BEHIND THE ONE-WAY MIRROR
Advances in the Practice of Strategic Therapy
by Cloé Madanes

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Understanding and Changing Relationships

When a child says "My head hurts," he may be referring to more than one kind of pain. He* may be saying that his feelings are hurt or that his mother is suffering, or he may be asking for help with his homework. A symptom is a message and, as such, it may have a second referent different from the one explicitly stated. The second referent, the second meaning, may refer to someone other than the person expressing the message.

Metaphor in Families

Just as a message may have a second referent, so may a sequence of interaction. That is, a sequence of interaction between two people may be a metaphor for and take the place of a different sequence of interaction between two other people (Madanes, 1981b). As an example, a father comes home from work upset, worried, and anxious about his work because

*The author uses *he* for reasons of convenience and acknowledges the inequity of the traditional use of the masculine pronoun.

he is about to be fired. As his wife reassures him and comforts him, their son develops an asthma attack. The father then begins to comfort and reassure the son in the same way that the wife had been comforting and reassuring him. The interaction between father and son replaces and is a metaphor for the interaction between wife and husband. At the time that the father is reassuring the child, the wife cannot be reassuring the husband. One sequence has replaced the other.

The concept of metaphorical sequences leads logically to the idea that the variations in the focus of interaction in a family follow cycles. Sometimes, for example, a sequence will focus on the father's work difficulties, sometimes on the symptom of the child, sometimes on problems with an in-law or on money difficulties. But the sequence of interaction will remain the same. For instance, there might always be someone helpless involved, who exhibits involuntary behavior, and someone helpful, who fails to help. This sequence might appear in various ways in a family and involve various dyads, with each sequence representing metaphorically another sequence. This is quite different from thinking about the metaphor in a dream or in a symbol. A different order of concepts is involved when we talk about the metaphoric aspects of sequences of behavior.

This progression in thinking about metaphors is relevant in various ways to the way a family is approached in therapy. In a first interview, it is useful to discover the metaphor expressed by the presenting problem and by the interaction around the presenting problem. This is not just of theoretical or intellectual interest in understanding a family; it is a practical issue, because the strategy developed to solve the problem will be based on this understanding. When a family presents a problem, it is useful to think: If the problem is a metaphor for another behavior, for what does it stand? Who else in the family has a similar problem? What interaction is not possible because this interaction is taking place? To what interaction does this situation lead? What is the situation that is replacing another situation? To answer these questions, one must understand metaphors.

Planning Ahead

These ideas about metaphor in families led to a second concept: the idea of planning ahead (Madanes, 1981b). Even though this is a simple idea, it has only developed recently as a result of a change in focus from past causes of current behavior to anticipated consequences of that behavior. The sequence is this: a father comes home from work upset and worried that he might be fired. His wife tries to help him and reassure him. Their child develops a symptom, and the father pulls himself together and behaves like a competent parent, giving his child medication, comfort, and caring. At that point, he is no longer a man afraid of losing his job. He has become a concerned father and a mature adult in relation to his child.

Is it possible that the child has planned this behavior to help his father pull himself together? Could the child have developed a symptom to free the mother from having to try to help the father? Is it possible that the child could plan ahead in this way? The question is not merely theoretical. If a therapist can develop such an hypothesis when interviewing a family, he can begin to understand the child's plan. To understand this plan, it is best to focus on the helpfulness and protectiveness of the child. In what way is the child's plan helpful, and what is unfortunate about this mode of helpfulness? The child's plan to help the parents often creates a worse problem than the one the child is intending to solve. The unfortunate nature of this helpfulness is what must be changed. This helpfulness causes the power of the child over the parents to be exaggerated. The child exerts power and influence inappropriate to his situation as a child in the family. Through problem behavior, the child can change a parent from a helpless, upset person into a competent, helpful parent.

When the child's plan is known, the strategy for solving the problem becomes immediately apparent: to arrange for a new sequence of interaction by which the same end can be achieved without the symptom. Then the child need no longer exhibit the symptom. It is difficult to think that a child has the

intelligence to plan such a sequence. Yet, it is difficult to think that a child does *not* have that intelligence. Children are intelligent in ways that are more complex than that. It is rather simple, for example, for a child to anticipate how his father will respond to his behavior; curiously, however, it has taken quite a long time to develop the idea that children do plan ahead in these ways. The issue arises: If the child plans, is such planning done consciously? Is it deliberate? At times it is. Children have been known to explain how and why they plan symptomatic behavior. For example: "If I am sick, then my father will not drink that day," or "he will not go away," or "my mother will not go out with her girlfriend." But the question arises as to whether the child really plans or whether it is the father who elicits this kind of behavior from the child so that he can pull himself together and think of himself as a caring father rather than as a failing adult. Or does the mother elicit the behavior in the child so she can be free from having to support her husband in his difficulties? What is the truth is really not the question. The important consideration is what kind of punctuation of the events will best lead to designing a strategy for change. Some therapists prefer to think of the child as the initiator of sequences and some prefer to think of the parents. Probably all are involved, although this is not necessarily the case. The issue is what kind of thinking will help the therapist develop a strategy to solve the problem. It is important to remember that a therapist is only seeking a workable hypothesis, one that will help him to develop a plan to interfere with the unfortunate plan of the family or the child.

The task of identifying helpfulness is complex. A child, for example, behaves in symptomatic ways that are helpful to his parents. The parents focus on the child to help him overcome his problems. This helpfulness on the part of the parents perpetuates the function of the child's symptomatic behavior, and he becomes more helpless in a way that is helpful to the parents. The ways in which the child protects the parents make the child appear helpless because of his disturbed behavior, yet he is powerful as a helper to the family.

