The Clinical Exchange: The Girl Who Cried Every Day for 3 Years

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The Clinical Exchange invites eminent clinicians of diverse persuasions to share, in ordinary language, their clinical formulations and treatment plans of the same psychotherapy patient— one not selected or nominated by those therapists—and then to discuss points of convergence and contention in their recommendations. This special Exchange focuses on family systems psychotherapy in the case of a family presenting with the identified patient being a 5-year-old who had cried every day for 3 years since the death of her father. Therapists Catherine Fuchs and Pam Fishel-Ingram (psychodynamic orientation with some integration of cognitive–behavioral therapy concepts), George S. Greenberg (brief systemic family therapy with a strategic therapy focus), Patricia Morse (Milan school of family systems therapy), and Scott Griffies (psychoanalytic object relations) are the featured commentators. Finally, Martin Drell, the case contributor, provides a few closing comments.

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Within the context of psychotherapy integration, the Clinical Exchange was designed to foster open inquiry and transtheoretical dialogue in terms of actual psychotherapy cases. Specifically, the purpose is for eminent clinicians of diverse persuasions to share, in ordinary language, their clinical formulations and treatment plans of the same psychotherapy patient—one not selected or nominated by those therapists—and then to discuss points of convergence and contention in their recommendations. Specific examples of published exchanges may be found in *Therapy Wars* (Saltzman & Norcross, 1990) and in previous issues of the *Journal of Psychotherapy Integration* (Allen, 2005; Allen et al., 2006).

In this edition of the Exchange, we look at issues involved with the family systems therapy of families with children. We are pleased to have as case presenter and commentators individuals who are all directly involved with the clinical education of psychiatrists in training. They are faculty in child and adolescent psychiatry residency programs: Catherine Fuchs and Pam Fishel-Ingram (psychodynamic orientation with some integration of cognitive–behavioral therapy concepts), George S. Greenberg (brief systemic family therapy with a strategic therapy focus), Patricia Morse (Milan school of family systems therapy), and Scott Griffies (psychoanalytic object relations). Commentators were asked to discuss what transpired in the case from their own theoretical perspective, as well as to discuss any clinical, conceptual, or training issues that the vignette raises for them. After their case commentaries, these clinicians briefly discuss points of convergence and contention with each other. Finally and appropriately, Martin Drell, the case contributor, provides a few closing comments as a postscript.

THE GIRL WHO CRIED EVERY DAY FOR 3 YEARS

Martin Drell

Matt, a father of an ex-patient called to say that I should expect a call from his new girlfriend about her daughter who needed help. While I was talking to him, his girlfriend called and left a message for me to call her. I returned her call.

"Matt suggested I call you about Cathy, my 5-year-old, who seems depressed since her father died 3 years ago. She's cried every day since. We went to a social worker who saw her for a while, but it didn't seem to be

helping so we stopped. Cathy had temper tantrums when she was 4 and used to wet the bed, but that stopped." In response to her rapid list of problems, I asked, "What do you see as the main problem?"

"The crying. If we could deal with that, I'd be happy."

"How's she doing in school?" I asked.

"She does okay in kindergarten. She doesn't cry at school usually. Occasionally she cries when she's about to get on the bus for a school trip. She does well in school. She's way advanced for her age."

"The bus thing sounds like separation problems. Does Cathy have that?" I responded.

"Yes," the Mom replied. "After her father died, both kids slept with me. Oh yeah, Cathy has a brother, Allan, who is 7 years old. Allan got over it quickly, but Cathy still wants to sleep with me every night."

Having received a snapshot of the problem, I suggested that the Mom come in for the first session to tell me the story of what was going on in more detail. In preparation for this session, I went over the information I had up to that point and decided to focus on the crying as a family problem. My guess was that the family was stuck for some reason. The fact that Cathy was doing so well in school reinforced this idea. As the first session began, I noted that, Janet, the mother, had sad eyes. After brief introductions, I asked her whether she cried.

She responded that she doesn't cry in front of the kids and burst out in tears. "My husband had cancer. I didn't cry in front of him either. I cried in the juice room at the hospital."

I smiled uncomfortably at the Mom's quick show of emotion. "There appears to be more than one girl crying every day . . . . How's Allan doing?"

"He doesn't cry. He is 'the man of the house.' Cathy was only 2 years old when her dad died. I thought she was too young to be upset."

"But she cried every day?"

"Yes. She cried 'I want my Daddy' every day. She was with him every day. He was the kid's primary caretaker as he worked nights. I worked days in a personnel department. Cathy's such a strong force. She tries to control everything. It's overwhelming. I try to keep on top of her, but I often give in. She's manipulative."

"For what is she manipulative?" I asked.

"For attention. She's smart and she gets it. She's horrible. She's jealous anytime I'm with Allen."

"And when Matt is with you?"

"She doesn't like that either, but she likes Matt. They have a great time together."

"I have a theory that this is a family problem. Cathy cries every day. Allan doesn't. And you cry every day, but not in front of the kids. There

seems to be some rules about crying that has the family stuck. What were the rules about crying in your house while you were growing up?"

"Oh, my Mom wouldn't tolerate it. She'd say, 'Stop crying. Stop feeling sorry for yourself.' I've been through years of therapy. It's not that. My parents weren't so bad. It was more like benign neglect. I raised myself from age 14 on. I can't cry in front of my parents. I don't know why."

"A logical reason might be that they appeared to have told you not to cry in front of them," I remarked. "Have you ever cried in front of your kids?"

"Yes, once when we had to put the dog to sleep. I usually don't cry in front of them. I occasionally cry in front of Allan when he gets me angry and I feel overwhelmed and hopeless."

"How do you feel about Allan not crying?"

"I'm more upset about him."

"But you came in because of Cathy?" I gently interjected.

"The kids have kind of forgotten their father."

"That would be another loss. First their father dies, then their memory of him."

"Allan has an unbelievable memory. I wish I could cry in front of them. My mother never cried. My parents divorced when I was 10 years old. My dad cries all the time. He's an alcoholic. He was the cause of problems in my family while I was growing up. He's a loving parent and my mother wasn't. Hmmm. I don't think I'm like my mom. I grew up with her. My father wasn't around much. I can count on him, not my mom."

"What happened after your husband died?" I asked.

"My mom helped. She surprised me and came over every day. She now comes over only a few times a year. She won't help."

"Why do you think that is?"

"I don't know. She doesn't seem to want to be with her grandchildren."

"And your father?"

"He'll do anything for us."

"What's he do for a living?"

"He manages a business for a friend. My mom is a nurse's aide. She takes care of others, but not me."

"And how does that feel?"

"Overwhelming. I'm angry."

"So you have trouble with other feelings besides the tears?"

The Mom, upon hearing this, paused a bit and then answered, "Yes . . . I met my husband 10 years ago. He had major depression. I knew he had it, but I didn't understand. When we met he was fine. After Cathy was born, he began to get depressed. He checked into a hospital and got medicated. He was never the same. And then he got cancer and died 3 months later. I was shocked. I didn't understand cancer. It went so fast. I

was angry. I didn't work for 6 months after he died. Actually, I went to work, but I didn't work. They were very nice to me at work."

"Are you depressed now?" I asked.

"I don't let myself be. I have to keep going."

"Why is that?"

"There is no one else to do it."

"Do you allow anyone else to help you?"

"I typically take care of things myself."

"Is that another family rule like the one that you can't cry in front of people? There seems to be lots of rules about all sorts of things like crying, and what men and women can do, and about anger. I suspect all these family rules are getting in the way of your family dealing with the death of your husband. Allan doesn't cry. Cathy does . . . every day. And so do you, but not in front of anyone. The family seems to be stuck. I suspect that Cathy will cry every day until the family gets unstuck. Let's see if we can unstick the family. I think we should have a family session next time with Allan, Cathy, and you to see if we can do that. Between now and then why don't you do some thinking about all the rules, when they are used and when not. 'Cause from what you've told me, the rules seem to be broken all the time. Cathy doesn't cry at school. You actually have cried in front of the kids. Your mother actually has helped. Your father, a man, does cry. The people at work do help out, as does Matt. Think about that."

