# Strategic family therapy: Three case histories

Methods developed by family therapists in the last 30 years allow the family physician to deal directly and rapidly with a range of psychological problems that previously required prolonged specialised psychotherapy.

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## The strange case of Carl's dizzy head

A mother rang for an urgent appointment for her 19-year-old son Carl. She was asked to come herself with Carl and her husband.

Carl was constantly dizzy and giddy, so much so that he had to leave work early most days. He spent most of the weekends in bed and complained that his head felt funny when he got up. His GP and a consultant physician had found nothing wrong.

Mother was very worried. She had heard that leukaemia could begin like this. She had tried to get Carl to eat more and to stay indoors on cold days to build up his strength, but to no avail. Carl had left home six months ago to share a house with friends, but returned to his parents' home after three months feeling run down and lacking energy. He went downhill from then on.

Father had tried everything he knew to help. He took several days off work to stay with Carl at his own place of work hoping that Carl would gain the strength and confidence to keep going. But this had failed.

The family together seemed very close and loving. They were courteous and respectful to each other. Mother addressed a string of anxious questions to Carl about his symptoms which Carl answered at length, but in a very vague and repetitive way. They all said there were no other problems in the family and stated they had few serious disagreements.

The therapist asked several times what they had tried in order to resolve the problem. The parents had only tried being helpful and sympathetic. Mother had thoughts about being stern with Carl and insisting that he get out of bed and act like a healthy 19-year-old. But she hesitated, thinking her husband would oppose her.

They were asked if they would agree to try something new. They said they were desperate and would do whatever they were asked.

Carl was told that his main problem now was that he was disgustingly unfit, as anyone would be who spent much of the day in bed. His homework was to run two miles a day for the next week. He was also asked to pretend on at least two occasions in the week that he was having a serious attack of dizziness. His parents were asked to take his complaints of dizziness very seriously and to show great sympathy and concern. But they were not to ask (and he was not to tell) whether his complaints were genuine or pretended.

They all were rather bewildered and amused by these instructions, but agreed to abide by them. As they left the room Carl said he might need an ambulance after he tried to run two miles. He was told that if he did, the therapist would pay for it.

They returned a week later. Carl was beaming and his parents were more relaxed. Carl had run two miles each day. He nearly collapsed the first day; his mother had put him to bed and thought of calling the doctor, but father persuaded her to wait. On several occasions Carl had arranged a very dramatic attack of dizziness for his parents' benefit. They had all been in fits of laughter about this, but



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● Strategic family therapy does not look for the problem inside people, but in the here-and-now goings on between people.

had kept strictly to the agreement not to discuss whether the attack was real or pretended. Carl was told that he was still unfit and needed now to run three miles per day. Several follow-up interviews at increasing intervals showed that Carl's symptoms had completely disappeared. He had returned to work full-time and had a steady girlfriend.

## The principles of family therapy

The approach adopted in this case may at first appear absurd. But the family therapist here is following some principles basic to his craft.

In the first place, to see the family as a whole is a very significant move. It is so often the case that a person seen alone presents a problem that defies comprehension. But seen in social context with his family, the problem makes sense.

Furthermore, the focus on what keeps the problem going is characteristic of family therapy. We are none the wiser at the end about why Carl was dizzy in the first place. But we do know that the anxious and sympathetic concern of his parents was feeding his anxiety about his health. We also know that Carl's incessant complaints about his symptoms were feeding his parent's anxiety. This feedback loop was sabotaged by the task of pretending to be ill. *It is typical of family therapy that attention is on how the problem keeps going, not on why it started in the first place.* As one noted family therapist says "In real life — understanding is the booby prize".

Carl's problem existed in a family environment characterized by a loving, but over-protected relationship with one and perhaps both parents. Salvador Minuchin and his colleagues regard this pattern as typical of families in which psychosomatic illness occurs. The outstanding results described in their recent book[3] encourages the family therapist to approach such problems with considerable optimism.