Hierarchy

A third concept regarding metaphorical sequences has to do with hierarchy. When problem behavior is metaphorical of other problem behavior, or when a sequence of interaction is metaphorical of another sequence, or when a child plans to be helpful to the parents in indirect ways, there is an incongruity in the hierarchical organization of the family. That is, when the child carries out a plan to help the parents in indirect ways with issues that are important to them, the child takes a position of leadership in the family; this is incongruous with the fact that the parents support the child, care for him, provide him with guidance, and so on. There is a dual hierarchy in the family: In one, the child is in charge; in the other, the parents are in charge of the child. The task of the therapist is to correct this hierarchy and reorganize the family so that the parents are in a superior position and help and support the child and the child does not take care of the parents in unfortunate ways. It is not sufficient for the therapist to come into the situation and correct the hierarchy in relation to himself, no matter how much authority he has over the child. The problem is in relation to the parents, not to the therapist, and the parents must correct the hierarchy. The therapist must create a situation in which this can take place.

Therapists have developed various ways of dealing with this dilemma, such as encouraging parents to ignore the problem behavior or having them pay attention to the child and reward him only when he does not exhibit the symptom. Behavior therapists have helped parents develop a set of contingencies that encourage and reward appropriate, nonsymptomatic behavior.

Reframing the problem and challenging both parents and child is one approach used by Minuchin in his work with the families of psychosomatic patients, particularly anorectics. "The therapist mobilizes the parents to treat their daughter as a rebellious adolescent, not as an incompetent, ineffective invalid" (Minuchin, Rosman, and Baker, 1978, p. 96). The anorec-

tic's symptoms are reframed as acts of power and manipulation. This approach supports the hierarchical organization of the family through therapeutic operations that "challenge" enmeshment and overprotection and support individuation and clear boundaries between the parental and child subsystems. The therapist also challenges conflict avoidance by these families, preventing cross-generational coalitions and supporting "the parents' right to establish rules in the house and the child's right to command respect for age-appropriate autonomy" (Minuchin, Rosman, and Baker, 1978, p. 105). In this approach, use of the child as a means to detour conflicts between the parents is challenged, and triangulation sequences in which the child repeatedly finds himself in situations in which he must choose between the parents are blocked.

Paradoxical techniques have been used to deal with the dilemma of the power struggle between parents and child. In these techniques, the parents are asked to request that the child actually try to have the symptom on purpose, so that the child, instead of involuntarily having the symptom and being supported and reassured by his parents, tries to voluntarily have the symptom at the request of the parents (Madanes, 1981b). The idea is that the more the child tries to have the symptom, the less likely he is to have it. The interaction between parents and child changes from a situation in which the child involuntarily has a symptom while the parents ineffectually attempt to prevent it to one in which the parents encourage the child to have the symptom and the child is unable to have it. Selvini Palazzoli, Cecchin, Prata, and Boscolo (1978) use a paradoxical approach in which the therapist defines the symptomatic behavior and the parents' helpfulness as positive and then requests that all family members continue to behave in their usual way, suggesting that this will best maintain the union of the family group.

A different approach to the problem of the child's symptom and of the power derived from the symptom is based on an integration of ideas about metaphor, planning ahead, and hierarchy. The approach is part of a strategic therapy focused on designing an intervention that will shift the family organization so that the presenting problem is no longer necessary. This is a

problem-solving approach in which a specific strategy is designed for each presenting problem. The two strategies presented here illustrate how to identify and understand both the metaphorical sequences of interaction and the helpful planning ahead involved in symptomatic behavior of children. In this approach, the therapist designs an intervention to raise the parents in the hierarchy so that they are helping and protecting the child and the child is not helping the parents in inappropriate ways. It is possible to use direct interventions in which the parents are overtly supported in a superior position. However, the examples presented here involve indirect interventions in which metaphors are used and the relationship between parents and child is redefined in playful ways.*

Pretending to be Nurses

It is not uncommon for parent and child to present the same symptomatic behavior. Correcting the hierarchy in such cases is particularly difficult, since the symptom equalizes the positions of parent and child. One approach to the therapy is to create an imaginary reality in which hierarchical differences are clear.

A pediatrician referred a mother and daughter to family therapy.** The daughter was ten years old and had been in and out of the hospital during the five years since she had been diagnosed as having juvenile diabetes. She had been hospitalized repeatedly for extreme weakness or diabetic coma. The pediatrician thought that if the child were properly cared for—her urine tested twice a day and her insulin shots given—the diabetes would be kept under control and the child could lead a normal life; she thought that the mother neglected the child even though the mother insisted that she did not and that she always

*The therapists in these cases were Rao Inaganti, M.D., and Linda Carter, Ph.D. The therapies were conducted at the Department of Psychiatry, University of Maryland Hospital, and the Family Therapy Institute of Washington, D.C.

**This case was described elsewhere (Madanes, 1981a) from a somewhat different perspective.

followed the doctor's instructions. The problem was further complicated by the fact that the mother was also diabetic and apparently had neglected to take care of herself—to the point that she had lost all her teeth, was losing her eyesight, and had a heart condition.

The Visiting Nurses Association had been unsuccessfully involved with the family in numerous contacts. The pediatrician had referred the case to a behavior modification program in a department of pediatrics, but the psychologist there had concluded that the child was not amenable to psychotherapy because she was too manipulative and used her diabetes to attract attention. The pediatrician, however, persisted in her attempts to help the child and referred the case to family therapy with the hope that the mother could be moved to take care of her child. The father had divorced the mother and had no contact with the child. The mother was on public assistance.

Even before the first interview, the supervisor was able to make certain assumptions about the case. It was clear that there was a great deal of antagonism between the mother and not only the pediatrician but probably all the physicians and nurses with whom she had come in contact during the previous five years. Probably the doctors and nurses had repeatedly, explicitly or implicitly, accused the mother of not following their instructions and had insisted that she do so, while the mother had repeatedly denied disobeying them and promised to follow their orders. However, she failed to do so. The issue presented to therapy was one that is always present in cases of neglect and abuse: how to raise parents in the hierarchy so that they will behave as competent, caring parents in relation to the child without putting them down by pointing out their shortcomings and telling them what to do. Attempts to tell a parent how to be responsible often only worsen the situation by putting the parent down even more. The issue was how the therapist would put the mother benevolently in charge of her daughter without exercising authority over her in a way that would prevent her from taking charge. The problem was how to put the mother in charge of the daughter when her reaction to being put in charge was to rebel against the authorities who were putting her in that

position—as is often the situation in cases of neglect. It was clear that, if the family therapy were to succeed, there should be no implication that the mother had been neglectful in the past and no accusations, and the mother would have to be moved indirectly toward competent parental behavior.