The mother called me the next day to ask for a clarification on something I had said in the session. "I was thinking about the rules and wanted to make sure what you had said." I answered her question and told her I'd see everyone the next week. As I hung up, I noted to myself that things usually go well when people do their homework. I had a hunch that the chief complaint of Cathy's daily crying would remit quickly.

As I turned the corner and entered the hallway that leads to my office, I saw the mother. She looked much better. She stood up, shook my hand and introduced me to Cathy and Allan, who were drawing on a blackboard. Allan looked up and said hello. I shook his hand. Cathy was more reticent. She did not make eye contact and softly said hi. She shyly smiled as I shook her hand.

As the kids entered my office, they commented on all the drawings on the walls. Allan was taken by a beautiful drawing of a duck. He wanted to do one himself. I directed him to a table in my office that has paper, pens, pencils, crayons, scotch tape, paper clips, scissors, and a stapler. He began to draw. Meanwhile, Cathy stuck close to her Mom and sat next to her on the sofa.

"Do you know why you're here?" I asked the children.

Both children said that they didn't know. Mom was mildly upset at their answer and let me know that she had indeed talked with them. Regardless, I gave a brief summary of what I knew.

"Your Mom came for help because she was worried that Cathy had

cried every day since Daddy died, that Cathy says she wants her Daddy and that she always needs attention." Before I could continue, Allan let me know that Cathy had been sick all week. Cathy nodded that this was true and just as quickly told me with considerable emphasis, that she didn't cry every day.

"When was the last time you cried?" I asked.

Mom answered, "She cried today!"

Cathy, with irritation, retorted, "Yes, but I didn't cry because I wanted my Daddy. I cried because you (referring to the mother) yelled at me." Mom looked a bit surprised at Cathy's answer.

I remarked that it is normal to miss one's Daddy and to cry and that there's lot of reasons to cry. I then turned to Allan and asked him if he ever cries.

Holding up the correct number of fingers, he answered: "I've cried three times since my Daddy died. No, two times."

"Boy, you've kept count. That's impressive. Do you ever cry about other things?"

Allan answered, "I cry when Cathy cries. That upsets me and gets me angry."

"So you cry about different things? I then turned to the Mom and asked her if she cried.

Allan spoke before his mom could answer: "There was a fire at Matt's (the new boyfriend's) apartment."

"Are things all right now?"

They all nodded that they were. "It's interesting that Mom didn't answer my question or Allen, you didn't let her."

Mom responded: "It's been a difficult week. First the fire, then I had a migraine. I was in excruciating pain."

"That must have been difficult. Who took care of the kids?"

"They went to their aunt's."

"And how did that go?" I asked the kids.

Cathy responded, "I don't remember."

"That's interesting," I said, "you don't remember." Cathy looked at me in silence. Her lips were shut tight. I was clear that she wasn't going to say anything more on the subject. I then repeated that Mom had not answered the question about crying. The Mom answered that she did cry, but that she did it while she was alone. The kids both turned to look at her with amazed expressions.

"Didn't you know that? Didn't you know that Mom cries?" I asked.

"No," said the children in unison.

"Look at her eyes," I said, "They're sad. Mom looks like she's ready to cry now. There's surely something about crying that's difficult for the family; that makes it hard to deal with." I waited to see if the Mom would say something.

I hoped she might, but she didn't. There was an uncomfortable silence, which I allowed to continue awhile before changing to a related subject.

"Upsetting things have happened to your family in addition to Daddy's dying. There's lots to be sad about. I heard your dog died and that Mom and Cathy cried and that Allan didn't."

Allan nodded that that was true. "I don't like to cry."

"That's okay. Lot's of men have trouble crying. They think they're supposed to be tough. In America, they have silly rules about men crying. They're not supposed to. The women can, of course. It's okay for them to cry. And so the poor guys have problems when they're sad. They have to keep it inside or do something else."

Cathy then remarked, "I cry, but I don't talk about why. I do talk about not liking when Mom goes away. I want a horse and to live forever with my Mom and to sleep with her."

"Has Mom not been there for you?" I asked.

Cathy replied, "She's not been there two or three times. One time, Auntie spent the night when Mom went out with Matt."

"Are you afraid Matt will take Mom away?"

Cathy responded, "Mom joked about leaving. That scared me." With that said, she announced that she needed to go to the bathroom. Allan said he needed to go too. Mom showed them where the bathroom was. As they all left and I was left alone, I wondered about the sudden exodus to the bathroom. I began to think about the "why now?" question. Why had the Mom called for help now as opposed to any time in the past 3 years? I wondered if the new boyfriend's entry into the family had been the impetus. After all, he had given the Mom my name. Had Matt's presence scared Cathy, who had become worse somehow in response? Or did Mom want Cathy to get better so she could spend more time with Matt? Or did Matt suggest therapy so he could have more time with Mom? After all, a little girl who cries every day and clings to her Mommie is not a boon to dating. As I mulled this over in my head, the "miracle question" (which is used in family therapy) came to mind. I decided to ask it.

When they all came back, I started, "If there was a miracle tonight and Cathy's crying went away, how would things be different?"

Allan responded with a smile, "I'd get more attention."

Cathy responded, "I'd get less attention."

Mom replied, "A great weight would be lifted from my shoulders. Cathy's crying is overbearing and oppressive."

I immediately reinforced what the Mom said by repeating it word for word. I accentuated the words "overbearing" and "oppressive" as I did. I then gently pointed out Mom's anger. She acknowledged what I was saying with a nod.

"The family's stuck. Everyone wants attention and there doesn't seem

to be enough to go around. Cathy cries. Allan doesn't. Mom does, but not in front of everyone. Everyone's sad and angry and stuck. Mom is stuck between her needs and yours (I pointed to Allan and Cathy). And Allan's stuck between being the man of the house who doesn't cry, a really lousy job, and being a 7-year-old. And Cathy is stuck between crying, which works really well at getting attention, and being 5 years old. I don't think she really wants to be a terrorizing, overbearing force in the family." I then switched to mentioning Cathy's strengths.

"This has been a great session. We now know that Cathy cries over lots of things, not just over Daddy's death. And we know that she doesn't cry at school and that she doesn't cry all the time at home. She certainly knows how not to cry. How does she do that? Cathy, that will be your homework for the next time—to think what happens all those times you don't cry. And Mom, your homework is two things: to think through your feelings when Cathy cries and to chart when Cathy cries and doesn't. And Allan, your job is to try using your not-crying skills to help your sister."

At the next session, everyone looked happy. First thing, Mom announced, "After the last session, Cathy didn't cry for an entire day. The next day she cried, but that was after a fight with Allan over who got to sit in the front seat next to me. And she seems to have so much more energy."

I responded, "If I cried all day, I wouldn't have much energy left over. Crying takes it out of you."

CATHERINE FUCHS AND PAM FISHEL-INGRAM

Psychotherapy is a term that applies to many different techniques used to help individuals process perceptions and events in life. In recent years, there has been a shift toward psychopharmacologic intervention in patient care, with a decrease in focus upon the teaching of the techniques of psychotherapy to residents in training in psychiatry. As academic faculty in the Department of Psychiatry, we are commissioned to teach our trainees the multiple types of psychotherapy that are currently recognized. Nationally, the Residency Review Committee for psychiatry training has developed competency requirements. These competency requirements include competency in types of psychotherapy. The expectation is that all trainees graduating from a residency in psychiatry will be competent for the level of training in applying supportive, psychodynamic, and cognitive–behavioral psychotherapies (CBTs) to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group, and other individual evidence-based psychotherapies.

Although our primary psychotherapy responsibilities are focused on

training psychiatric residents, this vignette offers an opportunity for all mental health clinicians. This case affords an opportunity to consider the complex clinical issues at hand, as well as the often difficult process of teaching psychotherapy to trainees.

