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Communication: Sequence and Hierarchy

Research investigators require complex theories; clinicians need simple ones. The researcher must account for and reflect on innumerable variables. The clinician must choose key variables and act. The situation is incredibly complex when several persons deal with one another in organized ways. Researchers who examine slow-motion films to study body movement, linguistics for vocal intonations, and semantics for the meaning of the verbal content find themselves in a world with an almost infinite number of variables. Fortunately, clinicians are more free to simplify; the problem is to choose the important variables most relevant to change.

Power and Organization

When one is observing people who have a history and a future together, one sees that they follow organized ways of behaving with one another. If there is any generalization that applies to humans and other animals, it is that all creatures capable of learning are compelled to organize. To be organized means to follow patterned, redundant ways of behaving and to exist in a hierarchy. Creatures that organize together form a status, or power, ladder in which each creature has a place in

the hierarchy, with those above and those below. Although groups will have more than one hierarchy because of different functions, the existence of hierarchy is inevitable because it is in the nature of organization that it be hierarchical. We may dream of a society in which all creatures are equal, but on this earth there are status and precedence and inequality among all creatures. In many societies, one does not even speak the same dialect to a superior as to an inferior, and everywhere the messages that creatures interchange in their repeating ways are messages that define positions in organizational hierarchies. If a group attempts to organize on the basis of equal status among the members, some members become more equal than others as organization develops.*

Before proceeding further with a discussion of hierarchy, it might be best to clear up a misunderstanding that can occur when power and hierarchy are discussed. Although one must accept the *existence* of hierarchy, that does not mean one needs to accept a *particular* structure or a particular family hierarchy. One need not accept the status quo either in the economic structure of society or in a particular unfortunate hierarchy. Everywhere there are hierarchical arrangements that are unjust. One economic class suppresses another. Women are kept in a subordinate position in both family and work groups merely because they are female. People are placed in subordinate positions because of race or religion. Children are oppressed by their parents, in the sense of being restricted and exploited in extreme ways. Obviously, there are many wrongs that need righting that

*A possible objection to the concept of hierarchy is that there are alternative ways to describe an organization. The "pecking order" we observe may be a product of our thinking, not of the nature of organization. For example, when horses enter a barn, we note that they assume a certain order and maintain it each time they enter the barn. We may not describe this pattern in terms of one creature being superior and one secondary. What we observe is a pattern in which the animals behave in a sequential order. The description scheme we choose will depend on our purpose in making the description. If our focus is on how to change a malfunctioning organization, then a description should clarify how organizations malfunction and offer ideas about how to produce change. The concept of hierarchy, or levels of status and power, seems most appropriate as a description for therapeutic purposes.

involve hierarchical issues, and any therapist must think through his or her ethical position.

It is crucial that a therapist not confuse the existence of an unjust hierarchy with a strategy for changing it. If one sees a child being oppressed in a family, that does not necessarily mean one should join that child against the parents to "save" her. The result could be an unhappier child as well as unhappier and more restrictive parents. By attacking the parents directly, the therapist may feel morally justified, but the goal of therapy is not the moral justification of the therapist and it is usually the child who pays for such an attack. To attack parents merely because they are the authorities and part of the establishment is naive and can easily lead to the failure of therapy.

Not only do all higher animals form hierarchical organizations, but it is important to note also that the hierarchy is maintained by *all* the participants. Those of higher status enforce their status by their actions, but those of lower status will act to enforce hierarchy if a higher-status creature does not enforce its status. When animals or humans step out of order, the reestablishment of hierarchy is a group effort, with those below as active as those above. (The cooperative behavior of those below has often aroused the despair of revolutionists.)

A family as a hierarchy includes people of different generations, of different incomes, and of different degrees of intelligence and skills. These complex hierarchical lines are related to the many functions of a family. The most elementary hierarchy involves the generation line. Within the family there are intricate involvements of uncles, aunts, cousins, and others in the kinship system. But at the most simple level it is parents who nurture and discipline children, who in turn nurture and discipline children as the generations proceed over time. At any one moment there are, at most, four generations operating. Most commonly there are three: grandparents, parents, and children. These three generations can be simplified into three levels of power, or status. In the traditional family, as still is evident in Asia, the greatest status and power resided with the grandparents; the parents were secondary and the children lowest in status. In the Western world, particularly in this time of rapid

social change, the status and power position of the grandparents is less. In the nuclear family living arrangement, the power often resides with the parents, and the grandparents are moved to an advisory, if not superfluous position. Professional experts tend to replace the grandparents as authorities.

Yet whatever the arrangement, every family must deal with the issue of organizing in a hierarchy, and rules must be worked out about who is primary in status and power and who is secondary. When an individual shows symptoms, the organization has a hierarchical arrangement that is confused. It may be confused by being ambiguous so that no one quite knows who is his or her peer and who is a superior. It may also be confused because a member at one level of the hierarchy consistently forms a coalition against a peer with a member at another level, thus violating the basic rules of organization.

