Approach nowadays

As at today, the most qualifying points of our model seem to be the following:

- Great **appreciation for the Batesonian** model (aesthetic approach) as it was set out in the author's original theories. More specifically, there remains a focus on communication, relation, context as a matrix of meaning, and on the fact that pathology can make sense when considered as part of broader processes. A therapist belonging to the Milan Approach looks much more like an artist than a technician

- De —pathologization of the client and de-reification of suffering systems. Suffering in the mental and relational worlds cannot be described exactly as we describe suffering in the biological world, even though the two different arenas belong to the same living world. Using diagnoses and other resources that are typical of the medical domain only makes sense in a context that takes into due consideration factors such as time, processes, relations, and cultures. A cautious approach is taken to using a "medicalizing" language implying an unavoidable determinism, while priority is given to using, insofar as it is possible, a language that enhances growth and the ability to choose
- Great value of the hypothesizing activity, both in its original sense of guiding the therapist's work but also — and perhaps much more so — as a model for conversation both in the therapy room and behind the mirror, and
- finally as a mental attitude of the therapist
- Circularity, i.e. the ability to guide the conversation based on the family's feedback and to think based on relations and differences
- The use of positive connotation, which is also meant as a mental attitude more than as technical trick
- Creativity, curiosity, and irreverence, which allow to privilege what happens at the heart of the relationship rather then what one might expect in light of the reference theories
- Focus on affections, i.e. pathways to participation into the client's system, and emotions, i.e. the privileged place for triggering change
- Attention to narratives and time as a recursive connection between past, present, and future and as an opportunity (or obstacle) for people to meet

- Focus on cultural changes, challenges posed by multi-culturalism, gender issues, and processes of change in the family identity. An increasingly stronger connotation as a meta—model in which, over time, each individual therapist finds that he/she can integrate his/her orientations and personal skills.

