Systemic family therapy owes its origins to the brilliantly creative and innovative clinical team of M. Selvini-Palazzoli, L. Boscolo, G. Cecchin, and G. Prata (1978, 1980). These four Italian psychiatrists have had an enormous impact on the conceptualization and practice of family therapy in the 1980s in North America and throughout the world. Drs. Boscolo and Cecchin have functioned as meritorious mentors to us through several workshops presented in Calgary, Canada, as well as through many personal discussions with them both in Calgary and in Milan, Italy. During the past 3 years, Dr. Selvini-Palazzoli has had a significant impact on one of us (L. W.) through various presentations and discussions in both Milan and the United States.

This chapter presents our interpretation and practice of systemic family therapy, particularly its application to families experiencing difficulties with health problems (e.g., angina, multiple sclerosis). It addresses the issue of family development and how it is viewed by systemic family therapists. A detailed case example illustrates the conceptualization of human problems from a systemic perspective and how that conceptualization influences treatment and the developmental implications.

**CASE EXAMPLE: THE HEARTBREAK OF PERCEIVED DISLOYALTY AND DISAPPROVAL**

**Context of Treatment**

The Family Nursing Unit (FNU), University of Calgary, an educational and research unit, was established in 1982 under the direction of Dr. Lorraine. The Chronic Illness Project cited in this chapter, which is conducted within the Family Nursing Unit at the University of Calgary, is funded by a grant from the Alberta Foundation for Nursing Research, Edmonton, Alberta, Canada.
Wright for the interactional study and treatment of families with health problems (Wright, Watson, & Duhamel, 1985). Two other nursing faculty members, Dr. Wendy Watson, Education Coordinator, and Dr. Janice Bell, Research Coordinator, complete the clinical, research, and education team of the FNU. The FNU offers assistance to families when one or more family members are experiencing difficulties with a health problem. Families seen at the FNU are either self-referred or referred by health care professionals such as family physicians or community health nurses. On average, five to six sessions are provided to each family.

Master-of-nursing students who wish to specialize in family systems nursing spend two practicums within the FNU. The FNU is an excellent training facility, utilizing a suite of five interviewing rooms and one large observation room. Each interviewing room has a one-way mirror, so that interviews can be observed and supervised. Because of the excellent facilities, and because of our commitment to provide intensive and frequent live supervision, families normally receive the benefit of a team approach. Graduate nursing students conduct the interviews, and a supervisor (one of us) and other graduate students observe. All team members have input into the assessment and intervention with the families. Videotape supervision is provided bimonthly.

In addition to the training and supervision of master-of-nursing students, several research projects are conducted within the FNU. One of these is the Chronic Illness Project, which examines the relationship between family functioning and illness and the effect of systemic family interventions on family functioning and the illness. We work as a clinical team with the families seen in the project: For each session, one of us interviews, and the other observes from behind the one-way mirror.

**PROFILE OF THE H FAMILY**

The H family was referred to the FNU by a mental health professional, who had noted the intergenerational conflict between the adult daughter, Janet, aged 39, and her mother, Mary, aged 66, and the concomitant stress to each. Because the mother was presenting with angina, the family was enlisted in the Chronic Illness Project. The family received a team approach (Dr. Watson, interviewer; Dr. Wright, observer) for six sessions over a period of 5 months.

Mary was a retired legal secretary presenting with angina treated with nitroglycerine. She lived with her second husband of 30 years, John, aged 73. Janet had been married 20 years to Gus, aged 46. They lived 15 blocks away from Mary and John with their three children, Mila, 16, Tara, 14, and Sam, 12. Janet's father, Mary's first husband, Imre, lived in Hungary, from which Janet and Mary had immigrated 30 years ago.

On recommendation from the mental health professional, Janet contacted the FNU and gave the intake secretary a brief sketch of the presenting
problem. She indicated that her mother was disapproving of how she (the adult daughter) was handling her life. Her mother thought that Janet should seek help from a psychiatrist. Janet also stated that Mary was having heart problems. Janet was concerned that the stress of their mother-daughter relationship might make her mother more ill.

Janet requested that the FNU not call her at home to arrange the appointment time. She stated that “the family” must not know about the conflict between her and her mother.

Based on this information, our team began to develop hypotheses about this adult daughter-elderly mother system. One hypothesis was that the reciprocity of concern between the daughter and the mother was a sign of overconcern, indicating an overly close parent-child dyad. The team was intrigued with the directive for the FNU not to call the daughter at home. The “secret conflict” information supported a hypothesis that the relationship between mother and daughter might be the most important “marriage” in the family.

One way in which systemic therapy (a nonnormative model) uses family development (a normative model) notions is in the generation of beginning/working hypotheses about the connection between the symptom and the system. Thus a second hypothesis was developed in the presession: that Janet and Mary were having difficulty negotiating the normal developmental tasks of an aging mother and a middle-aged daughter. The elderly mother and her adult daughter constitute a system that, according to family life cycle stages, consists of the interfacing of the mother’s “aging-family” tasks with the daughter’s tasks of “families with teenagers.” A developmental perspective on the elderly mother as a member of an aging family indicates that she would be concerned about the following:

1. Shifting from a work role to leisure and semiretirement or full retirement.
2. Maintenance of couple and individual functioning while adapting to the aging process.
3. Preparation for her own death and for dealing with the loss of spouse, siblings, and other peers (Wright & Leahey, 1984).

Concurrently, the adult daughter, Janet, would be focused on the following:

1. Development of increasing autonomy for her adolescents.
2. Refocusing on midlife marital and career issues. Certainly Janet and her husband were in the midst of this, as evidenced by the marital conflict present.
3. Beginning a shift toward concern for the older generation. It has been stated that the last developmental task of middle age is adjusting to aged parents (Havighurst, 1948). Neugarten (1979) has wisely observed that “concern over an aging parent or parent-in-law has come to be part of the psychological baggage that most adults carry around in their heads” (p. 259).