When the status positions in a hierarchy are confused, or unclear, there will be a struggle that an observer would characterize as a power struggle. An observer who has a theory of innate aggression or of a need for power may say the participants are satisfying an inner drive by struggling for power. Yet it would seem more useful to characterize such a struggle as an effort to clarify, or work out, the positions in the hierarchy of an organization. When a child has temper tantrums and refuses to do what his mother says, the situation can be described as an unclear hierarchy. In such a case the mother is often indicating that she is in charge while treating her child as a peer, and so the hierarchy is confused. There are various explanations of why a mother would behave in this contradictory way. It is possible to say there is something wrong with the mother's thinking if she offers conflicting messages. For example, if she asks her child how to discipline him, she is taking charge by putting the child in charge. If one thinks in a larger unit than mother and child, it is possible to note that the child is in coalition with some powerful person in the family, such as a father or grandmother, and so the child has more power than the mother. The mother is in charge by the fact of being a parent, but she must ask the child's permission to discipline him because of his power. The inclusion of a wider interpersonal context offers new explanations of why people do what they do.

If there is a fundamental rule of social organization, it is that an organization is in trouble when coalitions occur across levels of a hierarchy, particularly when these coalitions are secret. When an employer plays favorites among her employees, she is forming coalitions across power lines and joining one employee against another. Similarly, if an employee goes over the head of his immediate superior to a higher authority and joins that authority against the superior, there is difficulty. If a manager sides with an employee against a foreman in the middle, trouble will occur. When such a coalition happens occasionally, it is a minor matter. But when sequences of this kind become organized so that they repeat and repeat, the organization is in trouble and the participants will experience subjective distress.

Since therapy includes the art of keeping the kind of relationship ambiguous, it is not surprising that power struggles often appear in a therapy context. For example, when a therapist defines himself as an expert by taking money for his assistance and then declines to be an expert and even asks the patient what he feels should be done, the hierarchy is confused. The patient will try to clarify the relationship. An observer might call the resulting action a "working through" of resistance, but it can also be seen as an organizational problem. To say that a therapist and patient struggle for control in therapy does not imply that they have a "need" for control but that the relationship is ambiguous because of the nature of the therapeutic process.

Sequences

One of the ways we can map out a hierarchy is by observing the sequences that occur in an organization. If we see that Mr. Smith tells Mr. Jones to do something and Mr. Jones does it, that may be an isolated act. If the act occurs again and again, we deduce that Mr. Smith is higher in the hierarchy than Mr. Jones. A structure is composed of repeating acts among people. What has revolutionized the field of therapy is the realization that a goal of therapy is to change the sequences that occur among people in an organized group. When that sequence changes, the individuals in the group undergo change.

A therapeutic change can be defined as a change in the repeating acts of a self-regulating system—preferably a change into a system of greater diversity. It is the rigid, repetitive sequence of a narrow range that defines pathology.

People seem to have a difficulty, in fact a reluctance, to observe and describe repeating patterns in a chain of three or more events. This difficulty is particularly great if we ourselves are involved in those events. For example, a therapist may notice that a wife repeatedly provokes him. Perhaps he will even recognize a sequence of two actions by noticing that she provokes him after he has criticized her husband. Yet, it seems more difficult to notice that the child was rude, the father disciplined the child, the therapist reacted against the father, and then the therapist was provoked by the wife. Our cognitive attention spans seem to have difficulty with such sequences. In fact, it is possible, as Braulio Montalvo has suggested, that we have built into ourselves necessary amnesias for overlooking parts of sequences. It is when we record interactions on videotape that we observe sequences for the first time and think about them in new ways.*

Let me give an example of a way to think about sequences as they have been thought about within the developing child guidance movement. There were progressive stages: first it was assumed that the problem was a child who had something wrong with him. It was hypothesized that he was responding to past experiences that had been interiorized.

Later, the mother was emphasized and it was said the child had a problem of the relationship with his mother. For example, it was said she was helpless and incompetent and the child was adapting to that behavior. To explain why the mother was that way, it was hypothesized that she was responding partly to past experiences and partly to the child.

Later yet, the father was discovered. It was suggested that the mother's behavior was explained by her relationship to the

*This idea about the function of amnesia was first suggested to me in a personal communication and is expressed in a videofilm of a therapy session edited by Montalvo: "Constructing a Workable Reality."

father. For example, if the mother behaved competently with the child, the father withdrew from the family; but if she was helpless and incompetent, he was involved. It was also hypothesized that her ineffectiveness with the child was a way of supporting the father when he was under stress and depressed. If the mother was helpless, the father would pull himself together to help her deal with the child.

Finally, it began to be recognized that a system was involved, and all participants behaved in a way to keep the sequence going. The father's state of mind was a product of his relationship with mother and child, who were also as they were because of sequences established with him and with each other.

To clarify a sequence further, a simple description can be made of a repeating cycle. The sequence can be absurdly simplified to three persons, each capable of two "states." There are father, mother, and child, and each of them can be either competent or incompetent (the child can be said to behave or misbehave). Since the sequence repeats in a circle, there is a series of steps each leading to the next and so back to the beginning again. One can start such a description at any point in the circle.