We spend a great deal of time teaching specific types of therapy to our trainees. This case is a nice demonstration of the process of integrated psychotherapy. The teaching question is, How do we guide trainees in the process of determining the appropriate approach/es to therapy? A clinician needs to determine who needs to be part of treatment first. In this case, the information can be addressed in many ways. The presenting individual is the mother who is concerned about behavior of her daughter. Presumably, the intervention could be individual therapy for the 5-year-old child, with the focus being upon her "crying." However, with the description of the mother about the child, the interviewer quickly identifies concerns about the family dynamics from a generational perspective, as well as an observation that the family has "rules" and is "stuck." This raises the potential need for family therapy. The communication styles of the various family members *are* explored, with the recognition that there are many nonverbal communications occurring.

The next step is to determine which therapy modality or combination of modalities to use; options include CBT, psychodynamic psychotherapy, family therapy, or behavioral therapy among others. As teachers we must address the process of educating our trainees about the various modalities of therapy but also address the decision making process that must be considered in determining the approach to therapy. How do we educate our trainees in the process of developing a treatment plan that takes into account the various dynamics and communication styles of the individual and the family? This is a family in which, by virtue of being stuck and following rules, there is a need for a specific intervention to "unstick" them. The process of providing homework to the mother and then to the children is a productive way to intervene. This strategy would utilize a more direct, strategic family approach with behavioral parent training components.

With this particular case vignette, it will also be necessary to look at the issues identified in each generation. The mother is dealing with anger and loss regarding her family of origin, her husband, and the normal development of her children. She is having difficulty letting them evolve developmentally, defining their behavior as a manifestation of assumptions made at the time of the death of their father. She is also attempting to develop a new relationship that can potentially threaten the relationship of the family of three. The daughter is dealing with the loss of her father and the emotional loss of her mother as her mother became depressed after the death of the husband. The child may associate depression with loss, as the mother described the father as becoming depressed just before the diag-

nosis of his cancer. This is an unspoken issue in the dialogue presented. The child is also able to perform adequately at school and to separate from her mother to attend school. This may be threatening to the mother as the child becomes more independent from the mother, a developmentally normal step in her life.

The son is dealing with the loss of his father, as well as the loss of being a little boy rather than the "man of the house." He is yearning for attention yet unable to seek it through communication of emotions because of the family expectations.

We must next ask ourselves, "What are the coping skills of each individual in the family?" The presence or absence of coping skills is a critical determinant of the initial focus of therapy with the recognition that it is necessary to teach certain coping skills before progressing to other types of therapy indicated.

Let us consider the types of therapy that may have been appropriate in this case and the potential decision-making process that can be used to determine a treatment plan. This case provides an opportunity to consider the process of integrated therapy as the therapist considers the treatment options. The family, in this case, does not have good skills at expression of emotion. The emotion is diffuse and unfocused. The strength is the recognition of emotion. The challenge to the therapist is to process the diffuse nature of the emotions within the family system. The therapist has chosen to take a strategic family approach to the case, with emphasis on interpretation as well as utilization of CBT techniques; the focus is upon the individuals within the family doing homework that helps them to reflect upon the pattern of the emotions being expressed. In this way, the therapist has taken the strength of the family (that being the ability to recognize the presence of the emotional expression of each individual) and used it to target the challenges facing the family (that being the diffuse nature of the communications). Once the mother and children are able to better focus the expression of sadness and anger, they appear to exhibit less stress in their interactions.

Once this goal has been achieved, the therapist is at a decision point in the therapy. The therapist must now consider whether it is appropriate to reassess the treatment recommendations, considering a potential shift in focus from the presenting request to a focus on individual issues identified in the process of understanding the dynamics of the family. The mother came in with a specific referral question: to deal with the crying of the daughter. The presenting symptom is already better after two sessions by the report of the mother. What, then, should be the next step? Should the therapist terminate the therapy with the understanding that the presenting complaint has been addressed? Should the therapist continue with family therapy addressing the dynamics of the family and their need for additional

help in their style of communication? Or, should the therapist shift the focus to individual therapy for the mother, addressing her apparent depression and the impact that has upon her parenting style? As we teach out trainees how to be therapists, we must introduce them to the consideration of how to both define treatment goals and then reassess treatment goals in collaboration with the patients and their families.

Once the therapist determines the best possible recommendations for therapy given the information available, he or she must then consider the definition of "best" in the context of the goals of the individuals within the family. The agenda of the therapist is not necessarily the same agenda as that of the patient and family. How one sets goals in therapy may affect the outcome of the proposed intervention. In a collaborative process, the patient and family would be presented with discussion about the changes that have already occurred, followed by a discussion about the process from which the changes were possible. This enables the therapist to challenge the individuals participating in the therapy to consider the expectations that they had when initially seeking help followed by consideration of additional change that they desire. The therapist may then discuss with the patient(s) the possible methods by which the additional change may be effected. In this way, the decisions about "the next step" could be a collaborative process. It is hoped that, with the collaboration of the patient(s), the decisions about ongoing therapy will have the commitment of the patient(s) as well as the therapist.

We suggest that the presence of depression in the mother is a central concern. Until depression in the mother is addressed, the mother will have her parenting guided by her fear of loss, her splitting of loyalty between her mother ("My mother never cried" and "I don't think I like my mom"), and her loyalty to her father ("My dad cries all the time" and "He's an alcoholic. He was the cause of problems in my family while I was growing up"). She expressed contradictions such as, "He's a loving parent and my mother wasn't . . . My father wasn't around much. I can count on him, not my Mom." Once communication styles are established, this mother may benefit from various types of therapy. Teaching trainees a thought process to follow in determining the appropriate type of therapy is a challenge to teachers of doctors in training.

It could be argued that this mother could benefit from psychodynamic psychotherapy addressing the role of family dynamics in her depression. She will also need to explore the role of depression in the family throughout the generations and look at her fear of depression repeating itself in her children. It could also be argued that she would benefit from a supportive approach combined with CBT exploring her cognitive distortions and beliefs about her role as a mother and wife and about her difficulty with the expression of painful emotions. A third approach could be to continue

family sessions with the expectation that mother's healing may take place as the system and her beliefs about emotional exchange shift through the process of family communication. Each of these interventions can be combined with antidepressant medication for the mother, if indicated. A final approach would be a combination of intervention with the family as a whole alternating with individual treatment of the mother to address her coping skills and communication style as the family system shifts through the process of family therapy.

This case presents many opportunities to look at the role of normal development in the expression of distress in children. It also highlights the interface between various types of therapy that we teach our trainees: the use of family therapy, individual therapy, a cognitive approach, a psychodynamic approach, the potential need to address pharmacologic needs of the mother. This latter issue also raises the interesting boundary issue of who the patient is. If it is the child, then who should take care of the mother? If it is the mother, then this needs to be clarified with the mother who came with the child in mind. If the family is the patient, then that too needs to be clarified when defining the boundaries of care.

Clearly, as we teach the competencies, we must help our trainees develop the skills necessary to determine the type of therapy indicated, but also we must teach them the skill and art of flexibility as they integrate the multiple techniques that we carefully outline for them. Clinicians often use strategies from a number of treatment modalities even when using one theoretical framework. We must teach them to use the initial exploration of the symptoms and coping skills as tools to be used in determining the appropriate type of intervention. The decision about type of intervention is best done in a collaborative manner empowering the patient to participate in the setting of goals for the treatment.

The flexibility of the therapy process is well demonstrated in this case vignette. The clinician in this case has demonstrated the process of combining an understanding of an issue or problem with which the patient presents and using a solution-focused, present-focused technique to alleviate the symptoms quickly, followed by a need to negotiate with the patient(s) the goals of intervention after the acute symptoms are alleviated. As we educate our trainees in the various therapy competencies, we must educate them in the thought process that goes into the decisions about therapy and the variety of choices that are dependent upon the communication styles of the patient, the goals of the patient and clinician, the motivation of the patient, and the cognitive and emotional capacity of the patient. This is what makes the teaching both challenging and enjoyable.

GEORGE S. GREENBERG

In reviewing this case presentation, I am immediately struck by its richness and complexity. Such cases in child and adult services frequently lead less experienced therapists and even their supervisors to overcomplicate, to overpathologize, or to proceed with approaches in which the family as client might be seen as less important then the index patient. Martin Drell has brilliantly followed the Law of Parsimony: "Do not unnecessarily complicate"; I too will follow his example while discussing my observations through the lenses of a consultative, brief systemic or family interactional perspective with a strategic focus.