A CASE ILLUSTRATION OF SYSTEMIC FAMILY THERAPY

Mrs. Moon contacted me as the result of a school referral. Her ten-year old son had been performing erratically in school, despite an outstanding intellectual potential. While his school work was superior on some occasions, at other times it was poor or left incomplete. When approached by teachers or the principal in his private school, he either withdrew, seemed not to hear, or blamed his poor performance on distractions caused by a school mate who sat at a nearby desk, or by noises" upstairs." At other times, he seemed preoccupied and looked out of the window. Mrs. Moon stated that David was bright but "'lazy, "and that the school had exaggerated the problem. However, she was interested in therapy because David was very hard to live with, he "didn't listen", and she felt troubled about the quality of their family life. She said, "I thought my home was pretty bad when I was a child, but my kids have it even worse. "Diagnostic evaluation revealed that David was indeed superior in intelligence, and evidenced no learning disabilities. While he was generally cooperative during the evaluation sessions he was very constricted both in handling test materials and in the interpersonal situation. His performance on both projective and semi-projective materials was suggestive of' pre-psychotic disposition. During **the interpretive** hour, mother **spontaneously stated her** concern with the functioning **of the** entire family unit. While most of the attention of this highly verbal woman was directed toward David, who was continually scapegoated in the process, she strongly criticized her husband as well. She expressed great dissatisfaction with her husband's lack of warmth and concern_ and felt the entire burden of raising the children was on her. While David was the **one with the most obvious** problems now, she **felt that his example could lead to problems** for her younger son, Robert, which was already being manifested in his social immaturity in the classroom? he was the "class clown", and had said on several occasions that he was afraid to laugh or cry, as he might not be able to stop. Floyd, the husband, said little throughout the sessions; indeed, he did little except to loudly correct Edith twice and say "Shut up" twice. He sat throughout most of the session in a darkened corner of the room with a copy of "Ranger Ricks" on his lap. David spent much of the session in a ducking position when criticized, while Robert seemed silent and uncomfortable, with a foolish grin on his face. In response to the suggestion that family sessions be tried, as the problem seemed to involve the whole family, all expressed assent. It quickly became apparent that having one therapist work with this family alone was insufficient. Interactions were exceedingly complicated at times and too much time was spent ina dyadic process between the therapist and Edith, the mother. While a therapeutic alliance seemed to be readily formed with Edith, others resisted; indeed, as the appearance of an alliance with Edith increased other family members increased their resistance and withdrew. In the typical scenario at the initiation of sessions, mother would list "family complaints" regarding her own problems and those that she perceived in other members, and would work to engage the therapist in joining her as judge, sympathizer and supporter. Efforts to move away from this pattern, whether through interpretation, role-playing simulations or even paradoxical tasks (4, 6) worked only briefly, if at all. At this point, and with the permission of the family, a male co-therapist was introduced, as suggested by Hurwitz (8) This person was familiar with the family as he had participated in the original assessment and had studied the videotapes and participated in case conferences in which the case was discussed. While he and I had not previously worked together in family therapy we had a mutually respectful and open relationship, and felt capable of handling disagreements which might occur. Introduction of the co-therapy arrangement was well-accepted by the family. During the first joint session Floyd, the father put down his copy of Ranker Ricks and smiled for the first time and both sons became somewhat verbal. Mother hesitated before jumping into the conversation, and found it harder to maintain her seat as spokeswoman, as the others became more assertive. While her essential therapeutic alliance remained with me, the males in the family were able to develop strong therapeutic alliances with the male co-therapist and in the process became more vocal and active. While Floyd's passivity and withdrawal had been strongly criticized by Edith, she found it difficult to relate to him when he was more outgoing. At these times she would provoke him sharply and his mood would go from relative cheerfulness to anger, to withdrawal. In trying to deal with this and other nonproductive family interaction patterns such as the family's continual placement of David on the "hot seat", by the end of six months of therapy we were no longer monitoring the very problem that had brought the family into therapy David's severe school problems, and apparent preoccupation. Our emphasis on the here-and-now and upon family communication patterns distracted attention from behavior not directly emitted within the sessions or (reportedly) in the family home. It was only much later that we learned that after an initial period of considerable improvement, in which he became more alert and assertive and both his academic performance and social interactions improved, David began to withdraw more than before. In retrospect, it was clear that early in therapy when his family

suppressed their tendency to scapegoat and attack David, his school performance greatly improved, both academically and socially. However, as the spotlight of the family shifted, David was essentially excluded from family interactions, and Robert received almost all of the family's attention, both positive and negative. That is, instead of replacing blame of David with loving concern, no replacement was made. He was simply left out. During a period of time in which Floyd was becoming more vocal and David took Floyd's seat, quietly in a corner next to the pile of Ranger Ricks, he failed all of his mid-year examinations. Nothing of the kind was mentioned during his session that week and it was only months later that we learned that the day after our session he had been found under his desk in school, rocking and crying, while other class members were painting posters. When mother was called into school during this time period, in contrast to earlier blaming behaviors, in which she allied with the school against her son, she expressed utter disbelief that David could behave immaturely. She insisted to school personnel that the family was in therapy and David was improving. She later told us that she had been very proud of her new way of handling "those school people". This incident was never mentioned during therapy sessions. Instead the family - primarily Edith, Floyd and Robert - reported great Satisfaction with therapy, and expressed the conviction that their quality of life as a family was improving. David was usually silent at those times. They never cancelled sessions or came late, and reported that they really missed their session and the therapists when a holiday or illness of a therapist resulted in postponement or cancellation. One and a half years after the onset of therapy, the therapists learned that David had been expelled from school. We also learned at that time about his increasingly regressive behavior. We finally realized that our "perfect" sessions were not working with David, who was the primary cause of our initial concern. Indeed his situation within the family and in school had gotten worse. Scapegoating in the family was replaced by virtual exclusion and school failure by expulsion from school. Even then, it was still hard to get this family to give up their dependence on this therapy which had failed, and to explore other treatment options.

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