Silverstone (1979) recognizes the multiple demands, transitions, and tasks these women may be facing. She notes that the tasks of middle age include the following: giving up one’s youth; adjusting to the “empty nest,” which she
terms a euphemism for the multitude of feelings this life cycle stage may provoke: facing one's mortality and aging; and taking on a filial role in relation to one's parents. It is the interdependence of these tasks that can complicate even further the potential conflicts among the filial, marital, and parental responsibilities of the middle-aged woman. The special burdens of members of this age group, who function as the "fulcrum of familial stresses" (Bloom & Monroe, 1972), have been unappreciated and unresearched.

Session 1

In the first session, the elderly mother-adult daughter conflict was described as being related to the daughter's having planned and taken a trip to see her father, Imre, in Hungary 2 years ago. Janet had planned the trip without consulting her mother: "I didn't want her to control this." When Janet anxiously told her mother that she was taking the trip, Mary was "stunned and then seemed to be out of her mind and became ill with her heart problems."

In systemic therapy, it is important to learn the family's hypothesis about the problem.

Therapist: When you saw that, how did you explain it to yourself? What did you think was happening?

Janet: I thought whenever she didn't want me to do something, she would have heart trouble.

Mary took an individual developmental perspective and attributed the conflict between her and her daughter to her daughter's "midlife crisis." Mary interpreted her daughter's planning and taking the trip as a "search for her real father" and as being untrue and "disloyal" to her mother and stepfather. Mary perceived her daughter as "firmly standing behind her father for the past 2 years and firmly not standing behind me for the past 2 years!"

Mary and Janet's relationship had reportedly deteriorated since the daughter's trip to visit her natural father in Hungary. Mary and Janet had in fact only spoken to each other in the context of family gatherings, to ensure that the "secret" conflict would be kept. During the first session, neither would acknowledge the other's presence or perspective. Mary presented her perspective of attempting to help her daughter and having that help "rejected." As Mary described the problematic cycle with her daughter, the process in the session was actually enacted in the reverse, with Janet offering to help her mother pronounce the word "wreck," and her mother disregarding the daughter's attempted assistance.

Systemic therapy considers the larger context in which a midlife crisis occurs. Mary and Janet presented a picture of a historically overly close mother-daughter relationship, which resulted from having come to a new country together and from there being no other children and no husband to divert their attention from and need for each other. In the context of this past,
overly close relationship, “initiation” on the part of Janet was perceived as “rejection” by Mary.

The life-threatening potential of the mother-daughter conflict was further dramatized by their both believing that Mary would die. From Mary’s point of view, her daughter’s continued disloyalty would lead to her (the mother’s) death! Her relationship with her daughter had “died” and so would she!

Therapist: I am trying to understand how a woman who could leave Hungary with a 10-year-old daughter and conquer the new world would find this present situation so terrible that it has affected you to the point that you might die.

Mary: Because to me my daughter was the most important in the world always. When I realized that I lost her, I felt I lost everything.

Feedback from the family to circular questioning in the first session led to the following hypotheses: (1) Mary’s heart problem was life-threatening for her and was autonomy-threatening for Jane; (2) intergenerational conflict was an issue of loyalty and control; and (3) intergenerational conflict between Mary and Janet was related to the lack of differentiation between them and to the daughter’s reconnection with her natural father.

Session 2

In the second session, support was given for the mother-daughter relationship being the “best marriage” in the family: The daughter had never felt “bonded” to her husband. She had hoped that when her mother-in-law died, she would be closer to her husband, but this did not happen.

A systemic view considers the nondevelopment of the daughter’s relationship with her husband in the context of the very close relationship between her husband and his mother, and between the daughter and her mother. The converse is also important to consider, that is, the very close relationship between each spouse and their respective mother in the context of the lack of “bonding” between the younger couple.

Developmental issues are clearly systems issues. A change in autonomy in one part of the system is associated with a change in control in another part of the system. Increasing autonomy by Janet involves a relinquishing of control by her mother. The systemic therapist asks herself/himself the question, “In what context is the increasing autonomy being sought?” Thus the systemic therapist is cognizant of the interfacing of individual and family life cycle developmental issues. The adult daughter’s midlife autonomy issues and her family-with-teenagers tasks interface with her elderly mother’s aging issues (health concerns) and her aging-family tasks in such a way as to make launching, at this time, precarious at best and impossible at worst.

Steinman (1979) uses the family life cycle to point out transitions that require modification in both family structure and family relationships. This
can place strain on family members and lead to conflict “because the urge is frequently to maintain the status quo. When a family is not flexible enough to withstand important developmental changes, conflict is likely to be a concomitant of transitional periods. If this conflict is not resolved, symptoms will frequently occur” (p. 128). During the second session, the polarization of the perspectives of Mary and Janet continued. However, with the use of triadic questioning by the therapist, they did agree on one issue—that they had been “too close” over the years and that they had not had a “normal” mother-daughter relationship.

Therapist: If your husbands were here today, how would they describe the relationship between the two of you as mother and daughter?

Janet: My husband would say we were too close. He was very threatened by it. Ours was much closer than “normal.” My marriage was very traumatic for her.

Mary: Very.

Janet: It was a difficult separation. Later it eased with the children. But even now, for some things to make this much trouble for 2 years, you must realize that this is not the normal laissez-faire relationship.

The intersession hypothesis was that the intergenerational conflict served to maintain and/or create distance in a historically overly close mother-daughter relationship. The end-of-session intervention consisted of the following:

1. Pointing out similarities between the mother’s and daughter’s individual developmental issues at age 38 (i.e., that Mary did not seek advice from her mother regarding her decision at 38 to come to the “new world,” and that when Janet was 38 and thought of another kind of “new world,” she did not seek advice from her mother).
2. Discussing the significant developmental issues of the mother–daughter relationship (i.e., that their close relationship had developed in the context of coming to a new country; that the mother had no husband for support and the daughter, no siblings; and that they needed to turn to each other for support).
3. Systemically reframing the conflict as a distance regulator (i.e., “Had it not been all these unexpected things, the two of you would have found something else unexpected and dramatic to help the two of you be a little less close”).