Basic Premises

(a) The therapist in large part serves as a consultant with members of the treatment unit and directly or indirectly furthers their roles as consultants to each other while promoting a collaborative change process (Greenberg, 1999).
(b) The therapeutic work centers around the process of helping the index patient and significant others to get unstuck.
(c) Being stuck is an impasse that occurs primarily when people's perspectives, their viewpoints, and/or their behaviors do not allow for change in interpersonal relationships as well as modification of a given circumstance, a problem, or a set of problems.
(d) An impasse denotes seeing no alternative—no way out of a troublesome or horrible set of circumstances. It is a dilemma.
(e) In such situations, individuals often identify themselves or others as helpless, hopeless, or "mentally ill."
(f) Therapists, when faced with such cases, can inadvertently find themselves in isomorphic situations, actually helping to maintain viewpoints or behaviors with self and others in the treatment set that amplifies and/or sustains impasse.

The Processes Involved in Collaborative Case Consultation

With this in mind, the processes involved in brief collaborative case consultation can be described as comprising the following basic components:

(a) Locating and conceptualizing the chief complaint(s). That is "what the consultee or consultees identify as the problem area, including

stated beliefs about causes and effects as well as any type of rationale they employ in explicating their viewpoints" (Greenberg, 1980; Greenberg, 1985).

(b) Clarifying the consultee's espoused goals or purpose for the consultations(s) that is "precisely what are the consultee's expectations or hopes for outcome" (Greenberg, 1985, p. 49).

(c) Formulating the presenting problem, which is "the sense and order the consultant makes out of the data obtained" in the interactional discourse with members of the treatment unit (Greenberg, 1994; Greenberg, 1985).

(d) How the family members and therapists acting as consultants to each other elaborate a process of change and therapeutic intervention (Greenberg, 1980; Greenberg, 1999).

Discussion

Drell enters the family dialogue, perhaps unsuspectedly, in conversation with the father of an ex-patient, followed by a brief phone consultation with Mom. While continuing a process of hypothesizing his notions regarding the presenting problems, he proceeds in a direction where he obtains and enlarges the information that constitutes the chief complaint while mapping the family, clarifying the social or organizational context, the time, place, situation, and the characters in the drama. As he structures and collaborates, he moves through a treatment cycle comprising (a) problem and/or (b) change delineation, (c) strategies, typically including tasks, and (d) achievements/accomplishments (Greenberg, 1994, 1999). Rapidly delineating what is at least an implicit goal regarding crying, or the crying metaphor, he meets with the mother as she is the complainant and, at this point, the one who has presented with a problem.

Problem Definition

Greenberg, in discussing problems, resolutions, strategies, and achievements with individuals, families, and groups as well as in case consultation (1980, 1985, 1999), has offered the interactional concept of problem initially developed at the Brief Therapy Center of the Mental Research Institute at Palo Alto as presented here:

> Problems are characterized as complaints typically involving a concern by one person about something pertaining to his or her own behavior or the behavior of at least one other person with whom he or she is significantly involved. Such behavior

> is depicted as undesirable, distressing, deviant, difficult, or harmful often relative to normative expectations. The behavior persists despite efforts to eliminate it and therefore professional help is sought [to effect change]. (Greenberg, 1985, p. 50)

I will continue to use this as a working definition.

As the drama—that is, the chief complaint(s), the presenting problem, and the process of the consultation—continues to unfold, Drell nicely reframes the mother's crying: "There appears to be more than one girl crying every day." This also delineates an exception to the family's party line on crying while beginning to help the mother restructure her ideas regarding the problem as well as subtly moving to depathologize the situation. Drell uses notions such as rules regarding crying and other family material, some related to her family of origin together with a variety of information while moving toward circumscribing what he identifies as a family problem. In the process, the dialogue is expanded. He has, I believe, helped to moderate or modulate the mother's views of her own issues and family operations. He also gives the mother a homework assignment, a suggestion, a task: "Between now and the family meeting, think about the rules when they are used and not used 'cause what you have told me [is] rules seem to be broken all the time."

This intervention is designed to influence mother's views and/or actions. Classically, a homework request is concomitantly designed to influence another social system; in this case, the family and its members. Often, changes will be observed in the next session without anyone knowing why. A basic strategic premise is that understanding can be helpful but it's not a necessary requirement.

At the conjoint family session, Drell nicely makes a transition from the previous session with mother with an inquiry: "Do you know why you are here?" He summarizes the chief complaint. "Mom came for help because she was worried that Cathy had cried every day since Daddy died . . . and that she always needs attention."

Please remember that an impasse occurs primarily because viewpoints and behavior don't allow for change in interpersonal relationships and modifications of circumstances or a problem. The corrective action or prescription is a process to interdict, modify, or change those viewpoints, actions, and relationships. This process is clearly seen as the family members continue their consultation. Cathy notes that she did not cry every day. Mother refutes this assertion. Cathy then contends, "I didn't cry because I wanted my Daddy." She exposes a relationship issue and a change in meaning: "[Mom] yelled at me." So as the process continues and using the language of crying and tears, crying is reframed as a universal phenomenon having variations of meaning.

The issues of loss, introduced in phone contact with the mother, issues of how people deal with painful matters, issues of fears of abandonment,

the presence of Mom's new boyfriend, the recognition that there are others such as the aunt, and the idea that no one is totally alone or responsible for everything—all these ideas are addressed along with issues of death and struggles with transformation. All are made overt. The mask is off the tears. The context has also been depathologized.

When family members make an exodus to the bathroom, the therapist attempts to reorganize aspects of the presenting problem leading to the use of the miracle question.

The Miracle Question

The miracle question is a question, an intervention, that asks the clients to disregard their notions of their current troubles, thoughts, and interactions and to imagine their lives in an altered, successful future. Although there are many variations, it is classically formulated as follows: Suppose you go to sleep tonight, and unknown to you, a miracle occurs and the problem is solved; "What do you suppose you will notice different the next morning that will tell that the problem is solved?" (Berg, 1994, p. 97). Such imagining that a miracle has happened often has powerful clinical impact. It can create a vibrant vision or image of what one's life "will be like when the problem is solved" (Berg, 1994, p. 97) while allowing the individual to view hope for himself or herself and others that life can be different when it is not "modeled on someone else's ideas of what life should be like" (Berg, 1994, p. 97). The use of the miracle question changes the time, place, and focus (the spatial/temporal boundaries). If it is effective, it reframes the idea of problem from one that needs to be solved to one that has already been solved. This intervention carries with it the implicit suggestion that, through future focus, change has already occurred in the present. This is a technique borrowed from hypnosis that uses age progression and time distortion. The shifting of the time frame, along with the concept of achievement, is accomplished by interaction between and among all the participants. It is not, as is often mistakenly believed, solely the therapist acting upon the family.

To introduce the miracle question (with the family) at the end of this session, Drell also prescribes what I believe has already occurred in the session while reinforcing it. As he draws the session to a close, he continues with the final feature of the consultative treatment cycle—accomplishment. The accomplishment phase is further addressed with summary and homework tasks that, at one level or another, focus on a shift in viewpoint, behavior, interaction, and relationship, as well as emphasizing the *difference(s) that make the difference*, which in the interactional literature is a

definition of change. The homework further emphasizes that the family can use those differences and homework tasks to help themselves individually and collectively to further solidify the interruptions of patterns and relationship positions that previously sustained the impasse while empowering the family toward further transformation. The homework also offers an exercise that is a roadblock to trying to reaffix the mask.

Drell reported that, after the last session, the family remains unstuck.