Step 1. *Father—incompetent.* The father behaves in an upset or depressed way, not functioning to his capacity.

Step 2. *Child—misbehaving.* The child begins to get out of control or express symptoms.

Step 3. *Mother—incompetent.* The mother ineffectually tries to deal with the child and cannot, and the father becomes involved.

Step 4. *Father—competent.* The father deals with the child effectively and recovers from his state of incompetency.

Step 5. *Child—behaving.* The child regains his composure and behaves properly or is defined as normal.

Step 6. *Mother—competent.* The mother becomes more capable and deals with the child and father in a more competent way, expecting more from them.

Step 1. *Father—incompetent.* The father behaves in an upset or depressed way, not functioning to his capacity, and the cycle begins again.

The therapeutic task is to change the sequence by intervening in such a way that it cannot continue. Making family members "aware" of the sequence by pointing it out to them does not change it and can raise resistance, causing failure. It would also appear that changing any *one* of the steps, or the behavior of any one of the three persons, is usually not sufficient to bring about change in the sequence. At least two behaviors must be changed.

A way to think about a sequence of this kind is to see it as an example of a malfunctioning hierarchy. Mother and father are not relating as peers with each other in an executive capacity. Their difficulties with each other, including the ways they protect each other, prevent them from defining a clear hierarchy within the family. As a therapist encourages them to deal jointly with the child, the issues between them that prevent their joint action become more evident. It also seems clear that if the therapist joins the child against them by attempting to rescue the child from them, he or she is not changing the sequence and is confusing the hierarchy even more.

A Note on Normality. These descriptions of human interaction are offered as a way of thinking for purposes of therapy. They are not offered as a model for what normal families *should* be like. In examining the context of a symptom, a clinician may find a confusion of hierarchical levels in a family. Such a finding does not mean that to raise normal children, one should not have a confusion of hierarchical levels in a family. It might or might not be so. Where there is a problem child, one can describe a certain organization in the family, but it is an error to deduce from that description how to raise normal children. I have observed over 200 normal, or average, families in research settings, and the patterns are so diverse that to talk about a "normal" family seems naive. How to raise children properly, as a normal family should, remains a mystery that awaits observational longitudinal studies with large samples. How to think about the organization of a family when planning therapy is a different issue. As an analogy, if a child breaks a leg, one can set it straight and put it in a plaster cast. But one should not conclude from such therapy that the way to bring about the nor-

mal development of children's legs is to place them in plaster casts. A clinical description that is used to plan for a change and a research description of ordinary situations are not synonymous.

Malfunctioning and the Family. A therapist should be able to think in terms of three steps in a sequence, at least, and three levels of a hierarchy. Once the therapist puts together sequence and hierarchy, he or she is in a position to devise strategies for bringing about change in a rational rather than merely an intuitive way. The simplest goal is to change a sequence by preventing coalitions across generation lines. When one changes a sequence of father consistently joining child against mother, the family will begin to function differently and the individuals in the family will give up their subjective distress. The goal can be presented in this simple way, but achieving that goal requires ingenuity and skill.

Although three levels of a hierarchy do not seem many when describing the complexity of human life, even that number creates sufficient permutations to be awesome. For example, if one thinks in terms of a triangular unit—such as mother and father and child, or mother-in-law and husband and wife—one can calculate how many triangles there are in the average family if we think in terms of three levels of a hierarchy. In a family with two parents, two children, and four grandparents, there are only eight persons, but there are 56 triangles (and this count does not include uncles, aunts, neighbors, employers, or therapists). Each person in the family is involved in 21 family triangles, and every one of the 21 triangles of parents and children carries the possibility of a coalition across generation lines and so the possibility of a malfunctioning structure.

Summarizing the hierarchical idea offered here, there are certain characteristics of a malfunctioning organization if one thinks in terms of three levels and a triangular unit.

First, the three persons responding to one another are not peers but members of different generations. By *generation* is meant a different order in the power hierarchy, such as parent and child or manager and employee.

Second, the member of one generation forms a coalition across generations. In a two-generation conflict one person joins

another against the other's peer. In a three-generation conflict the person at the top forms a coalition with the person on the bottom against the person in the middle. The term *coalition* means a process of joint action *against* a third person (in contrast to an "alliance," where two persons might share an interest not shared by the third).

Third, the problem is most severe when the coalition across generations is denied or concealed.

In this scheme it should be emphasized that an organization is not malfunctioning because cross-generation coalitions exist but because such coalitions are repeated again and again as part of the system. A woman must save her child from her husband at times, but when this act becomes a way of life, the family organization is in trouble.

Three-Generation Conflicts

Therapists should keep in mind that the "map" in their heads will never be identical with the "territory" that they are offered when a case walks in the door. The clients just will not present their problems in the properly contextual way. For example, a woman might come in complaining about her daughter being irresponsible, and she will add that her daughter drinks and leaves the child alone at night. Or a mother might bring in a twelve-year-old child complaining that he steals from her, which upsets her and his grandmother who lives around the corner. A noncontextual therapist might see the child as sullen and deprived, having a poor self-image, and feeling unloved. When therapists watch their colleagues at work in inpatient institutions, they will observe at times that a patient becomes obstreperous and "acts out." The staff may decide that the patient is "acting out" an internal conflict and may put him in a group to express himself. They may also discuss him as spoiled, rebellious, regressed, and so on.

