# On getting unstuck: Some change-initiating tactics for getting the family moving

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The goal of the family therapist, whatever his theoretical orientation, is to promote change, and the initial problem he faces is finding a way to break into a rigid system. Interventions which deliver a shock to the system and throw it out of equilibrium, are an effective way to initiate change.

One of the most versatile tools for this type of intervention is the "therapeutic hunch." The therapist can set the stage by telling the family early in the first session that he often gets "hunches" – sometimes rather strange ones – about the family situation, and that when these funny flashes come, he'll offer them to the family for discussion and comment. If he assures them that he doesn't expect the hunches to be accurate all or even most of the time, and emphasizes that everyone is free to accept or qualify or reject them entirely, the family may make a mental note to check the yellow pages for a new therapist, but they'll probably accept the premise. The therapist can then cash in on the implicit agreement by using, when appropriate, any of several interventions he labels "a hunch."

The most obvious use of the hunch technique is to force the pace by taking flying leaps ahead in an attempt to eliminate pointless repetition of the destructive interaction pattern. For instance, if there is a chance that useless verbal scapegoating can be halted quickly by demonstrating that the scapegoat's

behavior is part of some sort of family agreement, the therapist can produce a shrewd guess about analogous behavior in other family members, call it a hunch and introduce it in the first session:

> One family whose I5-year-old daughter had run away several times was undergoing treatment to solve the problem. The family was defensive and verbally attacked the "problem" adolescent. Early in the first session I announced I had a hunch that everybody in the family had his own method of running away – implying a family consensus that the home situation was bad enough to justify running – and that the 15-year-old's method was just the most obvious one. The reaction was hostility and absolute denial. In the third session, however, Father came to the conclusion that each family member "sort of runs away from things": when pressures got too strong, he went for long walks; Mother stayed in her room and slept for hours; the younger child hid in the house and pretended not to hear them calling.

If the family had been able to hear and accept the suggestion in the first session, the session and a half that was devoted to endless repetition of the same sets of accusations could have been bypassed. However, the hunch is useful even if the family rejects it, as happened in this case: first, the therapist has let the victim of the scapegoating know that he's being heard (the 15-year-old spoke up after Father had announced his discovery and pointedly reminded the family that the therapist had made a similar suggestion in the first session); second, the idea has been planted and is likely to reappear fairly soon, often offered by a family member who has no memory of it having been mentioned before.

As a tool, the hunch is less valuable for its accuracy than for its startling effect. Often the therapist can use it as a kind of "land mine" to break up the pattern in which a family is locked. He explodes the "hunch" in their faces, deliberately, exploiting the surprise factor and thus introducing a kind of random element, the value of which, according to Carl

Whitaker, is that it "can give the whole process a new twist. Whatever comes of it will be unforeseen and unexpected." (Haley, J., & Hoffman, L., *Techniques of Family Therapy*. New York: Basic Books, 1967, p. 270):

During their first and second sessions, a family talked about the fact that they had developed labels (sometimes used as nicknames) for each other. Mother, divorced for several years, was nervous and brooded over things; her label was "hypersensitive." The 13-year-old, who had a lot of energy, was busy and impatient, and labeled "hyperactive." The nine-year-old whined and complained, and so was labeled "hypochondriac." The three lived in a "hypermad" house – that is, a house that was active, busy and noisy. While they were describing and justifying their labels, I announced the arrival of a "hunch" and asked them to cooperate for a few minutes in a "silly" enterprise. With sheets torn from a memo pad I made I.D. tags for each of them: "I'm a hypersensitive – Love me," "I'm hyperactive – Love me," "I'm a hypochondriac – Love me"; and one for myself: "I'm me - Love me." Each of us then revealed his tag to the others. There was a short silence. Afterwards, each of the three admitted feeling very tied to the family and blocked in attempts to move outside the rigid pattern of expectations and labels. They agreed to drop the restrictive labels and make an effort to get off each other's backs. Therapy moved rapidly from this point, and at termination (fifth session) all three family members were operating more independently, the children's resistance to Mother's having male friends had diminished, and Mother no longer insisted on her dates being family affairs.