PATRICIA MORSE

The temptation in this case is to complete an individual evaluation on the mother, Cathy, and Allan; provide a diagnosis for each in accordance with the *Diagnostic and Statistical Manual of Mental Disorders* (text revision; *DSM–IV–TR* American Psychiatric Association, 2000); and potentially begin all members on a course of individual psychotherapy. However, it is clear from the mother's presentation that, although individual treatment has been ongoing for the mother and tried for Cathy, it has not been viewed as successful in assisting either Cathy or her mother with regulation of affect, particularly, sadness and anger. The information presented provides justification for a range of possible *DSM–IV–TR* diagnoses for Cathy and her mother including depression, separation anxiety, and bereavement. An individual therapy approach, although feasible, may not be the most efficacious approach for this case. The case data as presented clearly suggest that a more interactive or systemic approach might yield significant positive results. In contrast to the many "internally focused" ways in which we conceptualize cases (e.g., biologically, as an exploration of internal conflicts, or as simple behaviorally oriented stimulus response sets), Cathy's family presentation describes relational or interactive concerns that form the nexus of the family members' problems. The relationship between Cathy and her mother is stressed by the crying; the mother says, "If we could deal with that, I'd be happy." Mother, on the other hand, identifies problems in her relationships with not only Cathy but also Allan ("I'm more upset about him"), her father ("He's a loving parent . . . [but he] wasn't around much"), and her mother ("She takes care of others," "She doesn't seem to want to be with her grandchildren"). In viewing this family as a system, it is easy to see how the members are trying to maintain an affect balance or, in family therapy terms, *homeostasis*, by either concealing feelings or by overcompensating for this concealment by "crying every day."

In this case, Martin Drell has done an excellent job of illustrating the basic tenets and techniques of one of the major historical schools of

systemic family therapy "the Milan School". Milan Systemic therapy was originally presented to the field in the early 1970s by Maria Selvini-Palazzoli and her colleagues (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). This case as presented used three very important techniques articulated by Selvini-Palazzoli and her colleagues in the now-classic article published in *Family Process* in 1980, titled, "Hypothesizing-Circularity-Neutrality: Three Guidelines for the Conductor of the Session" (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1978). As described in detail later, Drell used hypothesizing as a basic assessment and therapeutic technique; circularity or circular questioning as the primary interviewing technique, and also as a therapeutic technique; and neutrality as the therapeutic stance.

Hypothesizing as used in family therapy is often described as the "therapist's guess" about his or her conceptualization of the elements presented in the case. The hypothesis is an attempt to link together information presented by family members into a useful interactive form which is, in turn, presented to the family members present. It is not important whether the hypothesis is "right" or "wrong." The purpose of hypothesizing in systemic therapies is to link behaviors together, solicit new information, and move the family forward in the therapeutic process. In this case, hypothesizing is used as early as the initial telephone contact. Here, Drell comments, "sounds like a separation problem. Does Cathy have that?" Later, in the first interview, Drell continues to present hypotheses to Cathy's mother, which result not only in the presentation of additional data but in the further refinement of the case conceptualization. Early in the first session, he states, "I have a theory that this is a family problem. Cathy cries every day. Allan doesn't. And you cry every day but not in front of the kids. There seem to be some rules about crying that has the family stuck." Additional information is developed, and Drell ends the session with a further refinement of his "stuck hypothesis." He concludes, "There seems to be lots of rules about all sorts of things like crying, and what men and women can do, and about anger. I suspect all these family rules are getting in the way of your family dealing with the death of your husband. Allan doesn't cry. Cathy does . . . every day. And so do you, but not in front of anyone. The family seems to be stuck. Cathy will cry every day until the family gets unstuck." At the end of the second session, Drell again presents the stuck hypothesis; this time, however, Cathy and Allan are also present. He states the hypothesis using almost the identical wording as in the first session when he saw the mother alone. He now adds to the hypothesis, incorporating the information gathered from the children and presenting to the children their mother's behaviors in interaction with their own. He adds, "Everyone's sad and angry and stuck. Mom is stuck between her needs and yours. And Allan's stuck between being the 'man

of the house,' who doesn't cry, a really lousy job, and being a 7-year-old. And Cathy is stuck between crying which works really well at getting attention and being 5 years old." As Drell presents each family member with a homework assignment tied to this hypothesis, it is evident that there has been significant movement in the therapeutic process.

The second technique illustrated by the therapist in the case is that of circular questioning. Circular questioning differs from linear or lineal questioning in that it does not focus on causality. There is no attempt to link cause and effect in a linear fashion that is to say that Behavior A causes Behavior B, which in turn, causes Behavior C. In contrast, circular questioning implies interaction and continuous feedback among behaviors. Behaviors A, B, and C all interact with each other and are modified only through this interaction and this continuous feedback process. The primary reasons for using the technique of curricular questioning are to discover interaction patterns among family members and to demonstrate to families the reciprocal nature of behavior. Circular questions often ask about similarities and differences in behavioral relationships. Solution-focused therapies are based on this technique and endeavor to answer questions about when behavioral interactions typically defined as problematic are indeed nonproblematic. Drell illustrates this technique clearly in the first session when he asks a series of questions about who cries and when. He determines that Cathy only cries at home, that Mom cries all the time but not in front of the children (with some exception), Allan doesn't cry, Mom's mother never cries, and Mom's father cries "all the time." The circular questioning techniques were used to uncover what Drell describes as the "family rules" about the display of affect and directly bear on the chief complaint as well as the overall case conceptualization. Similarly, Drell uses a form of circular questioning when he uses what the family therapy literature has described as the miracle question (de Shazer, 1991). The miracle question and the responses to it are used to move the family into the future where the problems that brought them to treatment no longer exist. In Session 2, he asks Cathy, her mother, and Allan, "If there was a miracle tonight and Cathy's crying went away, how would things be different? After Drell gets everyone's response to the question, he uses the data to continue to refine his family hypothesis and feed it back to the family. Thus, circular questioning as demonstrated here gathers additional family data, emphasizes the stance that this is "a family problem," not just Cathy's problem, and highlights the interactive nature of the family's relationships, which in turn, suggests that the solution to or treatment of the family's concerns is also interactive and the responsibility of the entire family.

The third technique demonstrated here is that of therapeutic neutrality. Although the concept of therapeutic neutrality is not unique to family

models, it is often a challenge for the family therapist in that frequently one or more family members attempt to solicit the therapist as an ally against other members. Similarly, it is often the case in family treatment that the initial request for therapy comes with one particular family member identified as the patient or the source of the problem. Taking a neutral stance means that the therapist does not align himself with any one member of the family but rather aligns with all members. Therapeutic neutrality implies that the therapist interacts with all family members and does not focus on, blame, or target any one member's behavior. In this case, it is clear that Cathy was presented by her mother as the identified patient. Beginning with his initial decision to treat this case a family case, Drell took the position of therapeutic neutrality. He repeatedly states that it is the family that is stuck, not any one of its individual members. His hypotheses include all family members and do not single out any one individual's behavior. Similarly, his circular questioning solicits information from all members about all members. He never blames or identifies Cathy, Allan, or their mother as the source of the family's problems. In the second session, Drell carefully makes sure that a balanced picture of Cathy is presented, focusing or her strengths and the observation that "Cathy knows how not to cry."

By using a systemic family perspective and using the techniques of hypothesizing, circularity, and neutrality, Drell has included all family members in both the definition of the problem(s) and the source and focus of the solution(s). This is not to say that an individual approach with one or all of the family members would not be as successful, but I would guess that any individual work would be more costly in terms of time and money and might not necessarily be generalizable to the solution of future family issues. In fact, it is important to note that this brief three-session model resulted in a significant outcome. Using this model, Drell has given the family a road map for the resolution of future family crises, thus increasing the potential for family resilience.

SCOTT GRIFFIES

Cathy, a 5-year-old identified patient, has cried every day since her father died 3 years ago. Cathy's brother, Allan, is 7 years old and doesn't cry, or at least he's only cried two to three times. Mom cries, but not in front of the kids. Martin Drell's evaluation reveals that the family is emotionally stuck and cannot fully grieve their father's death because of family rules about crying. He reveals, however, that the rules are merely for appearances, because the person most in charge of the rules, Mom, really does cry. Drell quickly normalizes crying and demonstrates the burden to

the family of role playing, suggesting that, if everyone did their own healthy crying, Cathy wouldn't have to cry and, reciprocally, if Cathy didn't cry for everyone, they could attend to their own crying. Within two sessions, the family appears to resolve a 3-year emotional stalemate.

When I initially heard this case, I wondered what thoughts Drell had concerning the positive therapeutic result in two sessions. Like all psychotherapists, I know all too well the mind's tenacious resistances to change. I also realize that there is a lot we don't know about how psychotherapeutic change occurs, and there are many possible mutative factors that are therapeutically beneficial.