A therapist must examine such presenting problems in terms of the hierarchy and the sequence that is being followed that requires people to behave as they are doing. All these examples of presenting problems can be seen in the following sequences.

One of the most common problem sequences met by a therapist is the one involving three generations. The classic situation is made up of grandmother, mother, and problem child. That is the typical one-parent family situation among the poor and among the middle class when a mother has divorced and returned to her mother. In the classic example, the grandmother tends to be defined as dominating, the mother as irresponsible, and the child as a behavior problem.* The typical sequence is as follows:

1. Grandmother takes care of grandchild while protesting that mother is irresponsible and does not take care of the child properly. In this way grandmother is siding with the child against the mother in a coalition across generation lines.
2. Mother withdraws, letting grandmother care for the child.
3. The child misbehaves or expresses symptomatic behavior.
4. Grandmother protests that she should not have to take care of the child and discipline him. She has raised her children, and mother should take care of her own child.
5. Mother begins to take care of her own child.
6. Grandmother protests that mother does not know how to take care of the child properly and is being irresponsible. She takes over the care of the grandchild to save the child from mother.
7. Mother withdraws, letting grandmother care for the child.
8. The child misbehaves or expresses symptomatic behavior.

At a certain point, grandmother protests that mother should take care of her own child, and the cycle continues, forever and ever. Included in the cycle, of course, is sufficient

*"In this type of family the grandmother is allocated executive power, while the mother and grandchildren function as one vaguely differentiated subgroup." See S. Minuchin and others, *Families of the Slums* (New York: Basic Books, 1967), p. 364. The authors also point out that in some cases a grandmother and mother may struggle in such a way that the child is simply neglected.

misbehavior or distress by the child to provoke the adults to continue the cycle.

When one thinks of generation lines as hierarchical lines of power, it is evident that the classic three-generation conflict can take place with an expert substituting for the grandmother. In long-term child-oriented therapy, the sequence is as follows:

1. The therapist deals with the disturbed child, implying that mother has not raised the child properly and so the expert must take over and free the child from internal conflicts. Insofar as the therapist is an expert, he is higher in the hierarchy than mother, and by attempting to save the child from mother he is forming a coalition with child against mother across generation lines.
2. Mother withdraws, letting the expert take responsibility for the problems of her child, feeling that she has been a failure or this intervention would not be necessary.
3. The therapist runs into difficulty with the child, and he also realizes he cannot adopt the child and so protests that the mother should do more for the child and care for him properly.
4. Mother begins to involve herself more with her child.
5. The therapist protests that the mother is not dealing with the child correctly. Taking over more, the therapist insists the child must be saved from mother.
6. Mother withdraws, letting the therapist take care of the problems of her child.*

This sequence continues until the child becomes an adolescent and graduates to a therapist who treats adolescents.

It is possible for clinicians to have this kind of three-generation conflict in relation to each other and not only to family members. Typically, student clinicians in training have a supervisor above them and a patient below them in the hierarchy. In the class structure of any agency, the same situation applies

*B. Montalvo and J. Haley, "In Defense of Child Therapy," in J. Haley, *Reflections on Therapy* (Washington, D.C.: Family Therapy Institute, 1981).

with clinicians who are not students. For example, a psychiatrist may be supervising a therapist staff member with patients. The typical sequence is as follows:

1. The supervisor disagrees with the way the student or staff therapist is handling a case and wishes to save the patient from the student. Sometimes the patient has come to the supervisor with a complaint, initiating this sequence, and sometimes it is merely apparent in the discussion between supervisor and therapist. As the supervisor insists on a particular way of dealing with the case, disagreeing with the therapist, she is forming a coalition across generation lines by siding with the patient against the student.
2. The student withdraws, either letting the supervisor handle the case or asking for excessive help from the supervisor.
3. The patient misbehaves or makes an extreme demand.
4. The supervisor protests that she cannot treat every case in the clinic and the student should be more autonomous and take responsibility for his own patients.
5. The student begins to deal with the patient in his own way.
6. The supervisor protests that the student is not dealing with the patient properly and takes over, insisting that she must save the patient from the student.

This sequence continues and the patient becomes part of the chronic caseload of the clinic. It is also typical of in-staff conflicts in a mental hospital setting.

The Parental Child. In some families, particularly one-parent families with many children, there is a third generation that is not clearly a "generation." There is a mother and her children, but in between there is an older child who functions as a parent for the younger children. He or she is not of the adult generation but is a child, and yet the child functions as an adult insofar as he or she is taking care of the younger children.*

*The idea of the parental child is described in S. Minuchin and others, *Families of the Slums* (New York: Basic Books, 1967).