Apparently, over a period of five years, many competent, intelligent professionals had attempted to help this mother and daughter; it was reasonable to assume that every possible direct method of influence had been used. These methods probably included explanations of: the nature of the illness; the rules for good medical care; the part played by diet, rest, urine testing, and insulin shots; the need for maintaining daily charts and for regular medical checkups; and the use of positive reinforcement to motivate the child to cooperate with the regime. All this had been to no avail. There was no reason to assume that the therapy would succeed using direct methods of influence where so many intelligent people had been unsuccessful. Indirect methods, however, might succeed in influencing mother and daughter where direct attempts had previously failed. The supervisor instructed the therapist before the first session not to argue with the mother or antagonize her in any way, since it was thought that others who had done so had failed to influence her.

As the supervisor thought about the problem before the beginning of the therapy, the question arose: Is it possible that the child goes into diabetic coma and gets herself into the hospital to help her mother? What could be helpful to the mother about the child's hospitalizations? A ten-year-old girl can take care of her urine testing perfectly well and can even give herself shots if she is of normal intelligence, as this girl was, according to the psychological reports. Could it be that this girl was not taking care of herself in an attempt to help her mother? Ths supervisor noted that the referral came from a general hospital, not a children's hospital. It was possible that when the child was in the hospital and the mother visited her, or when the mother frequently had to take the child to the hospital, she would be inclined to take the opportunity to see her own physician in another department of the same hospital. This

seemed a possibility, and the supervisor decided to pursue this line of thinking. Perhaps the child did not take care of herself and was so frequently hospitalized because in that way she could put her mother in contact with doctors who might help her take better care of herself. That is, it was assumed that the mother avoided going to the doctor for her own health; however, if she had to take the child to the hospital or visit her there, she probably consulted about herself also. In this way, the child planned ahead to help her mother through symptomatic behavior that was a source of power over the mother and a metaphor for the mother's own helplessness and neglect of herself. However, this helpfulness by the child was self-destructive and dangerous. The problem was how to arrange for the daughter to protect the mother and get her to take care of herself without harming her own body to do so. The child's need to be helpful could not be avoided due to the chronic nature of the mother's illness, but a more direct, less costly helpfulness could be arranged.

The goal of the therapy was to solve the problem of the mother's neglect of her daughter. In terms of metaphor, the child's helplessness and incompetence in taking care of herself were thought to be a metaphor for the mother's helplessness and incompetence in caring for the child and for herself. In terms of planning ahead, the girl was thought to plan for the mother's medical care by putting her in contact with physicians through her own frequent illnesses and hospitalizations. In terms of hierarchy, the child exercised a tyranny over the mother through the helplessness of her precarious health, the emergency hospitalizations, and the humiliation suffered by the mother for being considered neglectful.

The therapy would take place in stages. First, the therapist would help move the mother toward behaving competently and helpfully toward the daughter so that in a later stage the child would behave in ways that would be metaphorical of the mother's competence and not of her helplessness. As the mother cared properly for the girl, her position in the family hierarchy would be raised. In the second stage, the therapist would arrange for the daughter to help the mother in appropriate di-

rect ways, without harming herself. In the third stage, a method would be established by which mother and daughter could alternately take care of each other, each without neglecting herself or the other person, and without the need to continue in therapy. This would be the general strategy of the therapy; the specific techniques that would be used to carry it out were not known. The plan was that the therapist would begin the first interview by talking with mother and daughter about the girl's diabetes and, while observing, the supervisor would devise specific techniques for carrying out the plan. It was necessary to wait for the family to provide a metaphor on which to base an indirect, playful strategy.

Mother and daughter came to the first interview. The daughter was a delicate, beautiful, angel-like, frail blonde. The mother was overweight, toothless, and wrinkled, and she looked at her daughter in awe, as if wondering how she could have produced such a lovely child. The therapist explained that the pediatrician had referred them because she was concerned that the child's diabetes was not under control, even though the child could be expected to lead a totally normal life if her urine were tested regularly and insulin shots were given. The mother said that she knew this and that the girl was certainly testing her own urine and taking the shots every day, although that morning she had not done so. The mother's tone and attitude were slightly belligerent, as if she were ready to argue with anyone who questioned the veracity of her statements.

The mother's account clearly was not exactly the truth, as otherwise there would have been no hospitalizations and no reason for the pediatrician's concern. The therapist, however, was prepared not to question the veracity of the mother's statement so that he could establish a cooperative rather than an antagonistic relationship with her.

As the therapist talked with the mother and daughter, the supervisor behind the one-way mirror observed the love with which the mother looked at the child. The mother was dressed as if her clothes had been donated by charity, while the daughter was expensively dressed. The supervisor thought of how this child was all that the mother had in life and of how afraid she

must be of losing the child's love. It was clear that this was not a mother who was neglectful because she did not love her daughter. On the contrary, it could be hypothesized that she loved her daughter so much that she was incapable of enforcing the basic rules that were necessary to control the diabetes. If the girl did not feel like taking an insulin shot, the mother probably did not force her to take it; if she did not want to give a urine sample, the urine probably went untested. In this way the mother did not risk the possibility of causing the child discomfort and pain and losing her love. As the supervisor was thinking about this, the mother said, with a touch of jealousy in her voice, that the child was more cooperative with the visiting nurse, for whom she would always produce a urine sample, than she was with the mother. This statement by the mother provided the metaphor that was the basis for the techniques that were developed to solve the problem.