I am an adult psychoanalyst/psychodynamic therapist and work most prevalently from an object-relational perspective. I am not a child or family therapist, but except for semantic differences, I believe that my formulation of the case would be similar to that many other therapists. From the object-relational perspective, I would conceptualize the children's psychic organizations as resulting from internalizations of Mom's psychic organization. Therefore, changes in Mom's psychic organization should potentially affect the children's. The converse should also apply; that is, changes in the children's psychic organization might change Mom. However, because of the children's ages and dependent attachments, Mom is a powerful influence on the children's developing psychic organizations, and therefore without some change in her psychic organization or the availability of other significant attachment objects for the children (e.g., long-term therapist), change for the children is more difficult.

Therefore, shifting Mom's psychic organization is important for the long-term success of mutative changes in the family's organization, and the million dollar question is how best to influence this change. The answer to the question, of course, also depends on the mutability of the mother's, and therefore the family's, defensive resistances. A family in regression after the death of the father/husband is a different family than one with fixed patterns of behaviors and defenses. From a psychodynamic perspective, it would be much less controversial to accept that long-term results from two sessions might be possible if the mother and family were in a regression, versus a more fixed defensive organization. The case vignette is an excellent example of how an experienced family therapist "unsticks" a stuck family, but if the family's organization was at a more fixed level, would this change Drell's technique? If not, how might Drell conceptualize the effect of two sessions on the family's organization long term?

Whether fixed or in regression, I would conceptualize the Mom's current psychic organization as shaped by internalized self–object relationships. Mom, it seems to me, has an object-relational split around crying or not crying. Within her implicit memory schemas, she has internalized a critical parental object that forbids crying. Attached to this critical parental

introject is the strong, noncrying self-representation that gains parental approval, but at a cost (she must not authentically cry or feel). Also within her emotional memory is a "crying child" self-representation linked to associated negative affects—shame, anxiety, and depression.

Within an individual psychotherapy with Mom of some frequency and duration, the various self–object representations with their corresponding affects are activated in the transference and interpreted. Initially in therapy, I would suspect that Mom would enact the strong, noncrying self-representation with me transferentially as an approving parental object representation. During this initial honeymoon stage, the critical, disapproving parental object representation and the corresponding crying, rejected, child self-relationship would remain repressed and disavowed. Gradually, however, I suspect that the "crying child" self-representation with corresponding shame and despair would emerge.

Once this occurs, I would suspect that Mom would more manifestly feel attacked and criticized by me as the disapproving, parental object representation and would feel as if she deserved this mistreatment. She would feel, as children so often do, that she must be the cause of the criticism or disapproval because she is somehow bad and unlovable. In other words, there would be a number of layers of defenses and resistances (the main one being the enactment of a noncrying self/approving object paradigm) to expressing anger (and other feelings) toward me as the critical parent (and other object representations), and feeling free to cry (and other emotions) healthily. With enough of a positive alliance, sufficient ego strength, and time and commitment to the process, the various object relational paradigms, defenses, and resistances would be enacted, interpreted, understood, and worked through leading to insight and shifts toward more developmentally healthy and freer relational interactions, perceptions and emotional expressivity. In addition, our therapeutic relationship and all its metacommunications (respect, nonjudgment, attunement, mirroring, value, believing in, etc.) would be internalized as a new self–object relationship with a number of psychic structural benefits. I would see our main therapeutic goal as helping her integrate the "crying" self and "noncrying" self into a more healthy, authentic (not role playing for defense and regressive wish gratification) self-representation.

The children's developing internalizations and psychic organization are shaped by the mother's internalized object relationships and psychic organization through introjective and projective mechanisms. In the present "stuck" situation, Mom's disavowed "crying self" manifests in Cathy, and Mom's strong but counterdependent "noncrying self" manifests in Allan. In public, Mom seems to manifest the critical parental object or the noncrying self-representation, while behind closed doors she manifests the "crying" self.

Although we do not know the extent, Mom was reported to have had "years of prior therapy." In addition, given that she appears to be able to acknowledge emotional dysfunction in herself and her family and to pursue and engage in therapy, she may be, outside of significantly stressful situations, a relatively "good-enough" mother with sufficient ego strength. Again, a regressive state in the context of unresolved bereavement would be much more amenable to a brief intervention than a condition with entrenched resistances. Mom's premorbid level of ego strength and Drell's skill in family therapy and ability to positively engage the family may have influenced Mom's relatively low resistance to Drell's clarification that she did cry and his message that crying while grieving was normal and healthy. The children's astonishment that Mom cried appeared to be an affecting and freeing realization.

Drell's miracle question was a form of a therapeutic suggestion, which can be helpful in this setting and in some forms of individual therapy as well. Often this implied suggestion is enough for the patient to try on a new behavioral hat, although again, from a psychodynamic perspective, unconscious resistances to the change would usually still need to be systematically interpreted and clarified to effect a more sustained level of change. A psychodynamic concern of the therapeutic use of suggestion would be that Mom's behavioral change might have occurred in response to Drell's authority only (a type of transference cure), and without insight, internal resistances to the positive behavioral suggestion might rear again later, leading to a new version of "stuckness." In other words, Mom might respond to Drell as a new self-representational version of the approving parent paradigm. She might enact a public crying self/approving parent object relationship, which might replace the noncrying self/approving parent internalization. In this scenario, Mom is still theoretically shaping herself in accordance to another's authority without the capacity to know her own true feelings and to creatively actualize them. However, given the time constraints and many other limitations, this may still be a favorable outcome, one that opens up new options for the children and family. I wonder how Drell conceptualizes "transference cures" and whether they can be beneficial and sustaining long term.

Therefore a central psychodynamic question would be whether Drell's interventions led to a shift in the psychic organization of Mom, and therefore the family, or whether his skill and authority in making a therapeutic suggestion led primarily to a behavioral shift in the family and whether this shift will be mutative over the long term. Psychodynamic theory would purport that change of relatively fixed psychic organization through insight and new internalized object relationships would require a reasonably significant treatment period. A shift in the psychic organization of Mom would entail Mom owning split representations and being willing

and able to integrate them. She then would, hopefully, be able to cry and be strong at the same time, which would free the children from enacting her disavowed and projected representations and enable them to develop more integrative psychic organizations.

An equally central question would be whether a behavioral shift in the family secondary to insight of the false rules and a miracle suggestion by a skilled therapist with authority might conversely lead to changes in the family equilibrium and, therefore, psychic organization. That is, if transactional behavioral interactions between family members shape psychic organization, would an intervention that shifts Mom or the children's behavior possibly lead to a psychic organizational shift in any one or several family members, which would, by reciprocal action, change each other? This premise would appear to support selective interventions that shift the behavioral equilibrium of the family as a way of resetting the psychic/behavioral transactional system. Traditional psychodynamic theory would again be skeptical of the benefits of behavioral change without insight and change of the underlying psychic organization. Without deeper structural work, it would be understood that, although the behavior might look different, it is often another version of an underlying object relational paradigm (e.g., self/approving parent paradigm), and therefore the children would still be prone to the inherent limitations of that level of psychic organization. Again, I'd be interested in hearing Drell's family therapy conceptualization of the idea that a behavioral shift alone might effect psychic organization changes through reciprocal action between family members. Is a main goal of family therapy to unstick the family and allow for such reequilibration? If so, what predictions can be made about what influences the ultimate state of that reequilibration and its long-term benefits?

In summary, Drell's case is an excellent teaching example of the technique utilized by an experienced family therapist in shifting the psychic/behavioral equilibrium of a family within a brief time. Drell's creative ability to reveal the false pathologic rules about crying freed the family from the rule's constraints. Once realized, the family seemed ready to accept Drell's miracle suggestion that they behave differently. From a traditional psychodynamic perspective, I believe that the degree of fluidity of the mother's psychic organization and resistances would influence the family's ability to remain relatively unstuck and continue to emotionally develop in the future. Unless the mother had had significant prior treatment and/or had good ego strength before a regression around her husband's death, I would normally be skeptical of the benefits of a brief two-session treatment that purports any significant permanent change in a mom's or a family's psychic organization. However, I'd be curious to hear from the discussants about how they feel the shift of the family's behavior

might affect the children's psychic organization, which would in turn affect the mother's, circularly, ad infinitum. I think we have a lot to learn, and Drell's very well-presented case offers a lot to think about.