We then contracted with the mother and daughter for three sessions, to assist them as they determined how close they should be to each other at this time in their lives.

Since interventions are delivered at the end of the session to further perturb the system, the reaction of family members to the team’s opinion constitutes a salient point. To the systemic reframing, the mother responded very positively, even clarifying the therapist’s words, whereas the daughter was more hesitant and struggled to understand the team’s opinion.
Therapist: To solve the situation of being so tight, you each did a good part to help you loosen. But now we think you’ve gone overboard. You’ve flown apart.

Mary: From one extreme to the other.

Therapist: Now you’re looking to find the right distance between you as mother and daughter at this time.

Mary: In a medium way.

Mary (to Janet): Do you not realize it?

Therapist: We need you both to think about this. Some of these ideas you may agree with, some not. We see that you are continuing to keep this extreme distance between you by each of you believing that you see things the right way and by not being willing to see the other person’s point of view.

Session 3

Considering Mary’s very helpful reaction to the team’s opinion, the team was surprised by the continuing symmetry between Mary and Janet in the third session. Just as Mary had “understood” the opinion at the end of Session 2 while Janet had not, now, in Session 3 Janet made “sense” of the intervention while Mary could not. In fact, Mary was more entrenched in her “correct” view that her daughter’s trip to Hungary was an act of disloyalty toward her and that Janet was accepting her father and rejecting her.

Using the language of her past profession of legal secretary, Mary brought to the session three typewritten pages presenting her “testimony.” Mary patronized her daughter throughout the session. Janet responded by becoming withdrawn and overwhelmed with the content and process of her mother’s presentation. The more nonresponsive Janet became, the more in control and persistent Mary became, and vice versa.

During the intersession break, it was difficult for the team to shift from a linear hypothesis that the intergenerational conflict was maintained by the mother’s very fixed beliefs. Slowly, however, the hypothesis became more systemic by considering how Janet’s impotent response could assist in the cementing of her mother’s fixed beliefs. Further discussion led the team to see that both parties had firmly held beliefs and that both showed impotence (Janet by becoming withdrawn, and her mother by attempting to take more control). Thus the systemic hypothesis was that the intergenerational conflict was maintained by the very fixed beliefs and the impotence experienced by both mother and daughter.

The team determined the necessity to (1) challenge the fixed beliefs of the mother and daughter, (2) empower each of them, and (3) maintain engagement with each of them. Fortunately, Dr. Bell, the FNU Research Coordinator, had joined Dr. Wright behind the mirror that particular day. This enabled Dr. Bell and Dr. Wright to reflect the conflict between the mother and daughter in the form of a split-opinion intervention. We wanted to
use the “language” of the mother (i.e., the written word) and heighten the curiosity of the family members by preparing a letter available for pickup 3 days after the session. Therefore Dr. Watson told the family, “Something unusual has happened today. My two team members behind the mirror cannot agree. It’s going to take time to come to a decision. Therefore we will write our opinion in a letter for each of you.”

The verbatim letter is as follows:

Dear Mary and Janet:

After much further discussion, our team unfortunately could not reach agreement about the way they see the problems between the two of you. Therefore, the solutions to these problems also differ. Realizing that we may never agree on how we see the problem, we have agreed to present our differing views to each of you:

1. One team member found herself taking Janet’s side:

   **Problem:** This team member sees that the problem is one of a misunderstood daughter who cannot convince her mother that she, as a daughter, loves, cares and is loyal to her mother.

   The reason that Janet cannot convince her mother is due to the fact that Mary, her mother, has very rigid, fixed beliefs which she is unfortunately not willing to give up at this time. Janet has tried to convince her mother that even if contact with her father, Imre, continues, this does not lessen her loyalty or concern for her mother, Mary.

   Unfortunately, Janet’s visit to her father in Hungary uncovered some deep, long-standing mistrust and misunderstandings between her father and her mother.

   This team member congratulates Janet on her attempt to reconnect with her father, as understanding your heritage and family background is a very important part of becoming a mature woman. This team member sees that it was not necessary for Janet to ask for approval from Mary to visit her father, as this team member sees that a relationship between you, Janet, and your father is a separate relationship from your relationship with your mother... especially in the case where your mother and father have been divorced for many years.

   **Solution:** This team member thinks that mother’s inability to see her daughter’s point of view and her continuing resentment toward her daughter has more power to break up the family than anything that Janet could do, or Imre could do, or that their husbands could do.

   Therefore, the team member that takes Janet’s side thinks that Janet should keep contact with her father, even though it may be infrequent. However, since knowledge of further contact with Imre generates too many bad feelings in Mary and also too many worries about the future, Janet should keep her contact with her father a secret from her mother. That is to say, as a loving daughter, Janet should not tell her mother, Mary, of her contact with her father, Imre.

2. One team member found herself taking Mary’s side:

   **Problem:** This team member sees that the problem is one of a misunderstood mother who cannot convince her daughter of the seriousness of her daughter’s action in visiting her father, without first seeking approval from her mother and stepfather.
This team member sees that Janet is a loyal daughter but was not courteous and sensitive enough to ask her mother for permission to see her father and to seek her opinion and advice on the matter before making plans to go. It would also have been respectful for Janet to explain her reasons for wanting to see her father.

This team member congratulates Mary for caring so very much about the stability of her Canadian/Hungarian family. This intense caring makes Mary very sensitive to the possibility that knowledge of the details of her daughter's trip and knowledge of the conflict between mother and daughter may break the family up.

This team member thinks mother is very desirous to not have the breakup happen, for if it did, both mother and daughter would be left without family members and without each other as well. This would be tremendously difficult for a mother and daughter who have been so very close and connected to each other. This team member thinks that mother is doing everything she can do to prevent her daughter, Janet from having to experience the pain of having a family break up. This team member congratulates mother on her efforts to save the family.

**Solution:** This team member sees that mother and daughter are close but that Janet's inability to understand the seriousness of continuing contact with Imre may break up the family.