The homework task for the family was designed to disengage the over-involved parents from Carl. This was necessary because the symptom itself seems to compel the parents to be over-solicitous. This problem will be familiar to anyone who has worked with a family that includes a child with severe asthma.

Another feature of this therapy is the relabelling of the problem. The family comes with a label of 'serious undiagnosed illness such as leukemia'. This is a label that does not allow any useful action except perhaps by experts in haematology. A substitute label of 'disgustingly unfit' was offered. This allows and even demands action on the part of the patient himself — namely, strenuous exercise. When he discovers that he can, in fact, run two miles without serious ill effects, his anxiety starts to subside. But even more important is the influence of this label on the interpersonal context. It demands a new line of behaviour from the rest of the family. It is so often the case that people will seek help for problems that they have themselves labelled in a way that makes them insoluable. If the problem is 'bad genes' inherited from grandfather or 'madness' like that of Uncle Harry, then it cannot be solved. But if the problem is labelled as 'defiance' or a 'clumsy attempt to prove she is grown-up' then it follows that if someone in the family behaves differently, the problem may change or even disappear.

**THE THERAPY IN OUTLINE**

- See the whole family
- Ask how each person sees the problem
- Summarize and ask if they agree
- Ask what solutions have been tried
- Identify the behaviour maintaining the problem
- Relabel the problem
- Prescribe new behaviour
- Review the effects of this prescription

## Puerperal psychosis or interfering mother-in-law?

Three weeks after she gave birth to her first child, a 23-year-old woman named Maria was readmitted to hospital. Her first efforts at breast feeding were a dismal failure and she became very upset. Her husband took her to stay with his mother after discharge from hospital so she would have help. When she became flustered and tearful, her mother-in-law took over the caring for the baby with her customary calm and efficiency. Maria made several attempts to resume responsibility, but was tense and lacking confidence. Her baby slept poorly and screamed for hours. Finally, Maria was reduced to despair and said that she hated the baby and never wanted to see him again. There was talk of 'puerperal psychosis', and readmission to hospital was arranged.

The therapist first saw Maria and her husband together at the hospital. She was angry and tearful, making rather disorganized criticisms of her husband and mother-in-law. She accused him of not supporting her and of thinking more of his mother than his wife. He offered half-hearted reassurances and she demanded proof. She wanted him to take her home to their own flat with the baby and to exclude his mother. He balked at this, and she railled at him in tearful and impotent fury. She accused her mother-in-law of being critical and interfering, and of destroying her marriage.

The therapist asked to see the mother-in-law and her husband. After exploring their views of the problem, he asked

for help from mother-in-law. He told her that obviously she was the only person available who knew from experience how to be a mother. He complimented her on her efficiency in caring so well for the baby under such difficult circumstances. He said that though she might shudder at the prospect of several years of dirty nappies and disturbed nights, she obviously was capable of handling the situation. But he also said that equally obviously the better solution was for the baby's own inexperienced and flustered mother to regain her poise and confidence, and take over. He pointed out that mother-in-law was better placed than anyone, including the therapist, to know what struggles a young mother had and how best to get on top of them. He asked if she could devise a plan, with her husband's help, for coaching Maria in how to handle the baby.

After several hours of discussion with her husband, she phoned and suggested that Maria be discharged from hospital and return to her own flat with husband and baby. Mother-in-law would move into the spare room for a few days and begin her coaching.

Maria was mollified by this plan and keen to try it. The mother-in-law took a back seat, leaving all the hands-on care of the baby to Maria. She helped out by washing nappies and preparing meals. She complimented Maria wherever possible and avoided criticism (with difficulty). After several days she began to absent herself from the house, and finally moved out leaving the mother much more relaxed and confident. The therapist rang to thank her for her help and commended her for her skill as a coach.