The supervisor instructed the therapist to say that the girl had proven to be irresponsible in the past in testing her own urine, and, consequently, now the mother had to be in charge of testing the child's urine and giving her the shots. In fact, the mother should imagine that she was a nurse. The mother laughed at this, pleased, and said "Oh, yeah, you could see that, could you?" not without certain pride. This was a good sign: If the therapist managed to change the situation into one of make-believe, giving the mother an imaginary higher status as a nurse, the mother would respond by living up to the situation and behaving more competently. To this mother, who did not have a high school education, being a nurse was as high a status as she could possibly imagine.

The therapist then said, "You have to take care of this patient," pointing to the daughter, and proceeded to make a chart that the mother would keep of the daughter's progress. She would regularly show this chart to the therapist, who would be the doctor checking that the nurse did her job properly. The therapist continued, saying that from now on the mother would be not Mrs. Robins but Nurse Robins and the girl would be not the daughter but the patient. The girl would no longer be responsible for her own urine tests and shots. The mother would

be in charge. The therapist said, "Think of yourself as a nurse, not as a mother. A nurse sternly tells the patient, 'You have to do this,' and the patient does it, because the doctor told her so. Imagine that you are a nurse and fill out this chart like a nurse does." The mother agreed. From then on, the therapist, who was really a doctor, referred to himself as "the doctor," in the third person, the mother as "the nurse," and the daughter as "the patient." The chart was prepared to show the schedule by which the urine had been tested, the results of the testing, and the schedule and dosage in which the insulin shots were given.

The therapist added that, in fact, the mother was like a nurse in that she knew so much about diabetes because she had the same problem. Actually, what the mother needed was a nurse's uniform, and the therapist could provide that. The mother laughed and said that he would never find one big enough for her, but the therapist assured her that he would and excused himself from the room. He came back with the nurse's uniform and gave it to the mother, who was very pleased and immediately put it on, with the help of the little girl. The therapist said that every morning the mother should put on the uniform and become Nurse Robins. Whenever she was wearing the uniform she would no longer be a mother—she would be a nurse. She then would wake up the child and take her to the bathroom to check her urine. The therapist asked the mother to show him in a pretend way in the session how she would do this. The mother took the daughter's hand and walked across the room to a pretend bathroom and pretended to test the urine. When mother and daughter returned to their seats, the therapist asked the mother to note the results of the test on the chart so she could show the record to the doctor. Then he asked the mother to pretend that it was evening and to give the child the insulin. Mother and daughter did this with quite extraordinary realism. They again returned to their seats and the mother was asked to note the amount of insulin on the chart. Then the therapist asked the mother to hug and kiss the daughter because she had been a good girl. (It was important to do this because, when a hierarchy is incorrect in terms of authority and caring, it is also incorrect in terms of affect.) After this, mother and

daughter pretended that it was nighttime, and the urine was tested again. The mother then spontaneously kissed the daughter and wrote the results of the test on the chart.

Through all this pretending, mother and daughter were pleased and cheerful. The mother was very cooperative and not at all antagonistic, as she had been at the beginning of the interview. As a nurse, she was very compliant with the doctor's instructions. The therapist instructed the mother to bring the chart (which he had placed in a folder so that it looked like a doctor's record) to every interview so he could check it.

That was the end of the first session. Therapist and supervisor thought that with this intervention, the hierarchy had been corrected and the mother's status raised sufficiently so that she would competently take care of her daughter. However, something also needed to be done about the mother's neglect of her own illness and the child's need to help her mother. This intervention took place in the second interview.

Mother and daughter arrived at the second session a week later looking very nice, with their hair curled. The mother spontaneously showed the chart to the therapist and was pleased because the child's diabetes was under control. She had also brought the bottle of sticks to show the therapist what she used to test the urine. The therapist congratulated the mother, saying that she was a good nurse, and asked her to show him how she did her nursing at home. The mother put on the nurse's uniform, which she had brought, and the girl helped her tie it. Mother and daughter pretended in the same way they had in the first interview, but with even greater detail and drama. The therapist was appreciative and asked the mother to continue doing the same and to keep the charts not only to show him but also to show the pediatrician.

The first stage of the therapy had been successfully completed, in that the mother had moved from a helpless position to one of responsibility. It was now possible to arrange for the daughter to behave in ways metaphorical of the mother's competence rather than of her helplessness. The daughter could also now begin to help the mother in appropriate and not unfortunate ways. This was the second stage of the therapy.

The therapist asked the mother to take off the uniform because he wanted to talk with the mother, not with the nurse. He then asked her how frequently she went to the doctor for herself and whether she tested her own urine and took the insulin shots. The mother said that she had to go to the hospital every three months for herself, although she had to go more frequently for her daughter. She said that she did take the insulin shots regularly but did not test her urine because the sticks were too expensive and she could not afford them. The therapist explained how she could cut the sticks in half longitudinally so that both mother and daughter could use one stick. The therapist also promised that he would try to provide them with free sticks or with a less expensive method.

The girl was very interested in this conversation and volunteered information, explaining that the mother should be testing her urine. The therapist said that the child seemed very concerned and mother and daughter agreed, saying that the girl had even "told on" the mother to the doctor and the nurse at the hospital. This confirmed the hypothesis about the child's concern for and protectiveness of the mother.

The therapist then gave the child a little nurse's uniform and asked her to put it on so she could play a game in which she was a nurse to her mother. He asked the daughter to pretend to take the mother to the bathroom for the urine testing, just as the mother had pretended to take her. They did this, and then the child pretended to remind the mother and supervise her while she took the insulin shots. The daughter was asked to hug and kiss the mother because she had behaved properly. She then pretended it was nighttime and tested the mother's urine again. Throughout the procedure, the girl was delighted, and the mother attempted to instruct the daughter on how she, the child, was to take care of the mother. In this way, the mother made it clear that this was "pretend" and the daughter was not "really" in charge. This is a usual response to a reversal of the family hierarchy by a therapist. The parent reacts by taking charge and correcting the hierarchy. In this case, the mother's reaction was interesting in that it was similar to the paradox "I want you to dominate me," since the mother was instructing

the child on how the child should supervise the mother. The therapist ignored the mother's attempts to take charge and remained in the role of the doctor instructing the little nurse on how to take care of her patient.