In this case the oddity of the behavior (therapist chortling in his beard as he pins signs on people) and the blatant theatrical quality of the situation were more useful than the "insight" offered. He had tossed a surprise into a system that rigidly excluded surprises; it obliged everyone to make a decision as to how to react, and how to react to the others' reactions. The-hunch-as-bombshell is valuable precisely for its equilibrium-destroying effect – the element of randomness

it introduces into the frozen stability of the dysfunctional family interaction pattern.

In general the hunch tactic seems to work best if its directness is tempered with humor. Labeling the interventions as "hunches" removes a little of the threat, and humorous presentation or cheerful admission that "I get these strange ideas sometimes" further reduces it.

Another tactic that is surprisingly useful is the *strength assessment task*, or the "good list." The therapist asks the family to list what they see as strengths and good qualities in each of the family members, including themselves, and in the family as a unit, and then to share this list during the next session. This is another way of putting a quick stop to the fruitless scapegoating of the "problem child" or "problem spouse." It is difficult to constantly belittle an individual when you have publicly read a list of his good qualities and the tape recorder is sitting strategically on the corner of the desk. All the therapist has to do is punch the playback button to create a perspective for the put-downs and accusations.

Often parents are honestly amazed to discover that the incorrigible kid or the hopeless adolescent looks definitely tolerable when they stop concentrating on the point of conflict and take a look at the whole picture. And as "good lists" are read, each family member is (perhaps for the first time in years) actually listening to and *hearing* everyone else. Children express surprise that parents are even aware of qualities and talents and noble efforts the kids had assumed went unnoticed because they were not expressed. Parents are startled at the shrewdness and maturity reflected in their children's assessments of them. In the course of one short session, each family member is forced to reconsider the way he sees each of the others, and they in turn, listening to him reel off a list of their charms and talents, are forced to revise their estimate of the-way-he-sees-me, which in turn calls for yet another rethinking of the-way-I-see-him. The general pool of good-will rises a fraction with each convolution, and by the end of the session the family has begun a substantial change of outlook. Therapeutic movement is underway.

Paradoxical intervention, which has the key virtue of permitting the therapist to focus his intervention with some precision, is another very versatile technique. Particularly useful is a kind of cross between paradoxical intervention and role-playing that might be called an "experiment." Once he has a basic idea of the part a symptom plays in the family interaction, the therapist may ask everyone to participate in an "experiment," and they will usually agree.

A family came in about their 14-year-old boy's stealing. They felt that it had become quite serious and that something had to be done quickly. After finding out that he stole from his father to buy things his friends had and that he also stole from his peers, I asked the family to take part in this experiment. The boy insisted that he wanted to stop stealing and agreed to write out and sign a statement to that effect. Later, at home, father and son were to hide five $1.00 bills around the house. I asked the boy to resist "stealing" this money for one week. If he resisted, he was to come in for the next session alone; if he stole, then the whole family was to come in. They all agreed to this.

At this point my knowledge of the situation was fairly general. I knew the family was well off financially, that the boy had adequate allowance and opportunity to earn any additional money he might need. Operating for the moment on the assumption that this was the typical case of an immature adolescent stealing money when what he wanted was validation, I began intervention immediately, despite limited particular knowledge.

I structured the initial phase of the "experiment" as described above for two reasons. First, I felt that the boy wanted to see me alone and was almost certain that his desire to talk things over without Mother and Father present (and to assert his individuality by having a whole session by himself) would override any temptation to steal the planted money. I took advantage of this to set the scene for quick reinforcement, and to give him an opportunity for individual attention and recognition. In addition, I wanted a chance to structure the second phase of the "experiment" – stealing to stop

stealing – without getting into the moral hassle I expected from the conservative parents.