The position of this parental child is often quite difficult because he has the responsibility for the younger children but not the power. Therefore, he is caught in the middle between misbehaving children and a mother who does not delegate full power to him. What typically happens is that the mother sides with the children against the parental child when there is trouble. She insists that the parental child be in charge while not giving sufficient autonomy to deal with the situation.

The sequence is very much like the grandmother, mother, and child conflict, but with different personnel. The indicators of this situation are an older child speaking for the younger children in a family session, protecting them, and often dealing with quite serious problems without letting the mother know about them.

In clinical organizations, this hierarchy is evident wherever there are paraprofessionals. Usually, the hierarchy includes a professional in charge, a paraprofessional who actually takes charge, and the clientele. The paraprofessional is not really at the staff level and yet does the actual work with clients and is blamed by the professional if there is trouble. Often there are secrets between client and paraprofessional, just as there are in families with parental children. This hierarchy is also typical in mental hospitals where the aides or attendants function as parental children because they are not professional staff members and yet are not at the level of patients. They have the responsibility but not the power and so must deal with the patients secretly on many issues, including disciplinary issues.

Two-Generation Conflicts

It is arbitrary to differentiate one-generation from two- or three-generation structures, since all situations involve multiple generations. Yet for practical reasons it can be helpful to focus on one set of levels rather than on another. There are two typical patterns that appear as two-generation problems.

The Overwhelmed Mother. In some families with many children there is a mother who is in charge of everyone, with no hierarchy among the children. The center of whatever happens,

like the hub of a wheel, the mother has each child go through her to deal with any other child. Such a mother appears overburdened by constant demands from the children. This structure can be seen if one asks the children to do something, such as draw a picture on the blackboard, while the therapist talks to the mother. The children will constantly interrupt to ask the mother something, show her what they have done, ask her to settle arguments, and check with her before doing anything. Such a structure is typical of organizations where an administrator cannot delegate authority and so remains in charge of everyone.

One Parent Against Another. The most typical two-generation problem is where one parent sides with a child against the other parent. The "child" may be two years old or forty years, since the problem is not age but organization. A depressed woman with several children may still be functioning as a child in the relationship with her parents. The sequence can also take place when the parents are separated, if they are still at odds over the child.

The typical sequence in this situation is as follows:

1. One parent, usually the mother, is in an intense relationship with the child. By *intense* is meant a relationship that is both positive and negative and where the responses of each person are exaggeratedly important. The mother attempts to deal with the child with a mixture of affection and exasperation.
2. The child's symptomatic behavior becomes more extreme.
3. The mother, or the child, calls on the father for assistance in resolving their difficulty.
4. The father steps in to take charge and deal with the child.
5. Mother reacts against father, insisting that he is not dealing with the situation properly. Mother can react with an attack or with a threat to break off the relationship with father. The threat to leave may be as indirect as "I want a vacation by myself" or as direct as "I want a divorce."
6. Father withdraws, giving up the attempt to disengage mother and child.

7. Mother and child deal with each other in a mixture of affection and exasperation until they reach a point where they are at an impasse.

This sequence can continue forever and ever as mother (or father) crosses generation lines and sides with the child against the other parent. Another way to describe it is as an intense involvement of one adult and child that regularly includes and excludes the other adult.

The fact that change in the child is followed by the development of a chasm between the parents, or even a threat of separation and divorce, has led to the family theory that a child with symptoms is always holding a problem marriage together. Some therapists who are "insightful" will even tell parents that they must have conflict in their marriage, or they would not have a problem child. Such an oversimplification of the situation is naive. The problem has two aspects.

The fact that when a child improves, the parents in some cases threaten separation does not mean that the child was holding them together by having a problem or that they want the child to have a problem. It merely means that once they are organized around the child as a problem, when the child improves that is a change with instability, which everyone must adapt to. If improvement in a child is followed by a parental threat of separation, that only means that improvement is followed by a parental threat of separation. The second aspect of this situation to be concerned with is the possibility that the reaction of the parents, and the whole family, is a product of the ways the therapist intervened in the family. That is, when a therapist encourages a peripheral parent to take charge, as the problem improves there seems to be more parental conflict than if the therapist encourages the more involved parent to be more involved and take charge.* The possibility that the conclusions we draw about families might be the product of the ways the therapist deals with the family is discussed further in Chapter Five.

*See C. Madanes, *Strategic Family Therapy* (San Francisco: Jossey-Bass, 1981).

As a sequence of this kind continues, the focus on the child becomes a way of dealing with issues that arise in marriage. In that sense it seems justified to say that the symptoms of the child have a function in the marriage. Many problems between a couple that cannot be dealt with directly may be communicated about in terms of—and therefore through—the child. The child becomes the communication intermediary and so stabilizes the marriage. For example, at those moments when mother comments on how the child is threatening to run away, she may be indirectly threatening to leave her husband. By discussing the child, the couple can deal with the marriage issue without making it explicit and therefore without making irreversible decisions.