The therapist prepared a folder that the daughter, as nurse, would keep on the mother's progress. The girl quickly understood how to keep the chart and was very pleased with what she was to do. The daughter could now be a metaphor for her mother by behaving as a caring nurse rather than as a helpless diabetic. The therapist asked both nurses to shake hands and to tell each other that they would do their jobs. The mother shook hands with the daughter and said: "Mommy will do our job." Although this was exactly what the therapist was after, he pretended not to hear and asked them to shake hands again while each said: "I promise that I will do my job." They promised to do so and shook hands.

In the next two sessions, mother and daughter reported that they had followed all the instructions, and they brought in their charts showing that their diabetes was under control. The therapist congratulated them and asked for a performance, and they were pleased to oblige. The girl, who had had some difficulties at school, was now doing much better and getting good grades, and the mother was participating in school activities. She had volunteered to help on the playground and in organizing a school picnic, was involved with other mothers, and was coming out of her isolation. The mother explained that they had gone to the hospital and shown the charts to the doctors and nurses, who were very pleased.

At this point, the end of the academic year was approaching, the training of the therapist was coming to an end and he was moving to a different job, and the supervisor was going away on vacation. The supervisor pondered what to do with this family. Even though they were doing well, ending the therapy appeared premature, given the long history of disturbance. To transfer to another therapist might mean that all that had been accomplished could be ruined. At this time also, from the medical point of view, a transfer to a new physician with whom the mother could have a fresh start could be beneficial. The therapist

discovered that there was a small clinic, mainly run by nurses, in the mother's neighborhood, to which the medical supervision of the child's diabetes could be transferred. He asked the mother whether she would be interested in transferring, and the mother said that it would be more convenient. It was thought then that it might be possible to arrange to transfer not just the medical but also the therapeutic aspect of the case to a nurse in this new clinic. The new nurse could be like the head nurse, with the mother and daughter under her, and she could visit them at home and make sure that they were taking care of each other.

With this plan in mind, a last appointment was set up, to which a nurse from the clinic was invited. The nurse was told only that she should come to the University of Maryland Hospital to arrange for the transfer of a case of juvenile diabetes. The problem was how to explain the procedure of pretending to be nurses to her so that she would be willing to assume responsibility for continuing with this strategy. In explaining the history of the case and the therapy plan, the therapist had to be careful not to make the nurse feel that she was not qualified to take over such a difficult case with a psychotherapy component that she was not trained to handle; perhaps if the nurse were introduced directly to the mother and the daughter, without being given any previous information or preparation, and witnessed their performances as nurses to each other, she would be emotionally moved and willing to take responsibility and play the part of the head nurse. The interview was conducted on that basis.

Mother and daughter had brought their charts and showed how both their conditions were under control. The therapist explained the charts to the nurse who would supervise them from then on. He asked mother and daughter to do both of their pretend dramatizations for the nurse to see, since she also would check regularly to see that each was nurse to the other. Mother and daughter put on a nice performance for the nurse. The daughter then said that she had an opportunity to go to camp for a few weeks but was reluctant to go because she was concerned that she would not be nurse to her mother dur-

ing that time. The therapist asked the nurse to promise the child that she would check on the mother three times a week while the daughter was gone and keep the chart for her. The nurse promised, and the child was reassured.

The therapist said that he would check regularly with the nurse to see that mother and daughter were all right and that he also would keep in touch with the family.

To summarize, at the beginning of therapy, the child's weakness and diabetic coma were expressing her unhappiness and her mother's unhappiness. They were a report on her internal feelings, as well as a command to the mother to take care of herself. The daughter neglected herself and became ill in a way that was metaphorical of the way the mother did not take care of her own illness or of the daughter. The pediatrician's complaints to the mother about her neglect of her child were metaphoric of the child's complaints to doctors and nurses about the mother's neglect of herself. The child's plan was to arrange, by being ill and hospitalized, that the mother would be in contact with doctors who might help her with her own illness. The daughter was helpless because of her illness, yet she was powerful as a helper to her mother. This helpfulness, however, was costly to herself and created a worse problem than the one it was intended to solve.

The strategy developed to solve the problem consisted of eliciting competent, caring behavior from the mother by giving her status and power in a make-believe way, which led to the mother taking charge of the child's diabetes in a real way. The mother was moved from a helpless position to one of responsibility. The child's need to help her mother was accepted, and she was provided with a playful but appropriate way to help the mother. When pretending to be a nurse, the child was behaving in ways that were metaphorical of the mother's competence and not of her helplessness.

In terms of the three concepts presented earlier in this chapter, at the beginning of the therapy the daughter was behaving in helpless and incompetent ways that were a metaphor for the mother's helplessness and incompetence. At the end of the therapy, the daughter was behaving in helpful and competent ways that were metaphorical of the mother's helpfulness and competence. At the beginning of the therapy, the daughter had a plan to help the mother by damaging her own body so that the mother might come into contact with physicians who could help her. By the end of the therapy, the daughter had an appropriate, successful plan to help her mother by pretending to be her nurse. In terms of hierarchy, at the beginning of the therapy the daughter was unpredictably in charge of the mother through crises and emergency visits to the hospital. By the end of the therapy, the daughter was in control of the mother only in a limited and predictable situation—when she wore the nurse's uniform.

From the point of view of the mother, at the beginning of the therapy she was behaving in a helpless and incompetent way. By the end of the therapy, she was helpful and competent, and she allowed the girl to be helpful to her. As she gained confidence in herself as a nurse to her daughter, she began to be caring and responsible in other areas of the girl's life.