The following week the boy came in alone. He had indeed resisted. For step two of the "experiment," I asked him to go through his usual behavior-before-stealing, then steal two of the $1.00 bills, and finally, go through his usual behavior after-stealing – except that he couldn't spend the money. He agreed and asked if "usual behavior" included feeling very guilty and then breaking down at the evening meal and confessing his theft. I asked if he could delay the confession until the next family session instead, and he agreed. He followed the instructions and went through the whole set of behaviors that he'd described, admitting later that it had felt "real." During the next session he broke down and confessed his theft, sobbing and shamed, creating exactly the sort of dramatic, attention engaging scene that usually took place at the family dinner table after a theft. The re-enactment-with-a-difference (Father's open complicity, the big confession scene coming in the therapist's office instead of at the family table) triggered instant realization on Father's part. Watching the other family members concentrating all their attention on the 14-year-old penitent, Father blurted, "It's the only time we ever listen to him." By the end of the sixth session Father and son had done some serious person-to-person talking, and Mother was begining to realize that her mental picture of the boy was several years out of date, that thus far she had been refusing to recognise the growing up process. The family was starting to make a serious effort to meet the real needs of one of its individual members.

Paradoxical intervention works equally well in combination with the "hunch." The strangeness of a paradoxical prescription, when coupled with the pace-forcing and disorienting effects of a really flamboyant hunch, can send even the most rigid of destructive family systems reeling. Clients are inclined to shoot suspicious glances at the therapist's framed diploma and mutter sotto voce conjectures as to the probability of its having been obtained in exchange for a

couple of Wheaties' box tops, but they will almost certainly be intrigued:

A couple came in complaining specifically about a sexual problem: the wife didn't enjoy sex, although she was able to reach orgasm manually. She would not allow her husband to finish coitus, and had not for three years. During the first session she referred several times to the many ways she had of deliberately "buying" him, including her control of what little sex involvement there was. She described herself as buying his loyalty by cooking for him and keeping the kids out of his way; her faithfulness purchased his permission for her to be very lazy; she used her depressions to buy his toleration of her sexual disinterest and inadequacy. After discovering that she controlled the money as well, I asked them if they were willing to try something strange. They agreed. I asked if they could manage to have some sexual involvement at least three times in the next week. They said yes. I then warned the woman I had a hunch she might, as a result of this participation, find herself enjoying sex one of these days, and if so, she might be more comfortable if she continued to verbally deny any pleasure, at least until she was more accustomed to enjoying sex. (Now when she said she wasn't enjoying sex, her husband couldn't know for sure, and there was an off-chance they might relax and enjoy each other. But more important, the peculiar nature of the prescription thoroughly confused them and threw them off balance.) I then suggested to the wife that if she was going to continue to buy her husband through sex, she ought to make it worth his while – for instance, pay him at least $5.00 for each sexual episode during the next week. Befuddled, but curious, she agreed.

In the second session, both said that they had had a good time playing with my "crazy idea," but that sex was no better than usual. I gravely assured them that it would take at least two or three weeks to undo the effect of many years. They accepted that.

The third session brought to light the fact that the wife had been pregnant when they were married. Since then she had

tormented herself wondering if he would have married her had she not been pregnant. She felt she couldn't be sure. I told her I had a hunch: wasn't it true that she wouldn't let herself enjoy sex because in the face of her uncertainty about her husband's feelings, she didn't dare admit to herself how much she loved him? Both husband and wife looked as if they had been slugged solidly in the jaw. Neither had any idea how to respond to that.

At the end of the fourth session the woman admitted to me that she had enjoyed sex "a little, once" during the previous week. During the fifth session she said that she had enjoyed their sexual contact over the weekend, and he added that for the first time in three years they had completed intercourse. We agreed to terminate, at least temporarily.

The interventions used in this case were designed to shake each person's conception of the other, and of what was going on between them. As a result of the destruction of old assumptions, the wife was able to cut through years of mixed feelings about herself, her husband and the marriage, and to solve at least one immediate problem: her inability to enjoy intercourse with her husband. At temporary termination, the entire relationship was in the process of opening up for rethinking, re-evaluation and some kind of reconstruction.

The techniques described here are particularly useful as a means of focusing on the immediate source of complaint, and of structuring change-initiating interventions. In addition, designing "far-out" interventions is a challenge to the ingenuity and creativity of the therapist: a rewarding activity when the maneuver works as planned.

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