### Some further principles of family therapy

In this case, the two labels offered by the family for the problem were 'puerperal psychosis' and 'interfering mother-in-law'. Both contain elements of truth, but neither is very useful. The therapist offers an alternative of 'inexperienced and flustered mother in need of coaching'. This sidesteps the risk of confrontation with an obviously powerful mother-in-law accustomed to getting her own way, and it also helps this women to direct her considerable energies in a more constructive direction.

Another feature of the family therapy approach is that the therapist works with the problem presented to him by the family. There may be other problems present. It is true that Maria's husband had not worked out whether his allegiance was primarily with his wife or his mother. It is true that his mother was a rather critical and controlling woman. It is true that Maria disintegrated rather alarmingly under pressure, and looked crazy at times. *But the problem as presented was how best to care for the baby and this was the sole focus of the therapy.*

It is this here and now, problem centred, active and prescriptive emphasis that makes family therapy such an ideal tool for the general practitioner. The apparently serious disorder afflicting Maria and Carl was resolved within a week.

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● Strategic family therapy is like Ju-jitsu. The therapist aims to mobilize the energies and resources of the family on his side, rather than have them deployed against him.

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Not all family therapy is so rapidly effective. But family therapists tend to start with the assumption that problems can be solved quickly. This is in stark contrast to the assumption held in some circles that rapid improvement is a sign of 'flight into health', and therefore a bad thing. Sometimes a problem is complex or deeply entrenched, so that a series of prescriptions may be needed before change occurs. But it is better to expect rapid results and be proved wrong at times than to expect very slow results and be proved right every time. The final case history is an abbreviated account of work with a more complex family problem.

**THE THERAPEUTIC POSTURE IN STRATEGIC FAMILY THERAPY**

- See the whole family
- Stay in the here-and-now
- Deal only with the problem presented
- Look at *how* not *why* the problem exists
- Study what goes on *between* people not *inside* people
- Be active, controlling, prescriptive
- Experiment with humorous or absurd interventions
- Expect rapid results

### A family with many problems

A 10-year-old boy, Andrew, was referred for help by his school psychologist. He was refusing to go to school and had threatened to throw himself under a truck if he was forced to go.

The household consisted of Andrew, his 16-year-old sister, his parents and mother's brother. The first interview was with Andrew and his parents. His mother described the problem as being that Andrew was withdrawn, timid and anxious. She offered extensive details about his early life and the difficulties she had with him as a baby. She saw Andrew's problems as deep-seated and resulting from many traumas over a number of years.

Andrew said the problem was that he was very worried about his mother, and frightened that she would die. He would not let her go away from him, even for a weekend holiday, for fear she would not come back.

Mother described herself as a person who had been anxious and frightened all her life. She had taken 'nerve pills'

for years, with little benefit. Father was silent for much of the interview. He worked at night, and stayed out of the house as much as possible because he regarded life at home as chaotic. He volunteered that he drank heavily and that he left mother to cope with Andrew. Mother's brother was described as a hopeless alcoholic who came home at all hours of the day and night, intoxicated and abusive. He would sit at the kitchen table and demand to be fed, and his sister would usually provide food even if it was 1 o'clock in the morning. There were a number of other frequent visitors to the house, who treated the place as a home away from home and consumed large amounts of food and drink at the family's expense.

The first session was spent exploring these problems. The only significant intervention was to highlight the idea that Andrew stayed away from school as an act of loyalty and concern for mother. This labels his behaviour in positive terms and also in interpersonal terms. The problem is not located inside Andrew, but in the relationships between people in the family.

At the second session, the 16-year-old daughter was present at the therapist's insistence. She was an apprentice hairdresser. But four years earlier she had serious difficulties getting herself to school, which she had completely overcome. Her current success in life was explored in detail. It emerged that she had made no less than 90 telephone calls before succeeding in getting her apprenticeship. Her resourcefulness and determination were underlined, and her parents were congratulated on how successful they were in raising such a resourceful young woman. She was asked to spend time at home telling Andrew in detail how she had got over her school problems. The first five sessions occurred during school vacation, so Andrew's attendance at school was not necessary at this stage.