For two years, mother and daughter were well and there were no hospitalizations. In the third year, the mother was hospitalized for heart failure, and shortly after that the daughter was also hospitalized in relation to her diabetes. By chance, the supervisor learned that a pediatrician was pressing charges against the mother for neglect and had arranged to give the child into foster care to a nurse who was caring for her in the hospital. The supervisor telephoned the pediatrician and asked her to withdraw the charges and to give her the opportunity to work once more with the family. Even though supervisor and pediatrician both worked out of the same university hospital, and even though it was explained that separating the child from the mother would only make it more difficult to control the diabetes, since the stress and sorrow would be unbearable to both, the pediatrician refused to withdraw the charges. The supervisor contacted mother and daughter and promised to help them. The ladies of the church to which the mother belonged hired a lawyer to defend her. On the day of the court hearing, an agreement was reached out of court, after much struggle. The supervisor would be given the opportunity to work with

the family for four months while the child lived with her mother. Then there would be another hearing to determine whether or not she would be placed in foster care. The medical care would be provided by the same pediatrician who was pressing charges against the mother. It was impossible to reach a better agreement with the representative of the Department of Social Services, even though it was explained that, were the child to be placed in foster care, she would probably go into diabetic crisis to prove that the foster mother was not better than her own mother, and even though it was emphasized that a diabetic should not be stressed with threats of separation.

The problem for therapy now was how to protect mother and daughter from the attempts of professional helpers (pediatrician, nurses, and social workers) to violate their human rights and their rights as a family. The supervisor proposed to mother and daughter that the problem for therapy was now the child's fear of doctors due to her bad experience with the pediatrician who was trying to take her away from her mother. They agreed that this was the problem and cheerfully accepted the suggestion that they should be transferred to a more kindly pediatrician, who would provide a corrective experience in contrast to the previous trauma. The author contacted the Department of Social Services and explained that the child's emotional problem was now a fear of doctors and that this fear was extremely dangerous in the case of a chronic diabetic who would always need to be under doctors' care. The author also pointed out that it is a child's and mother's right to choose a pediatrician that they like. The social worker agreed and said that, as long as the new pediatrician was reputable, Social Services would accept the change, since families do have the right to choose their physician. A transfer was arranged to a more benevolent pediatrician, who gave strict control and supervision of the child to the mother. As this book goes to press, mother and daughter are well and trustful of the new doctor. The Department of Social Services has agreed to close the case if the new pediatrician reports in three months that the child is well taken care of. Only then will mother and daughter be relieved from the threat of separation and loss to which they were so unfairly subjected.

The Suicidal Sisters

Sometimes a child's problem behavior expresses metaphorically the problem of a parent and helps the parents by shifting the family's focus of concern from a parent to the child. In this situation, the parents covertly ask for the child's help and the child covertly helps the parents through symptomatic behavior.

When a child protects the parents through symptomatic behavior, he is helping them in a covert way. An approach to therapy is to encourage the parents to *pretend* to need the child's help and protection, rather than to actually need it. The child then can be encouraged to pretend to help the parents when the parents are pretending to need his help. The child will no longer need to behave in symptomatic ways in order to protect the parents, since the parents' need for help will be a pretense and so will the child's helpfulness. In a pretend framework, parents and child will be involved with each other in a playful way.

A mother consulted because her fifteen-year-old daughter, Amy, wanted to do "bodily harm to people" and her sixteen-year-old daughter, Beth, could not sleep at night. In the first interview, the therapist discovered that Amy had been scratching her wrists for some time, making superficial cuts with knives, bobby pins, paper clips, staples, and so on. Beth had previously written suicide notes. There were five daughters in the family between the ages of twelve and nineteen and one nine-year-old son. The father was a working man who was also going to college. The mother told the therapist on the phone that the father was too busy for and would be unwilling to come to therapy, but when the therapist called him he said he certainly would come and subsequently always came to the sessions. The mother worked a night shift as a nurse to pay debts that she had incurred for the family. She was always exhausted, because she also did all the housework with no help from the children. The mother was very young and attractive, as were the daughters, and they looked and behaved like sisters.

A supervisor other than the author was involved with the

case during the first five months of therapy. Several direct interventions were used during this time. The first was to organize a twenty-four-hour suicide watch for Amy that involved all family members, who took turns watching her constantly. The strategy was to dramatize the seriousness of the problem, since the family seemed to minimize the seriousness of the suicide attempts. In one or two weeks the problem with Amy appeared to be solved.

The focus of the therapy then shifted to schedules and household responsibilities, since the mother was obviously overburdened. The father was seen as uninvolved, angry, and excluded from a collusion among the women in the family. The girls did nothing around the house, and the mother preferred exhaustion to going after the girls to do some chores. The father was put in charge of organizing the children with charts of chores they were to do. This went well for a few weeks, and then they slipped back to the previous disorganization.

An appointment was made to see the parents alone to resolve whatever issues were preventing them from organizing the household. However, this meeting had to be postponed because Beth said she needed help because she was an alcoholic, although she had recently stopped drinking, and she was having problems in school. When this problem subsided, Amy said she was moving out with her boyfriend. Then Beth had temper tantrums. The two girls took turns bringing up a problem every time the therapist wanted to approach the parents' marriage.

The mother talked about how tired she was of everything and how she felt like taking off and leaving the family. Apparently, she resented an affair that the husband had had at the beginning of the marriage. The mother was going out to bars with an unmarried sister, and she was having thoughts about affairs. When she talked about leaving the family, the father responded impersonally, saying that she was too responsible to leave. The mother said that she no longer had any feelings for him and was thinking of leaving him in April. Several attempts to improve the marriage were made, but to no avail. Every directive given by the therapist was followed by the couple in a way that disqualified the therapist. For example, when asked to go out to

dinner together, they went to McDonald's. When the father was asked to give the mother a gift, he gave her a cranberry dish.