The two-parent sequence is seen most clearly in a family where one parent is a stepparent. For example, an unmarried woman with several children may marry, partly to have a man's help in raising her children. When the new husband begins to discipline the children, or perhaps show affection to them, the mother may react against him by saying he does not truly understand these children. She may even suggest that the marriage was a mistake. The husband will withdraw, not wanting to upset his marriage. Then the children will have a problem that the mother will have difficulty with. She will call upon her husband again, and the sequence will repeat. Such a situation can continue for many years, since it is independent of time.

The Problem in a Clinical Organization. The situation of a person of the parent generation siding with a child against the other parent is also typical in staff conflicts in agencies and mental hospitals. The situation occurs whenever a therapist is dealing with a patient and a fellow staff member is in charge of that patient and many others on a ward. The typical sequence is as follows:

1. An "intense" relationship, a mixture of affection and exasperation, develops between a therapist and a patient on the ward.

2. At a certain point the patient misbehaves or requests something special, such as some privilege or freedom from discipline for some misbehavior.

3. The ward administrator insists on dealing with the patient as one of many who does not deserve anything special, and he tries to persuade the therapist that this approach is best.

4. The therapist reacts against the ward physician, saying he does not truly understand this patient.

5. The ward physician withdraws, giving up the attempt to intervene between therapist and patient.

6. Therapist and patient continue in their intense relationship, therapist joining patient against ward doctor by attempting to save him from the doctor who does not understand him.

This organizational situation and others like it are inevitable in the nature of mental hospitals. The pattern may explain why so many patients and doctors become chronic members of such institutions.

Variations. The marvelous complexities of human life have been simplified here to three generations and a short sequence, which is rather like describing a human being as a skeleton without flesh. These different sequences have also been presented as if they occurred independently. However, one may also find a two-parent family in which mother and grandmother are in the central struggle over the child and the father is outside the sequence. One may also find a situation in which the grandparents are crossing generation lines, the parents are in conflict over a child, and a parental child is saving the child from the parents. That situation is sometimes called a *psychotic family.* It is probably true that an individual is more disturbed in direct proportion to the number of malfunctioning hierarchies in which he or she is embedded.

The Therapeutic Problem

The goal of any clinical description is that it should lead to ways a therapist can think about what might cause change and what might not. The sequences have been oversimplified here, but even in this form it becomes possible to think about how change may be induced. What would *not* bring about change

seems evident. If a person is caught up in a sequence of this kind, expressing his emotions is not likely to cause change.* Similarly, if a person discovers "why" she is behaving as she does, through some explanation in terms of her past history, change is not likely to occur. From this point of view she is behaving as she does because of the ways other people are behaving, not because she was programmed by her past. Whether in terms of catharsis or insight into the person's unconscious, the theory of repression is a handicap if one is thinking about how to change sequences.

It is tempting to believe that if a person only "discovers" she is part of a sequence, she can change—that if a mother could only "learn" that she is regularly including and excluding her husband from caring for their child, she would be able to stop such a sequence. However, the evidence indicates that such learning, or discovery, does not usually lead to change but, rather, becomes a rationale for continuing the sequence. When such insight is offered by a therapist, the mother may "discover" that the therapist is just like her husband and does not truly understand her special child. She may exclude the therapist as she does her husband, only to bring the therapist back again when she has difficulty with her child. The therapist may develop a theory of resistance to explain why his insightful approach is not producing change.

If expressing emotions or having insight does not produce change, what does? A few general ideas guide this new way of thinking about the therapeutic problem. The first and primary

*When a person expresses his emotions in a different way, it means that he is communicating in a different way. In doing so, he forces a different kind of communication from the person responding to him, and this change, in turn, requires yet a different way of responding back. When this shift occurs, a system changes because of the change in communication sequence, but this fact has nothing to do with expressing or releasing emotions in the sense of catharsis. For example, if a man gets red in the face and is silent every time his wife criticizes him, the therapist may arrange for the man to express his anger in words instead of by changing the color of his face. If the man does so, the wife must respond differently, and a new system is being generated. Asking "How do you feel?" about something is the least likely way to bring out emotion; the client simulates it in words. It is better to provoke him to more anger, perhaps by sympathizing with him, to shift the way he is communicating.

idea is that change occurs when the therapist joins the ongoing system and changes it by the ways he or she participates within it. When dealing with a governed, homeostatic system that is maintained by repeating sequences of behavior, the therapist changes those sequences by shifting the ways people respond to each other because of the ways they must respond to the therapist.

At the most general level, therapists should not side consistently with anyone in the family against anyone else. But that does not mean they should not temporarily side with one against another, because that is in fact the only way therapists can induce change. If they only place their "weight" in coalitions equally, they will continue the sequence as it was. In the same way, if they only join one person against another, they may maintain the system as it was by simply becoming part of the deadlocked struggle. That task is more complex: the therapist must temporarily join in different coalitions while ultimately not siding with anyone against anyone.

With situations in which a family has a severely disturbed member, it is necessary for the therapist to join in multiple coalitions simultaneously. One must, for example, side with the parents in their executive function in relationship to a disturbed young person while at the same time siding with the young person toward the ultimate goal of helping the young person out of that disturbing situation. With skill gained by experience, one can learn to skate among coalitions, being partially involved at one moment and firm at another. It is necessary to retain the freedom to join in whatever coalition is appropriate at any particular time.