This team member thinks that Mary has made a valiant effort over the past two years to try to convince her daughter of the seriousness but sees that mother's efforts have not had much effect on Janet.

In fact, this team member thinks that the more Mary repeats the same facts, over and over again, the less that Janet listens. This team member is concerned that all of mother's efforts are being wasted on the deaf ears of her daughter. Therefore, this team member advises that Mary seek some new ways to encourage her daughter to discontinue contact with her father. Mary should not repeat anything that she has already said to Janet. Instead Mary should find some new reasons for no further contact with Imre. This team member also thinks that mother should continue to watch over the safety of her Canadian/Hungarian family and keep the conflict with her daughter a secret.

3. I (Dr. Watson) strongly disagree with both Dr. Bell and Dr. Wright. I think that the other two members of the team are not looking at the real issue. They are being sidetracked by their own emotions and are not willing to consider another point of view. By each of them sticking so firmly to their own view, I think that they are missing what is really going on between the two of you as mother and daughter.

Here is my opinion:

After hearing the disagreements of Dr. Wright and Dr. Bell, I am even more convinced that the real issue between you as mother and daughter is the following:

**Problem:** I see that the problem is one of a mother and daughter who have been too close in the past due to the circumstances of coming to a new country, having no other family members initially to interfere with your focusing on each other . . . that is, there were no husband and no other children in the family to talk with or do things with. Even with the addition of family members, your new husbands, the two of you as mother and daughter were very close . . . and perhaps the best "marriage" was between you as mother and daughter.
I believe that each of you was sensitive to this very deep closeness and was aware that it had the potential of interfering with your relationships with your husbands and other family members that you love and care about.

I believe that at an unconscious level each of you knew that something had to be done to loosen the very close bond between the two of you. Because of the intensity of the bond, you knew it had to be something very dramatic, something very unexpected . . . to be successful to give you a more natural mother-daughter relationship.

Janet's trip to see her father has served the purpose to loosen the bonds between you. Janet's taking the trip was very unexpected to Mary, as was Janet's not seeking permission first; Mary's response (becoming ill and continuing to be resentful) was very unexpected to Janet. Thus, the trip has helped the two of you to be less close. But the two of you have taken it too far . . . you have gone overboard in loosening the bonds. You have each distanced too much from the other. The more you distance, the more difficult it is to see the other person's point of view.

Something that had the potential for good . . . that is, loosening the bonds between the two of you, so that you each could be closer to other family members . . . you were each willing to sacrifice a bit of closeness in your mother-daughter relationship for the overall good of the family . . . this potential good, has been taken too far and now is turning to the detriment of all.

Let me emphasize that since you were both sensitive to the overcloseness in your mother-daughter relationship, if the trip to Hungary to visit Imre had not been the thing to distance you from each other, you each would have found something else to help you not be so close to each other.

Solution: You as mother and daughter have taken your task of trying to be close too far. You are now too distant. It is becoming more and more difficult to see each other's point of view or to hear what the other is saying. You both need to find a happy medium . . . a place that is not too close to each other so that other relationships are blocked out, nor too far apart so that you can no longer find each other. I am very willing to assist you in your efforts to find the right balance in your mother-daughter relationship. Finding the right balance will be a difficult but very worthwhile pursuit for two people who have such a great amount of caring for each other.

Conclusion:

With the very strong disagreement present in the team and the disagreements between the two of you, I think it is best that you carefully and thoughtfully consider the ideas presented in this letter. This will take time and concentrated effort.

I would therefore like to offer you your next appointment in three weeks. I will be looking forward to hearing your points of view at that time.

Sincerely,

Wendy L. Watson, R.N., Ph.D.
Education Coordinator, Family Nursing Unit
Associate Professor, Faculty of Nursing
University of Calgary

cc Dr. L. M. Wright
Dr. J. Bell
Three days after picking up the letter, Janet called Dr. Watson requesting an earlier appointment and stating that her mother and she had gone for lunch together the previous day. We decided as a team not to see the family before the scheduled time in 3 weeks, in order for the split-opinion intervention to have further time to percolate in the system.

Session 4
Mary came beautifully dressed to the fourth session. She brought her copy of the letter, announcing as she entered the therapy room, "This is the most wonderful letter I have ever received!" Janet had read, memorized, and destroyed her copy of the letter, to prevent her husband from accidently finding it and discovering the "secret" conflict. Mary spontaneously reported that she was going to go to the doctor for her heart condition. This was a major change from her previous stance of saying that she was just going to die and that she would not seek medical attention.

When the women were asked what stood out for them in the letter, it was clear that the letter had had further dramatic and system-perturbing effects.

Mary: I realized how very wrong I was in many places. It was like getting shock treatment on my head. Before I was discredited and alone. I was like a shivering "wo," "wor," "worm?" [Mother sought help from her daughter to say the word "worm." Another change.] But now I am myself again, I am like a bear and I want to help this overaged cub. She is a wonderful woman and I love her.

The daughter was surprised that the letter had "so much insight, so much more than she expected!" The daughter was a bit hesitant about having a team member take her side so strongly. She was weepy throughout the session and explained that it was such a relief to have a change in the relationship with her mother, a change that had eluded both of them for 2 torturous years.

The letter had prompted the mother and daughter to talk more, and they had been out to lunch together. They reported that "they could now solve their own problems; they could now get on with talking about the 'real' problem." The context for change had been created. Both mother and daughter brought "new" information to the session that day to share with the other. In each case, the "new" information clarified the fears of the hearer and illuminated instrumental and affective issues around the problematic trip to the "old" world!

A ritual was prescribed at the end of Session 4. To help their two hearts start healing, two "heart meetings" were prescribed. One meeting was to be initiated by Mary, the other by Janet. We structured the meetings, giving details regarding length (1 hour) and process (during the first 15 minutes, one would talk and the other only listen, and vice versa for the next 15 minutes).
Details on content were general. The rationale for the intervention was to enhance and facilitate the new balance of closeness and distance that this mother-daughter system had discovered. The mother’s response to the suggestion of the ritual was, “This is the first time in 40 years my daughter and I have talked like this. Now my daughter will have time for me!”