In the fifth month of therapy, the family said that things had improved and they no longer felt the need to come to the sessions. Shortly afterward, the mother called the therapist and said that she had had a physical examination and was very frightened because there were signs of cancer. This turned out to be a false alarm, but a few days later she brought Amy to a session because once more she had cut her arms with a knife. The mother was vague about this episode, as she had been about most others, and it was an older sister, Meg, who had taken care of Amy and called the ambulance. The cuts were not life threatening, but Amy's behavior was bizarre. She acted as though this was something cute and mischievous that she had done. The next week Beth took an overdose of Midol and beer. She called the ambulance herself before losing consciousness and was admitted into a medical hospital, where she stayed for two weeks.

At this point, therapist and supervisor consulted the author to see if a paradoxical pretending technique could be used to solve the problem of Beth and Amy's recurrent self-destructive behavior. The author asked the therapist the following question: If one were to assume that the suicidal girls were protective of one of the parents, which parent would it be? Which parent were the girls most concerned about? The therapist answered that the girls were concerned about the mother, since the mother was tired, overworked, and unhappy in her marriage, even though she was much more attractive than the father. The author proposed that an appropriate intervention might be to have the mother pretend to be exhausted and miserable in the session and have the daughters pretend to reassure and comfort her. At home, in the evening, the mother would do the same thing and would try to deceive the girls so that they would not know whether she was pretending or really feeling that way. The girls would reassure and comfort the mother to make her feel better. In this way, the mother would be overtly asking for help and the girls would be overtly helping her. The girls would be able to help their mother in a more appropriate and playful way than by attempting suicide. The mother would

be overtly put down in the hierarchy in relation to the daughters, and she would react against this situation by taking charge with appropriate motherly behavior—thus correcting the hierarchy. The hypotheses were that: the girls were a metaphor for the mother's depression and despair; the girls' plan was to help the mother by eliciting her concern for their suicidal behavior and getting her to focus on her situation as mother rather than as dejected, unhappy wife; and the helpfulness of the girls toward the mother resulted in a hierarchical reversal so that, in fact, the mother could not effectively help the daughters.

The supervisor in the case decided that it would be best to start the session with a review by the therapist of all the problems the family had brought to therapy and of everything that had been done during the therapy to solve those problems. If, in the discussion, the issue of the daughters' concern for the mother came up, the author would be called in behind the one-way mirror to supervise the pretending intervention and would continue to supervise the case from then on.

The parents and four daughters (one was away at college) were present at the session that began with the review the therapist had planned. Then the father was asked to read a suicide note by Beth that the mother had brought to the session. In the note, Beth said that her mother was "working her ass off to pay the fucking bills" and was "unhappy all the time" and that she, Beth, "worked my ass off in school to make only one person happy and that's my mother." When the father finished reading the note, the mother was teary, and Beth and Amy hid their faces under their hair. The therapist talked with them about the girls' concern for their mother. It was decided that there was enough evidence for this preoccupation, and the author was called in behind the one-way mirror to supervise. The pretending intervention began with the therapist asking the mother to pretend to be very tired and depressed, as she usually was at home, and for the rest of the family to watch to see if she did it well. At this request, Beth and Amy came out from under their hair for the first time in the interview and looked at the therapist and the mother with interest. The mother said it was difficult to pretend while sitting on a chair instead of lying

down, so the therapist suggested that she could lie down on the floor and all the others could join her by also moving from their chairs to the floor. They did this with considerable giggling, and the mother lay on her side on the carpet, faintly muttering that she was tired. When asked if the mother's pretending was realistic, the father said that it was and that sometimes she would lie on the couch and sometimes on the bed. The older daughter Meg said that the mother usually covered herself with an afghan, and the therapist asked Amy to give her mother her jacket to use as a pretend afghan. The therapist encouraged the mother to pretend more realistically by saying that she felt like a little baby who was tired of all these children and all these responsibilities and that she just wanted to cuddle up and do nothing. In fact, these words described the way in which the mother often presented herself.

After a few minutes of pretending by the mother, the girls were asked to approach her and comfort and reassure her. Meg and Jo quickly sat next to her, patted her on the back, and asked her if there was anything she needed; but Beth and Amy remained shy and distant, despite numerous attempts by the therapist to encourage them to approach their mother in a helpful way. Finally, Beth went over to her and playfully said, "Get up, Mom. I have to sell the couch," and sat across the mother's legs. Then Amy got up, offered the mother some tea, and aimlessly wandered around the room pretending to get her a cup. The therapist suggested that all the girls should embrace and kiss the mother because she needed a great deal of love and caring. The girls embraced her affectionately, with Beth and Amy again being the last to do so.

While all this pretending and hugging was going on among the women in the family, the father had moved to a chair in the corner of the room and was sitting hunched over, with his head in his hand, a picture of total dejection. The author, supervising from behind the mirror, became concerned about his depressed attitude. This concern led to the thought that if the supervisor could be so worried, how much more worried his own daughters must be about seeing him in this dejected mood. Perhaps the intervention was wrong and the par-

ent that the daughters were trying to help in devious and self-destructive ways was the father and not the mother. In fact, the girls' suicide attempts had the quality of the despondent gestures of an abandoned lover. Furthermore, what the suicide attempts accomplished was that the mother could not leave the father while they were trying to save the lives of their daughters —and this was April, the month in which the mother had said she would leave. The girls were helping the father by keeping his wife with him. But this helpfulness incapacitated the father and prevented him from being either a father to the girls or a husband to the wife.