POINTS OF CONTENTION AND CONVERGENCE

Catherine Fuchs and Pam Fishel-Ingram

The case by Martin Drell presents a wonderful opportunity to think about the therapeutic process from a number of different perspectives. It is with great pleasure that I have read the various commentaries on this case. The editor of this journal has given each of us the flexibility of reviewing the case from our own theoretical perspective, as well as considering any clinical, conceptual, or training issues that the vignette raises for us. This has resulted in a rich set of case commentaries, each of which has many similarities.

Our commentary is from the perspective of training, considering how to use a case such as this to facilitate the process of training mental health professionals in the development of skills as therapists. We gravitated toward this perspective naturally; Catherine Fuchs is the training director for our psychiatry residents, both adult and child, and Pam Fishel-Ingram teaches many of the psychotherapy seminars, in addition to supervising psychiatry and psychology residents in their clinical work. The two of us work together in an effort to train the various specialties in the field of mental health.

Reading the other contributors' commentaries affords us the opportunity to consider a variety of perspectives as they relate to training at a detailed level. The comments of Scott Griffies provide an insight into the necessity of conceptualization of the case as the therapist considers how to intervene. He makes excellent observations about the importance of the balance between the level of the defenses of the patients and/or family involved and the degree to which the presentation represents regression from a healthy norm. From an object-relational perspective, he considers the process of understanding the psychic organization of the mother as a means of assessing the level of defensiveness and, hence, the potential for lasting change in a brief intervention. Griffies also introduces the concept of a transference cure and the question as to whether a transference cure can produce long-lasting change. Finally, he considers the therapeutic process from both the individual perspective (that of the mother) and the family perspective ("whether a behavioral shift in the family secondary to insight of the false rules . . . lead to changes in the family equilibrium and,

therefore, psychic organization."). Such a review of this case provides an excellent opportunity to observe the complexity of the conceptualization process and how one may determine appropriate therapeutic interventions.

At the end of his commentary, Griffies raises a question that I think is well addressed by Patricia Morse in her commentary. Specifically, he wonders how others would address the potential for a shift in the psychic organization of the children in response to a shift in the family's behavior. Morse provides us information about the techniques of "hypothesizing-circularity-neutrality" when discussing Milan systemic therapy. She points out the use of circular questioning to affect a shift in the behavior of the family as a whole by demonstrating to the individuals in the family the "interaction patterns among family members and to demonstrate to families the reciprocal nature of behavior." It is through this circular questioning that the individuals are able to make the shift in psychic organization through a reciprocal process in which the changes of each member of the family affect change in the others. Making reference back to the comments of Scott Griffies, I reflect again on his observation that the potential for lasting change is dependent in part upon the balance between the level of defenses and the degree of regression in the various individuals. I would suggest that this is true with regard to the process of circularity as well. As Morse noted at the end of her commentary, there may be other effective approaches to therapy for this family. In this case, the systemic family therapy model appears to have been effective. The consideration of the potential for lasting change is a question that can encourage our students to consider the complexity of the human psyche and the process of therapy.

George S. Greenberg provides a very useful model for case conceptualization. He outlines the basic premises of the case, followed by the steps that the therapist should take if one conceptualizes a case "through the lens of a consultative, brief systemic, or family interactional perspective." This process incorporates the therapist's understanding of the dynamics of the family and how each individual affects those dynamics. Within this framework, the therapist can work with the consultee to determine the goals of treatment. This enables treatment planning to be a collaborative process. He also notes the importance of "depathologizing" as part of the problem definition. Once the presenting complaint(s) are "depathologized," the therapist is able to help the family confront the various meanings of the problem as well as address the family's strengths. In addition, various techniques are highlighted, including the posing of the miracle question and the use of homework.

Each of these commentaries is an excellent exemplar of the complexity of case conceptualization. Although there are obvious conceptual differences, there are notable similarities that can, and should, be addressed while training clinicians to be psychotherapists. All three of the discussants address the

therapy from the perspective of the definition of the problem and consideration of the strengths and potential weaknesses of the various participants. Each acknowledges the successful intervention described by Martin Drell, and Scott Griffies suggests the necessity for considering the attributes of the family members that are necessary for long-term change, information that we do not have available to us at this time.

We appreciate the opportunity to participate in the discussion of an interesting case that afforded the opportunity for readers to consider how multiple therapists conceptualize such a case for treatment planning while utilizing multiple frameworks. Through this type of exercise, we hope that both seasoned clinicians as well as trainees can further their learning. We certainly have.

George S. Greenberg

Martin Drell's stimulating article and the excellent presentation by the discussants allow for an interesting format for brief reflection on aspects of convergence and contention. In reviewing their responses, I am keenly aware of the differences in language emanating form their preferences for particular paradigms and perspectives. It is important to emphasize that these different languages do not constitute a Tower of Babel, but we need to keep in mind that the meanings, nuances, and contextual perspectives are not necessarily congruent.

Scott Griffies speaks from a language matrix where the child's psychic organization results from internalizations of Mom's psychological organization and postulates that a change in that organization should potentially affect the children and, conversely, a change in the children's psychic organization should affect the Mom. So, Griffies's language informs us of the loci of the problem as internal and the foci of treatment as a modification of underlying psychic structure or organization. For him this includes notions of transference.

Patricia Morse concluded that, on the basis of the linguistic narrative, the nexus of family problems is a function of relational or interactive concerns. She focuses on interviewing strategies and intervention techniques of the Milan School (Selvini-Palazzoli et al., 1978, 1980). Morse presents a perspective wherein therapeutic interventions are systemically targeted to the cast of characters in the case drama and their linkages in the relational sets. No mention is made of the transference phenomena or of underlying introjects. There also appears to be more emphasis on conjoint family work while never forgetting that families, social systems, or social organizations comprise individual members.

One shift made by Selvini-Palazzoli et al. and, by extension, Morse's application in this case, is indeed demonstrative of a move from language of traditional internal dynamics to one of systemic interactional foci. It is my belief that this shift allows for a broader examination and assessment of social and organizational contexts and structures that Griffies proposes. Griffies is keenly aware of this when he suggests that successful treatment of Mom would have significant impact on other family members. Although the recognition of relational impact is congruent with family concepts, it appears that he would prefer to select a therapeutic modality that is relatively long term and predominantly individually focused. A second shift made or derived from the interactional perspective explicated in Morse's response is an emphasis on more rapid change, as a goal of therapy.

Catherine Fuchs and Pam Fishel-Ingram's cogent discussion stems from their interest and focus in the training processes of psychiatric residents and mental health professionals. Again rich and sensitively presented, as is true of the other commentators, I am particularly drawn to their emphases on the importance of the therapists and their professors on their need to be flexible—knowing multiple paradigms—and the crucial importance of clinical judgment. They also touch on the tension that arises for the clinician relative to their selection of language, treatment modalities, and accompanying methodologies including family and individual psychotherapies. They note that Drell has chosen to take a strategic family approach to the case as well as using CBT techniques in his original case presentation. They further use their discussion of the original case as a forum to delineate issues and challenges within training milieus. Whether one focuses on the psychotherapy or on issues in training, I suggest that they are essentially isomorphic.

I add that the observation of CBT techniques and their use often does not include recognition that the preponderance of strategic and interactional therapies are themselves cognitive–behavioral therapies. This is another area that merits further examination in terms of convergences and contentions. Furthermore, the question of paradigm choice and questions related as to whether theories and derived techniques are eclectic or not also appear to be an area of common concern and ongoing struggle for professors, their students, and clinicians alike.

I look forward to further interchange related to our discussions and appreciate the opportunity to have participated with Drell, Morse, Griffies, Fuchs, and Fishel-Ingram in this challenging and most interesting forum.