Session 5

Session 5 was held 2 weeks later. Janet reported that the relationship with her mother was now filled with hope. She no longer felt guilty or that she had done something “bad or wrong” in taking the trip to visit her natural father. Mary reported that her daughter was “no longer on trial” and that she was now “willing to believe” her daughter. The two “heart talks” had resulted in Mary’s being able to talk to her daughter for the first time in 2 years. “Too much pride” had prevented her from doing so before.

Mary’s comments on their readiness to work on a new relationship were particularly systemic in nature: “I will give her freedom. She will give me freedom. I am not hanging onto her. She’s not hanging onto me.”

The session focused on having Mary and Janet convince the team members behind the mirror that there was another point of view to take, one that differed from that which the team members had so rigidly ascribed to in the letter. That is, the mother was able to present her daughter’s point of view, and vice versa.

The women eagerly awaited the “verdict” of the team during the intersession break. Had they swayed Dr. Wright and Dr. Bell to take another point of view? The team again mirrored the perceptions of the mother and the daughter with the perceptions of Dr. Wright and Dr. Bell. To further perturb the system, each reflected position was taken a bit beyond what the mother and daughter had presented during the interview.

Therapist: The team member who originally could only see your mother’s point of view could now see yours, Janet. That person was impressed that you could say so clearly and directly to your mother that Imre is an SOB but he is your father and that you want contact with him.

Mary: That’s right.
Janet: I’ve come a long way!
Mary: Yes, I appreciate that.
Therapist: The team member who could originally only see Janet’s point of view was able today to see Mary’s view. This person is impressed with your ability and willingness to be less . . .

Mary: Stubborn! I’m going to push myself behind her! This is the first time in my life!
Therapist: This team member thinks that you will actually have a greater influence on your daughter by holding back. You’ll be even a better mother by
being able to hold back, being able to give her the freedom to make decisions, even at those times when you may not agree with the decisions. You may even need to say in the future when she comes to you for a decision (Mother laughs), "I have confidence that you can handle it!"

To continue to maintain the positive changes in the relationship and to deal with unresolved hurts, a "burial ritual" was prescribed. The mother and daughter were encouraged to (1) write on pieces of paper any "old hurts" that they were ready to bury, (2) place their pieces of paper in a box, and (3) bury the box. They were told that this would help their two hearts continue to heal toward each other. In the future, if they wanted to "dig up the old hurts," they would know where to find them. A follow-up session was scheduled for 3 months later.

Follow-up Session

Janet attended the follow-up session by herself. (Had the mother launched her daughter?) She had tried to encourage her mother to attend the session, but her mother perceived coming to therapy as indicative of problems being present. Since the problems were resolved, she saw no need to attend but had sent her feedback with her daughter. It was hypothesized that she was showing confidence in her daughter's ability to present her (the mother's) point of view. What a dramatic change!

Janet reported many improvements in the relationship and was most eager to tell about the changes in her mother, stating that the team would not recognize Mary.

Janet: She looks 10, no, 15 years younger. Her skin is smooth. She has a new hairdo with gentle curls around her face. She had really let herself go, but now she is dressing beautifully. She used to dress OK but it was always polyester! [The clinical research team decided this could possibly be a new outcome criterion: raw silk versus polyester!] She feels good about us. She takes much less medication and is willing to go to the doctor when she needs to.

Therapist: So her heart is healing. And the two hearts?

Janet: We're easy with each other. We didn't do the burial you suggested. There are no bad feelings. My mother says she can't imagine any bad feelings. It was so good to hear, the last time we were here, that she will trust what I'm doing and that I know what I'm doing and that it won't cause problems for us. That was a great thing for me to hear. It took a long time for me to hear it, I know. I never thought I would hear it!

Therapist: If your mother was here, what would she say she enjoys the most about your relationship these days?

Janet: The stress is not there.

Therapist: How would you define your relationship?

Janet: Easy.
Systemic Family Therapy

Systemic family assessments focus on family relationships, family development, alliances/coalitions, and the process of communication between family members. The three fundamental principles necessary to conducting a systemic interview are hypothesizing, circularity, and neutrality (Selvini-Palazzoli et al., 1980). All three of these principles are interrelated.

The assessment process is based on the formulation of hypotheses by the therapist about the family organizational patterns connected to the problem. The therapist first gleans information about a family from intake data, from previous experience with other clinical families, and from various theories and research regarding the presenting problem or the “type” of family and then generates one or two initial working hypotheses (Fleuridas, Nelson, & Rosenthal, 1986). Family development theories can be useful in pointing the therapist to “tasks” and attachments that may be taxing the presenting family. Throughout an interview, questions are asked in order to validate or invalidate alternative hypotheses. Based on the information gathered from the family, the therapist modifies or alters his or her hypotheses about the problem and about the family and continually moves to a more “useful” understanding of the family.

In our view, the hardest work that occurs in systemic therapy is in developing systemic hypotheses. Linear hypotheses are so much easier to generate, particularly judgmental linear hypotheses (e.g., a mother is too controlling of a father). Systemic hypotheses connect the behaviors of all family members in a meaningful manner (Tomm, 1984b). (For example, a father shows little initiative or concern regarding his future. The less concern he shows, the more concern his wife shows; eventually, she directs him in what to do. The more she directs him, the less he directs himself, and vice versa).

“Circularity” refers to the therapist’s ability to develop systemic hypotheses about the family based on the feedback obtained during questioning about relationships (Selvini-Palazzoli et al., 1980). circularity is based on Bateson’s (1979) idea that “information consists of differences that make a difference” (p. 99).