Acting on this hypothesis, the therapist was instructed first to finish the previous directive by asking the father to also embrace and comfort the wife, then to shift the focus to the father and ask *him* now to pretend to be depressed and miserable. The father knelt on the floor and embraced his wife tenderly; the mother hugged him back and appeared pleased. The therapist asked the father to sit down and pretend that he was depressed and overwhelmed with financial problems, ashamed that his wife had to work, and very worried about the troubles that his daughters were giving him. The father said that that would take no pretending. In fact, the father had used these very words in the past to describe his situation. He proceeded to pretend by sitting in the chair for a few minutes looking dejected, just as he had looked for most of the session. Then the girls were asked to comfort the father. They all jumped up immediately and stood in line to hug him and kiss him, Beth and Amy equally or perhaps even more eagerly than the other two sisters. The therapist asked the father whether he would like to have the girls do this a second time; he said yes, and the girls jumped up once more with great enthusiasm. The reaction from the girls indicated that the hypothesis probably was correct and that the girls were very interested in helping the father. The girls' cooperation with the directive to pretend to comfort the father was an indication that the metaphor had been understood and the therapy was on the right track. In contrast, they had been extremely reluctant to pretend to comfort the mother. If the children refuse to participate in a pretending tech-

nique, the therapist has probably made a mistake and misunderstood the metaphor in the children's symptomatic behavior. In this case, the girls also were probably reluctant to comfort the mother because, if they were attempting suicide to keep her at home, they had to feel resentful toward the mother for requiring from them such extreme, destructive behavior.

The mother was then asked to approach the husband and embrace him. She responded as if she had to go out of her way to establish in front of everyone that she had a special position as the wife and that the husband belonged to her. She slowly strutted toward him, sat on his lap, and talked about their quiet moments in the kitchen while she hugged and kissed him.

The therapist instructed the parents to each perform this pretending at home several times every evening that week, just as they had done in the session, emphasizing that sometimes they would really be feeling tired and depressed and at other times they would be just pretending, but they would do it in such a way that the girls would not know when they were pretending. The girls would comfort each parent in the same ways as they had in the session, and they would also each plan a small surprise for each parent that week.

The next interview was held one week later. The family lived an hour and a half away, and when the mother was getting ready to leave for the session with three of the daughters, she discovered that her car would not start. The father was on the other side of town with Amy and the nine-year-old son, whom he was bringing to the session. There was no time for the father to pick up the rest of the family, so he came alone with the two children. He looked happy and optimistic and reported that, even though there had been no pretending, everybody in the family had hugged and kissed each other very frequently that week and the whole atmosphere of the house had changed. The girls had gone out of their way to be nice to each other, to their brother, and to the parents. Beth, whose suicide note had been read in the previous session, had left another note for the father, apologizing for having difficulty in being affectionate to the parents as had been required in the session. The father had spoken with her and told her that it was not her fault but his,

because he had never given any of the children the kind of affection that a child needs in its early years. This was the first time the therapist had heard that the father felt guilty and neglectful, but she did not comment on his statement. This kind of insight often follows rapid change in therapy, and it is best to accept it respectfully and move on. The father said that from now on he would change and devote himself 100 percent to taking care of his family.

The therapist told the father that the same directive about pretending would carry over for the next week since half the family was not present, and she asked him to explain the instructions to his son, who had not been at the previous session. The father carefully explained the instructions without omitting anything. He then pretended once more to be depressed, and Amy and the boy comforted him. In this way they would remember what to do at home.

Amy reported that the girls had solved one other serious problem at home. The family had only one bathroom, and all four girls needed to wash their hair every morning before going to school or they would refuse to go. The only hair dryer the family owned was in the one bathroom, so every morning a battle for the bathroom took place. The girls had solved the problem that week by organizing a shifting schedule in which they would take turns using the bathroom starting at six o'clock in the morning. This solution had made for a better feeling between the sisters.

The session ended with the therapist congratulating the father for the changes he had brought about in his family. The father was pleased and said that he now knew what he had to do and would do it. He would devote himself "100 percent full time to his family."

Therapist and supervisor planned that the next session would be the last. Once the father had expressed that he would solve the problem, the therapist had to give him the chance to do so and let him go. His confidence indicated that the girls no longer needed to protect him, and it would have been an error to undermine this confidence in any way.

The next session was a week later, and the whole family

was present. Everybody was happy. There had been no pretending, but the children had done little things for the parents, such as giving them breakfast in bed, tea, hugs, and surprises. They were all getting along well. The therapist congratulated both parents and asked them how they could ensure the continuity of change. The father answered that he would do so by demonstrating affection to the children and spending time with them and that the children needed to continue being affectionate to each other and to the mother. That day was the parents' wedding anniversary, and the therapist took the opportunity to bring them closer together. Each was asked to express his or her love to the other, which they did, and they kissed romantically, to the giggles and applause of all the children.

A follow-up a year later showed that all was well with the family; the father had remodeled the house and was very proud of his wife and daughters. A second follow-up three years later showed that the girls were still symptom free and the parents were together.

To summarize the case, the girls' suicide attempts were expressing their own despair and that of the father. The command aspect of the self-destructive behavior was to order the mother to take care of them and not to leave them and, therefore, not to leave the father. The daughters' request for the mother's caring presence was conveyed through self-destructive behavior and was a metaphor for the father's need for the mother. Because the parents' attention was focused on the girls, the father had never had to overtly express his wish for the mother not to leave him: the girls expressed it for him. The girls' plan was to prevent the mother from leaving, since she was needed to take care of two suicidal daughters. This helpfulness toward the father, however, created a worse problem than it was intended to solve, preventing the parents from coming together in joy and with a focus on their own relationship rather than on the girls. The daughters appeared helpless because of their suicidal behavior, yet they were powerful as unfortunate helpers to the parents.

The therapeutic strategy was to arrange for each parent to overtly appear helpless by pretending depression rather than

covertly requesting help as they had been doing. The daughters would overtly help them by demonstrating affection rather than by behaving suicidally. Both parents then could spontaneously imitate the daughters' behavior and demonstrate affection toward each other. The father reacted against being in an inferior position when he pretended depression and helplessness. He took charge of the girls in appropriate, caring, paternal ways, and the hierarchy in the family was corrected not only in terms of authority but also in terms of affect. Without the girls' interference, the parents could resolve their difficulties with each other in their own ways and come together in good feeling.