It is also necessary at times to cause a crisis in a situation by siding only with one person for an apparently indefinite period. When a husband and wife are stable and miserable, the therapist can induce instability by joining one or the other and saying that person is completely right. This temporary firm coalition can later be balanced by shifting to a coalition with the other person, but at any moment in time the coalition can appear permanent.

The most typical way to proceed when balancing within

different temporary coalitions is to proceed in steps. The first step is to determine what type of sequence is maintaining the presenting problem. The second step is to specify a goal. If grandmother is joining child against mother, the goal is to have the mother in charge of her child and the grandmother in an advisory position to the mother. If mother or father is too intensively involved with a child in a coalition against the other parent, the goal is to have the parents involved with each other and the child more interested in associating with peers than with parents. The goal in all cases is to draw a generation line and prevent consistent coalitions across it. By the ways the therapist forms coalitions from his or her higher status as an expert, the therapist prevents the family from forming coalitions across generation lines. The third step involves a new idea. It is improbable, if not impossible, that a system will go from "abnormal" to "normal" in one step. Change must occur in stages, and the first step should be to create a different form of abnormality.

The idea that therapy has stages is relatively new. Possibly the first clinician to introduce stages systematically was Joseph Wolpe with his reciprocal inhibition technique.* Another early designer of stages was Murray Bowen. He reports, in a personal communication, that the way he once began family therapy was by seeing an individual alone and asking that person to take a stance in relation to his or her family that he had always wished to take but had not taken. As the person takes that stance, stages follow: first the family members attack that person as disloyal, and second they threaten to divorce or expel the person. If the person holds out against them, then the third stage is Bowen interviewing the whole family together.

Although specific stages for most therapy methods have not usually been worked out, a variety of therapeutic approaches do assume that the therapeutic process is such that one cannot go *directly* from the problem at the beginning to the cure at the end. The process takes different forms. There is a class of therapeutic situations in which the problem presented must be

*See J. Wolpe, *Psychotherapy by Reciprocal Inhibition* (Stanford, Calif.: Stanford University Press, 1958).

redefined as another problem before it is resolved, because the kind of abnormality has been redefined as another kind. Sometimes this shift occurs routinely as part of the initial negotiations to select a solvable problem and sometimes it occurs later.

For example, a case of "mental illness" may be redefined as one of bad behavior. The family of a psychotic might be asked to put him in jail rather than in a mental hospital. "Crazy" and "bad" should not be confused as one category if the therapist is thinking of shifting from one to the other. Similarly, criminal behavior is sometimes solvable if it is redefined as an "illness" problem. (This approach has nothing to do with the philosophical issue of whether crazy people are bad or criminals are mentally ill. It is a tactical therapeutic issue.)

In more minor form, it is not unusual for a clinician to define the psychiatric or medical problem of a child or an adult as a misbehavior problem. For example, anxiety attacks might be redefined as manipulative and so misbehavior. In the case of a child starving herself, her not eating can be redefined as not minding. The problem shifts from a child who is ill to parents who should pull together to make her mind.*

In all forms of therapy there has been a tendency to take whatever the patient says as something that needs to be redefined as a different problem. The patient who is too emotional needs more cognition, and the overly intellectual patient needs more emotion. The patient who concentrates on details needs to generalize, and the one who consistently generalizes needs to be more concrete. The client who talks about her "misbehavior" needs to have that behavior redefined as something she cannot help and therefore an "illness." The "ill" psychiatric patient needs to take responsibility for his actions, and therefore his "illness" is redefined as "misbehavior."

Whenever the therapist prescribes a symptom and so offers a paradoxical directive, he or she is requesting a different abnormal situation by exaggerating the presenting abnormal

*S. Minuchin, "The Use of an Ecological Framework in Child Psychiatry," in J. E. Anthony and C. Koupernick (eds.), *The Child in His Family* (New York: Wiley, 1970).

situation. This approach is clearest with the procedure of "flooding" someone. An abnormal situation is made into a parody of that abnormal situation, and so into a new one, when someone who is afraid of bugs is forced to think about bugs crawling about everywhere. In most of the behavior therapies, the presenting problem is redefined as a different one. Some behavior therapists translate the presenting problem into a frequency count of certain behavior, and this new definition of abnormality is then resolved. Wolpe transforms a presenting problem into a list of anxiety situations that are items which he can set up a procedure to cure.

When we turn to the schema of pathological systems outlined here, it becomes evident that one way to think about designing a strategy and planning the stages of therapy is to think about shifting from the presenting system to a different abnormal one. This different abnormal system may be the presenting system of some other family. The following examples serve to present this idea (further examples are given in Chapter Five).

A mother may be too central to her children, so that there is no hierarchy in the family and all the children function through her as if she were the hub of a wheel. In such a case it may be appropriate to create a system where an older child relieves the mother by taking charge. Essentially, this change creates a parental child hierarchy. From this new abnormal state, it is possible to shift to a more reasonable hierarchy in the family so that all children can participate with different responsibilities.