Differences between perceptions/objects/events ideas/etc. are regarded as the basic source of all information and consequent knowledge. On closer examination, one can see that such relationships are always reciprocal or circular. If she is shorter than he, then he is taller than she. If she is dominant, then he is submissive. If one member of the family is defined as being bad, then the others are being defined as being good. Even at a very simple level, a circular orientation allows implicit information to become more explicit and offers alternative points
of view. A linear orientation on the other hand is narrow and restrictive and tends to mask important data. (Tomm, 1981, p. 93)

Circular questioning involves the ability of the therapist to conduct the assessment on the basis of obtaining information about relationships (Selvini-Palazzoli et al., 1980). Linear questions tend to explore individual characteristics or events (e.g., How long have you had angina?), whereas circular questions tend to explore relationships or differences (e.g., Who in your family is the most confident that you can manage your heart problem?; Selvini-Palazzoli, et al., 1980; Tomm, 1981, 1985).

If the therapist wants to validate or invalidate the hypothesis that a family is having trouble launching the eldest daughter, a useful circular question, directed to other children in the family, could be, “What will be different in the family when Susan leaves home?” Interventive (reflexive) questions induce a family to reflect and therefore think and act in a new way (Tomm, 1987). Although many kinds of questions have the potential for inducing new cognition, affect, and behavior, all questions are not created equal! Using the preceding family situation, consider the following interventive developmental question, directed to the parents of Susan: “If you decided to convince Susan that she was ready to leave home, how would you go about it?”

“Neutrality,” the third principle of systemic assessments, refers to the ability of the therapist to respond without judgment or blame to problems, change, persons, and various descriptions of relationships. For example, if a family makes a connection between a developmental problem, such as a young adult’s reluctance to leave home, and their belief that it is due to the young adult’s having a chronic illness, the therapist would be as neutral as possible in his or her reactions to this description, but it does not mean that the therapist has to accept this connection. The assessment information obtained through circular questioning about the meaning and belief of developmental problems will greatly assist the therapist in intervening. However, it must be emphasized that it is necessary to intervene only if particular beliefs interfere with or block the problem-solving efforts.

Family Development through a Systemic Lens

In the systemic approach, families are viewed as self-regulating systems controlled by rules established over time through a process of trial and error (Selvini-Palazzoli et al., 1978). If the rules do not allow for a natural progression through various family life cycle stages or for an accidental shift (e.g., chronic illness, divorce), a family member may develop a symptom as a “solution” to helping the family progress along its evolutionary path (Hoffman, 1981; Tomm, 1984a). The symptom, or presenting problem, represents an interactional dilemma that is derived from particular family beliefs. In this model,
one of the therapist's goals is to offer the family an alternate "belief" or "reality" about the problem, which may then allow the family to discover its own solutions. More specifically, the therapist aims first at understanding the family's reality surrounding the problem and then at challenging this reality by introducing "new connections" between relationships, beliefs, and behaviors.

The family finds its own solutions once its ability to change has increased. This is accomplished following a change in the "reality" of, or in the beliefs about, the problem: new views of old problems. Ugazio (1985) emphasizes that the first phase of any systemic interview should focus on the family's interpersonal belief system and should explore family members' explanations, interpretations, and attributions of meaning and intentionality for their own and other members' behaviors. We concur with this focus and make it a routine pattern of our clinical practice to explore consciously and deliberately family members' beliefs about and meanings for the presenting problem (i.e., cause, course, cure, consequences).

Systemic therapists do not adhere to the belief that the past determines the present or the future. Rather, they find it more helpful, from a systems view, to believe that the past can illuminate the present and vice versa. The systemic lens enhances the therapist's ability to view the past in a variety of ways. In the case example we presented earlier, the intergenerational conflict between the elderly mother and her adult daughter was illuminated by the information about the intensity of their closeness in the past. This allowed for a more positive understanding of why they had "chosen" and applied their present solution (extreme emotional distance) to their past problem of extreme emotional closeness.

An understanding of developmental stages and transitions could generate an alternate useful hypothesis to illuminate the past emotional closeness and give another view of the problem. Most family life cycle stages are highlighted by the addition and/or departure of family members. The stage of families launching children is perhaps the most dramatic and traumatic in this respect. It is punctuated with numerous entries and exits of family members: the departure of young adult children, the addition of sons- or daughters-in-law, and the attrition by death of the grandparent generation. Families frequently find themselves involved in a series of adjustments and readjustments at this stage of development. How families cope with this particular stage is best understood if a three-generational view is taken (McCullough, 1980). For example, the amount of success parents encountered in dealing with autonomy and separation issues with their families of origin will, in turn, have a definite impact on their ability to deal successfully with these issues with their own grown children (McCullough, 1980). In the case example, the elderly mother had had great difficulty separating from her mother and had exhibited her autonomy by disagreeing with her mother's counsel that "suffering is part of being a wife" and thus divorced her husband and immigrated to Canada.
When a family encounters difficulty in accomplishing the task of parent-child separation, it is usually manifested in one of two ways (Wright, Hall, O'Connor, Perry, & Murphy, 1982). Wright et al. (1982) indicate that one common response is for parents and children to be so loyal to the nuclear family that they disregard their own individual development. In families characterized by a high degree of loyalty, it is often difficult for the young adult to individuate because individuation may be seen by the family as a form of rejection. Some young adults respond to this dilemma by remaining highly dependent on their parents for emotional and, sometimes, economic support, and they often provide companionship and nurturing for one or both parents. One could hypothesize that the adult daughter and the elderly mother in the case example responded to the threat of transition posed by the launching stage by being overly close for many years.

The second extreme response of families negotiating the launching stage is for parents and children to distance themselves emotionally from each other to such an extent that they appear to be totally disinterested in each other and totally consumed by self-interest. For example, young adults may declare their independence and cut ties completely with their family in an effort to individuate. When the women in the case example presented clinically at the FNU, they appeared to be exhibiting this type of extreme response. For example, they had not spoken to each other in 2 years. Their inability to accomplish the task of parent-child separation consequently thwarted reinvestment in each of their marriages. However, determining what direction their relationship would take was not the primary goal of the clinicians. Rather, the aim of the systemic therapy team was to create a context for change and to offer an alternate epistemology of the problem so that the family could discover their own solutions. Therapists must trust the solutions that families find and must recognize that the pace the family takes toward problem solving is often different from that which the therapist might establish (e.g., sometimes much slower, sometimes much faster). To induce the elderly mother-adult daughter system to find the direction and pace of its solutions, the therapists accepted each family member's perception of the problem (as highlighted in the split-opinion intervention) and also offered an alternate view, or "reality," of the problem. The aim of this systemic perturbation is to enhance the autonomy of the system.