In the third session the focus was on how father, who had previously been largely uninvolved, could help Andrew to prepare for school. Andrew was frightened of bullying from children at school, and father who was experienced in these things was asked to help him to learn some of the skills of self defence.

The session just before school resumed was spent exploring Andrew's fears about going to school. It emerged that there were several bullies at school who made life very difficult for some of the smaller children. One villain in particular stood out. Father was asked to go to this boy's house and speak directly to the boy about his violence towards Robert. Father followed through with this and when he got to the boy's house, only the boy's mother was at home. This mother was surprised at the criticism of her son, saying that she regarded her son as a cry baby. Andrew was astounded at this news. Father informed the woman that if her son gave Andrew any more trouble then he would have to answer to Andrew's father for it. Following these moves, Andrew was able to attend school without too much difficulty.

On a number of occasions during the work with this family, the problem of mother's brother and the uninvited visitors to the house was explored. Mother had great difficulty setting any reasonable limits with other people, because she was frightened they would reject her. After long discussion it was arranged that father would act as gatekeeper, by courteously asking visitors to leave when it was inconvenient for them to be in the house. At no stage were any direct plans made about how to deal with mother's brother.

After a total of seven sessions over a three-month period, Andrew was attending school regularly. Father was drinking much less, spending more time at home and was more actively involved in looking after Andrew. Mother's brother was drinking less and was no longer demanding to be fed at all times of the day or night. But the most impressive change was in mother. She had become confident and assertive, and was much more relaxed and cheerful. These changes were still present at a follow-up interview three months later.

Again in this case the focus is on the here-and-now interactions in the family. Mother was very interested in the past and its influence on Andrew. But this was put aside, as is characteristic of family therapy.

## Family therapy training

Family therapists prefer to work as much as possible on the directly observed interaction between people actually present in the room. This avoids the enormous distortion introduced by secondhand reporting of events that occurred in the past, even the recent past.

This same preference is carried over into approaches to training in family therapy[5]. It has been one of the great contributions of the family therapy movement to make the process of therapy public. This occurs in several ways.

Firstly, most training centres have a library of video tapes, so the trainee can see first hand many of the world's leading family therapists as well as local practitioners (leading or otherwise) directly at work. Secondly, the trainee is encouraged to seek supervision in a group with his peers and to bring along to the supervisor videotapes of his work. In recent years supervisors have moved a step further, and introduced direct and live supervision. The trainee is observed at work with a family from behind a one-way screen. The supervisor phones him to suggest how to proceed or to ask him to come out for more detailed discussion. In these ways much of the mystery and mystification involved with certain other forms of psychotherapy is avoided.

**Summary:** Strategic family therapy is a focused problem solving approach that is compatible with the traditional orientation of general practice. Three case histories are presented which outline the use of this approach in a diversity of apparently serious problems. The therapist deals directly with the problem

presented without detailed exploration of the past. He utilizes the strength and resourcefulness available in the family to bring about rapid resolution of the problem.

## Acknowledgements

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## References

1. Haley, J. *Problem Solving Therapy.* New York, Harper & Row, 1976.
2. Minuchin, S. *Families & Family Therapy.* Cambridge, Mass, Harvard University Press, 1974.
3. Minuchin, S., Rosman, B. L. and Baker, L. *Psychomatic Families.* Cambridge, Mass, Harvard Univers Press, 1978.
4. Napier A. Y. and Whitaker C. A. *The Family Crucible.* New York, Harper & Row, 1978.
5. Stagoll, B., Lang, M. and Goding, G. A. Training the family therapist: a model for family therapy training. *Aust. J. Fam. Ther.* 1979; **1:** 35:42.

(The first two references are the best available introductions to family therapy. 'The Family Crucible' is a fascinating account of several months' work with a family in USA). ■