Patricia Morse

In their discussions of this case, Scott Griffies and George S. Greenberg highlight a conundrum that has permeated the practice of psychother-

apy for several decades—the relationship or lack thereof between behavior change and insight. Greenberg states that in treatment, "understanding can be helpful but it is not a necessary requirement (for change)". In contrast, Griffies suggests that traditional psychodynamic theory would be skeptical of behavior change without insight . . . while behavior change might look different . . . children would still be prone to limitations of that level of psychic organization." Similarly, Griffies questions whether disequilibrium or a "behavioral shift alone might effect [sic] psychic organization," whereas Greenberg sees the fostering of disequilibrium or "the interruption of patterns and relationship positions" as "empowering further transition". At the heart of this debate is a basic epistemological difference between cognitive–behavioral and psychodynamic thought.

For the clinician and the family the simple question is often: What constitutes a measure or marker of the family "getting better"? It might be suggested that a cognitive–behavioral therapist and the mother in this case, have defined Drell's brief intervention as successful, yet we are struck by Griffies's concern for long term success. Who then decides the "success" of the treatment outcome?

As my colleagues, who are excellent seasoned clinicians, struggle with these questions, I am struck by Fuchs and Fishel-Ingram's focus on the training perspective presented in their discussion of this case. How do we, as teachers and supervisors, convey to our trainees, in a clear coherent way the complexities of different psychotherapies when these therapies have significant differences at their core? How do we juxtapose the goals of the therapeutic modality (insight vs. behavior change) with our trainees' understanding of whether or not their patient is "getting better" and concomitantly who actually makes this wellness determination? As we aspire to provide comprehensive, quality training experiences, the core competencies as delineated suggest a roadmap for our efforts, yet how many stops we make along the way and the amount of time and depth of our exploration at each of these stops is a tremendous responsibility, dictated by us as teachers. One of the most basic lessons that trainees need to learn goes beyond core competencies and the multitudes of evidenced based practices and is skillfully illustrated by Drell's approach to this case and that is that the relationship between the therapist and the patient or family sets the tone for the treatment regardless of the technical skills of the clinician.

Scott Griffies

This very good teaching case explicates many aspects of an integrative model of psychotherapy. Patricia Morse and George S. Greenberg explain

the merits of an interactive family system approach, and Catherine Fuchs and Pam Fishel-Ingram underscores the importance in teaching our residents flexibility of approaches depending on many clinical and motivational variables. Because I am an individual therapist, I focused on the mother's object relations and how this affects family psychodynamics and the psychic organization of the children. In all our approaches, we are together on the need to emotionally unstick this family and its members.

It appears that we also feel the need to first precede with a formulation that, as Greenberg points out, makes sense and puts order to the data obtained. Traditionally, the first section of a written formulation describes presenting problems, complaints, symptoms, and behaviors. The second section speaks to a conceptualization or explanation of the derivatives that are thought to precipitate, influence, and sustain the presenting problems. The last section focuses on how these behavioral/relational patterns will manifest in the treatment and therefore require strategies for change along with, I hope, a subsequent sense of accomplishment.

In our work toward achieving these common goals, there are many convergences. It appears from reading the other consultants' discussions of the case that all of us agree that stuckness or emotional impasses occur when people's perspectives are fixed in rigid ways that don't allow for new and different means of emotional expression and relational interactions. We are all working in a variety of ways to help patients gain perspectives that will allow for change.

Greenberg emphasizes the role of the family therapist as facilitating the family members' capacity to be "consultants to each other while promoting a collaborative change process." This function appears similar to the traditional psychodynamic therapist's goal of promoting an individual's capacity of an observing ego and self-analysis. It seems to me that in a successful family therapy, the family would not only gain a greater freedom of developmentally appropriate roles but would also develop some capacity to perform their own hypothesizing and "miracle questioning." That is, the family would develop a higher ordered level of self-reflection, which is a common goal in psychodynamic therapy.

Fuchs and Fishel-Ingram alluded to a central issue of where to go with the members of two families after the two sessions. It appears that the two sessions have benefited the family and initiated change, but will additional therapy be necessary to sustain change? Will the family's shift in roles lead to a new family system and collaborative process that will sustain them in the future, or is continued family therapy or a shift to individual therapy indicated? Ideally, some degree of follow-up would be most helpful in making this assessment, and determining whether more or other integrative therapeutic interventions might be indicated.

POSTSCRIPT

Martin Drell

> "Well, what do you know about that! These 40 years now, I've been speaking in prose without knowing it."—*The Bourgeois Gentleman,* Act 2, Scene 4, Moliere

Like Monsieur Jourdain in Moliere's "The Bourgeois Gentleman," I am amazed to find out from the discussants that I am a strategic family therapist who emphasizes interpretation and uses CBT approaches, that I am a collaborative case consultant who uses solution-based techniques, that I may be skillfully using transference cures and/or interventions to undo regression, and that I practice the basic tenets of the Milan School of Systemic Therapy. How is this to be explained? I suspect that this phenomenon can be explained in many ways. For one, it may be that I have been well trained in several modalities and that I have liberally stolen from all to create the therapeutic stew known as "Drell's therapy." My 35-year therapeutic journey began with psychodynamic training with an emphasis on object-relations theory. My interest in Winnicott and infant therapy led to a fascination with interactions (maternal–infant, paternal–infant) that led inexorably to an interest in parent and family/systems work, which in turn led me to study several different schools of family therapy (structural, Bowenian, CBT, strategic, and psychodynamic).

If I am indeed a mixture of all these techniques, then the discussants may be focusing on those forms they most like or are most comfortable with in their own and my work. Similarly, because of their own interests (should I be provocative and say biases?), they may think that a particular technique or set of techniques was responsible for the changes reported in this case history. For instance, Dr. Griffies points out that the changes in the family described might have been possible if my intervention "popped" the family out of a regression they had become stuck in.

It may, however, be that ultimately all the therapies described share similarities that are obscured by naming them different things. Does not getting people to change their behaviors lead to their thinking differently? Does not getting people to think differently change how they act? Are there not numerous ways to get people to act and think differently? Does not the simple act of individuals and therapists talking about what they are doing and what they wish to be doing change the way they think, feel, and act?

Over the years, I have tended to solve these intellectual issues by going "meta." This is easily done by becoming systemic and seeing the system as the proverbial multipoint elephant with parts that many people feel/think/act on.

I have been especially influenced by George Engel's systemically oriented biopsychosocial approach (Engel, 1980) that implies that problems and their solutions evolve from the systemic interactions of biological, psychologic, and social phenomena. Engel reminds us in his work that all parts of the system/elephant are worthy of study, are valuable unto themselves, and integrally and nonlinearly involved in the functioning of the whole. For better or worse, I have found system's thinking freeing in that it allows for multiple approaches to understand and intervene into systems. Of late, I have taken to the gross oversimplification of speaking of families with problems as systems that are stuck. I believe that the goal of therapy is to "unstick them" and that because of the nature of systems, there are many ways that this can be done. Different schools/techniques of therapy intervene at different levels of the system (through medications, individual therapy, couples therapy, family therapy, or biopsychosocial combinations of these) and by various means that seek to change how people think, act, or feel. Because of this, I attempt to teach myself and my trainees various forms of therapy. As I say: "When you go hunting, it's better to go with several different arrows in your therapeutic quiver rather than just one."

In analyzing what I actually do in therapy, I have realized that I do indeed use many techniques. I have a propensity to say to myself that I should start off with psychoeducation and behavioral approaches, followed by cognitive–behavioral, then strategic, and then psychodynamic approaches. In reality, it appears like I'm doing everything all at once. As a clinician and not a researcher, I feel I have an obligation more to relieve suffering (i.e., to unstick families) than to figure out which of my techniques are more effective. I look forward to further research, by others, on these important questions. Until that occurs, I will relish the thought that not only do I speak prose, but am a multifaceted therapist who uses all sorts of therapeutic techniques.

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Correction

In the September 2008 issue of the *Journal of Psychotherapy Integration,* a correction notice was printed with an incorrect DOI number (*Journal of Psychotherapy Integration*, 2008, Vol. 18, No. 3, p. 362). The DOI for this correction notice should have been the following: 10.1037/a0013563.

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