The challenge for the therapist is not to become "married" to the alternate reality that is presented to the family or to think it more correct than the view a family holds. It is, at best, a more useful view, in the sense that the new reality frees up the problem-solving ability of the system. There are more realities than there are families, and these realities only need to be modified when they inhibit individual or family development.

An important difference between this model and other family therapy models is that the systemic approach utilizes a nonnormative model of family functioning while recognizing that there clearly exist various developmental
transitions and stages. (It is intriguing to us that an understanding of a normative model enhances the learning of a nonnormative model). However, systemic therapists work against the impulse to direct families as to how they should function or develop. The use of the split-opinion intervention in the case example is an excellent illustration of how to intervene not only with the family but also with the therapeutic team, to prevent the latter from pushing the family to change in a particular direction and/or at a particular pace. If families are influenced in a particular direction, that will, in turn, direct family development and/or family functioning.

**THE PROCESS OF CHANGE**

To facilitate change in a family system is the most challenging and exciting aspect of family therapy. The process of change is a fascinating phenomenon, and various ideas exist about how and what constitutes change in family systems. Liddle (1982) has suggested that one of the basic issues of all of us who engage in family therapy is the interviewer’s theory of change, “that is what mechanisms permit or force change to occur? Even more basic, what is the nature of change itself according to one’s own model.” (p. 248).

We concur with Bateson’s (1979) notion that systems of relationships appear to possess a tendency toward progressive change. However, there is a French proverb that states, “The more something changes, the more it remains the same.” This highlights the quandary frequently faced in working with families. Systemic therapists must learn to accept the challenge posed by the relationship between persistence (stability) and change. Watzlawick, Weakland, and Fisch (1974) suggest that persistence and change need to be considered together despite their opposing natures. They have offered a notion of change that is accepted by most systemic therapists, which is that there are two different types, or levels of change. One type they refer to is first-order change, or change that occurs within a given system, that is, in the elements or parts of the system, without changing the system itself. It is a change in quantity, not quality. First-order change involves using the same problem-solving strategies over and over again. If a solution to a problem is difficult to find, more old strategies are used, and they are usually applied more zealously.

Second-order change is change that alters the system itself. This type of change is thus a “change of change.” (It appears that the French proverb is applicable only to first-order change.) In second-order change, there are actual changes in the rules governing the system, and therefore the system is transformed structurally and/or communicationally. Second-order change always involves a discontinuity and tends to be sudden and radical; it represents a quantum leap in the system to a different level of functioning. Systemic therapy focuses on facilitating second-order change. Our case
example beautifully exemplified changes that were dramatic and rapid. A change occurred in the system itself, in addition to a change in the presenting problem.

In summary, we concur with Bateson (1979) that change is constantly evolving in families and that frequently we are unaware of change. This is the type of continuous or spontaneous change that occurs with everyday living and with progression through individual and family stages of development. These changes may or may not occur with professional input. We also believe that major transformations of an entire family system can be precipitated by major life events and/or interventions by family therapists. We view change as a systems/cybernetic phenomenon; that is, change within a family may occur within the cognitive, affective, or behavioral domains, but change in any one domain will have an impact on the other domains. However, we believe that the most profound and sustaining change will be that which occurs within the family's belief system (cognition).

**Concepts of Change**

There are certain concepts regarding change we have found particularly useful in our systemic clinical work with families. We will discuss the two most salient concepts here.

First, the ability to alter one's perception of a problem enhances the ability for change (Wright & Leahey, 1984). It is essential that both family members and family therapists alter their perceptions of a problem. If a therapist agrees with the way a family views a problem, then nothing new will be offered. How we, as therapists, perceive and conceptualize a particular problem determines how we will intervene.

When a therapist conceptualizes developmental problems from a systems/cybernetic perspective, his or her perceptions will be based on a completely different conception of "reality" as a result of these theoretical assumptions. Our clinical practice with families who present at the FNU with developmental problems is based on a systemic-cybernetic-communicational theoretical foundation. Interventions are based primarily on the systemic model (Selvini-Palazzoli et al., 1980; Tomm, 1984a, 1984b). These are some of our efforts to think systemically. But what of families?

Individual family members construct their own realities of a situation based on personal beliefs and assumptions. Families and family members need assistance in moving from a linear perspective of the problem to a circular one. This is possible only if the therapist doesn't become caught in linear thinking when attempting to understand family dynamics.

We have found that one way to avoid becoming linear in conceptualizing developmental problems is to avoid thinking that the views of a particular family member or of all family members are "right" or correct." The challenging position of the therapist is to offer an alternate perception, reality, or
epistemology that will free the family to develop its own solutions to problems. 
This alternate reality is usually redefined as an interpersonal or relationship 
problem.

The second salient concept is that change does not occur as a result of 
therapeutic elaboration of a family's understanding of developmental problems. 
In our clinical experience, we have rarely found that changes or improvements 
regarding developmental issues occur by embellishing a family's view of the 
problem. Rather, we have observed that the solutions to problems change as the 
family's beliefs and interactional patterns change, whether or not this is accom-
ppanied by further insight. Systemic therapy avoids the search for lineal causes 
and seeks, instead, to provide systemic explanations of problems and impasses.

ROADBLOCKS TO FAMILY DEVELOPMENTAL CHANGE

Family therapists, regardless of theoretical orientation, have noticed that many 
families have not progressed smoothly or automatically from one life cycle 
stage to another. Their clinical interventions focus on the stressful transition 
points between stages. Certainly, in our own clinical work, we have sometimes 
succumbed to the temptation to focus on particular transition points that have 
become problematic. The potential trap is for systemic therapists to become too 
purposive, that is, to become too invested in a particular outcome and to 
then direct the family to function or be restructured in a particular way. 
Systemic therapists try not to "get in the way" of family development by not 
being directly directive. Thus the notion that families must progress smoothly 
through the family life cycle stages must be confronted. Smooth progression, 
in our estimation, is not characteristic of a developing family.

However, there are occasions when families have "derailments from the 
family life cycle" (Carter & McGoldrick, 1980, p. 9). This notion of derailments 
is useful, because it conjures up a much more optimistic view of family life 
cycle difficulties. One of the most common derailments that we encounter in 
our practice is the derailment by illness. The impact on the family of a chronic 
or life-threatening illness does not automatically result in a derailment, but 
it almost always interferes with roles, rules, and rituals. From a systemic 
perspective, a derailment also frequently occurs when family members are 
attempting to obtain meaning and clarification in a relationship. The greater 
the ambiguity regarding relationships, particularly at various developmental 
junctions throughout the family life cycle, the greater the chance for family 
and individual symptoms. In the earlier case example, both illness and an 
attempt to obtain clarification and meaning in the elderly mother-adult 
daughter relationship had manifested in a family life cycle derailment. A former 
family life cycle derailment, or nonnegotiation, and an attempt to obtain 
clarification and new meaning in the elderly mother-adult daughter relationship 
was associated with the presentation of angina in the mother.
With any derailment, it should not necessarily be the therapist's goal to have the family return to the original "track." Rather, it behooves the therapist to create a context for change for the family, to allow them to decide which track will provide the greatest opportunity for reduced stress and increased growth.

**INTERVENTIONS THAT CREATE A CONTEXT FOR DEVELOPMENTAL CHANGE**

There are numerous interventions that can be utilized to facilitate or create a context for change. However, we will discuss only **systemic** interventions that create a context for developmental change.

**Offering Alternate Realities**

Systemic family therapists frequently offer beliefs, opinions, or conceptions about problems without regarding them as interventions. However, when strategically thought out and planned, these various types of opinions serve as potent and useful interventions, offering an alternate reality to those experiencing particular problems.

1. **Information and advice.** Families find advice and information about developmental problems valuable and beneficial. Frequently, information about developmental issues (e.g., elderly parents' needs for "spatial but not social isolation" and for "autonomy with contact"; Banziger, 1979) can liberate a family so that the members are then able to resolve their own problems.

2. **Systemic opinion (reframing).** Presenting symptoms may serve a positive function for a family. A systemic opinion is offered by conceptualizing the presenting symptom as a solution to some other hypothetical or implied problem that would or could occur should the symptom not be present (Tomm, 1984b). In the case example, the intense intergenerational conflict was positively connoted as a distance regulator in an overly close parent-child relationship. The symptomatic behavior is systemically reframed by connecting it to other behaviors in the system. The connections are based on the information derived in the assessment through the process of circular questioning. It is essential, when offering a systemic opinion to a family, that the recursiveness of the symptom be delineated: The symptom serves a positive function for the system while at the same time the system serves a function by contributing and maintaining the symptom (Wright & Leahey, 1987).

3. **Redefinition of the context of therapy.** A powerful opinion can be given by redefining the context in which family therapy is provided. If a family objects to attending sessions for what they have defined as family therapy, then, based on the assessment, the family could be told that family therapy sessions will be discontinued and that developmental sessions will begin (Wright & Watson, 1982). It is not that the nature of the work between the
therapist and family changes but rather that the context, or “name,” of the work is made more palatable. With the family described in the case example, the nature of our work was named research rather than therapy.

4. **Commendation for family and individual strengths.** Following a recent analysis, by three observers, of 28 sessions we conducted with four families in a hypertension project, one of the common themes identified was our routine practice of commending families on particular strengths at the end of interviews. Feedback from both research observers and families has made us cognizant that this practice involves more than just being courteous—it represents a significant intervention that can alter family members' realities of themselves.

5. **Split opinion.** We have found the split-opinion to be a most powerful systemic intervention. Normally, a split opinion offers the family two or more different and opposing views. Each point of view is equally valued and the family is left to struggle with the various views of reality. The split-opinion intervention in the case example was the single most powerful intervention delivered to the family. It enabled each woman to have her view of reality strongly supported while at the same time providing each with the opportunity to entertain a totally new epistemology with regard to the presenting problem. This intervention created a context for change that had previously been impossible because of the extreme rigidity of each family member’s beliefs.

**Prescribing Rituals**

In designing and prescribing a ritual, a therapist requires that a family engage in behaviors that have not been part of their usual patterns of interaction. The existence of confusion is normally an indicator for the use of the ritual intervention. The confusion is due to the simultaneous presentation of incompatible injunctions within the family. Rituals introduce more clarity into the family system. In systemic work, the actual execution of the ritual is not as important as the feedback about what new connections the family has made and, consequently, what new beliefs or realities the family now entertains. In the case example, two rituals were prescribed. The “meeting of the hearts” involved ritualizing a talking-listening session for the mother and daughter, who, for 2 years, had not spoken to each other. The “burial of the hurts so the hearts could heal” provided a forum for further purging. The mother and daughter did not execute this second ritual. The mother had stated to her daughter that there were no more bad feelings for her. In fact, she could not imagine any more bad feelings! Selvini-Palazzoli (1986) indicated that some families respond just to the idea of doing something unusual. Thus the enactment of the prescribed ritual may not be essential to induce a change in the family system. Useful information to the family and the therapist may be provided through just the description/prescription of a ritual.
CONCLUSION

Traditional life cycle theorists and therapists imply with their clearly demarcated stages, tasks, and attachments, "we know how your family should function." Systemic therapists use life cycle information to generate (1) working hypotheses about the connection between the symptom and the system and (2) questions to perturb the family system, so that the family can answer its own question, "What is the most useful way for our family to function at this time?"

REFERENCES