Conversely, if the family comes in with a parental child system, one possibility is to make the mother overly central as the first stage. This change frees the parental child, and from this new abnormal hierarchy it is possible to go to a more normal one.

If the sequence involves a grandmother who is crossing generation lines and siding with the child against the mother, one can follow the procedure suggested in Chapter Five in which full responsibility is given to the grandmother. One can then go from this abnormal stage to another abnormal one in which all responsibility is given to the mother and the grandmother

must not discipline the child at all. From this abnormal state one can go to the more normal one.

If mother and child are in an overly intense relationship and the father is peripheral, the first stage can be one where the father takes total control of the child and the mother is excluded. This is an abnormal system, and from it one can move to a more normal one. It might also be possible to use an older sibling as a parental child to disengage mother and child, thereby introducing a parental child system as the first stage. Similarly, one might introduce the grandmother and create that hierarchy as a first stage.

In summary, one of the reasons some therapies have failed has been that they assume one can go from an abnormal state directly to a normal state. It is more productive to think in terms of stages between abnormality and normality. Faced with a malfunctioning system, one can think of how to transform that into another malfunctioning system that can then be shifted to normal.

Sequence and Hierarchy

It is in the ways that repetitive sequences define hierarchies that systems theory and hierarchy come together. The hierarchy is shaped by the behavior of the people involved, and insofar as the behavior is repetitive and redundant, it is a governed system that is error-activated in that deviance activates a governing process. If the person deviates from the repeating behavior and so defines a different hierarchy, the others react against that deviation and shape the behavior back into the habitual pattern.

Pathological behavior appears when the repeating sequence simultaneously defines two opposite hierarchies or when the hierarchy is unstable because the behavior indicates different shapes at different times. For example, if the parents at one point take charge of a child and at another point accept the child as the authority in the family, the hierarchy is confused.

A parallel can be drawn here between levels of communication and levels of hierarchy. The "double bind" was a concept derived from the paradoxes that occur when messages

are on multiple levels and are conflicting.* For a therapist to ask another person to disobey him, or to direct someone to behave spontaneously, is to produce a paradox. The person cannot behave spontaneously if she has been *instructed* to behave in that way.† In the organizational description offered here, the same principle applies to a larger unit. To direct someone to disobey is to define the hierarchy in two incompatible ways. The person directed is lower in the hierarchy, since she is being told what to do, but she is also equal or higher in the hierarchy, since she is being expected to disobey or to behave spontaneously. Two incompatible definitions of the hierarchy are offered simultaneously by communicating paradoxical messages. Just as one cannot *not* communicate with other people—even trying to avoid someone is communication‡—so must one always deal with the issue of hierarchical position in relation to the other person. When a therapist indicates he is not superior to a patient (by being "human" with her or even asking her what might be done) while accepting an expert's fee from the patient, he is offering incompatible positions in a hierarchy: he is a paid expert and therefore higher in the hierarchy, since he is a helper paid to help the other, but he is also asking the other's advice on what to do. Quite possibly the nature of therapeutic change centers in the ways the hierarchical issues are kept unstable in the therapeutic relationship, either by being ambiguous and confused or by being defined in shifting and incompatible ways.

A changing definition of a hierarchy may develop as part of a sequence. For example, when a mother asks her husband's assistance with a child, she is defining the hierarchy as one in which two parents are joint authorities over a child. When the

*G. Bateson, D. D. Jackson, J. Haley, and J. Weakland, "Toward a Theory of Schizophrenia," *Behavioral Science* 1 (1956): 251-264.
†J. Haley, *Strategies of Psychotherapy* (Orlando, Fla.: Grune & Stratton, 1963).
‡It should be emphasized that most of the ideas about communication in this book derive ultimately from Gregory Bateson. I participated in his research project for ten years, along with John Weakland, Don D. Jackson, and William F. Fry. An idea such as the one that people cannot not communicate predates that project: it was published by Bateson with Jurgen Ruesch in *Communication, the Social Matrix of Psychiatry* (New York: Norton, 1951). For a collection of Bateson's writings, see *Steps to an Ecology of Mind* (New York: Ballantine, 1972).

husband responds by dealing with the child, and the mother reacts and condemns him for not understanding the child and joins the child against him, the definition of the hierarchy has shifted. She is now defining it as one in which she and the child have the authority over father's behavior.

It is the task of therapists to change the sequence and so change the hierarchy of the family. It is also their task not to be caught up in a sequence in such a way that they are perpetuating the problem they are supposed to resolve. If the goals therapists have are clear to them, they are less likely to be caught up helplessly in the ongoing process.

Certain consequences of a theory of systems as a model for therapy are sometimes not thought through by members of the profession. If we assume that a family is a system, we must accept the premise that behavior will repeat and also the premise that movements toward change will activate the governing processes that have been keeping the system stable. Granting these premises, once therapy has begun and the therapist has become part of the system, we must assume that when change occurs he or she will react to keep the system as it was during therapy. That is, we must assume that the therapist, the change agent, will resist change once the therapy is an ongoing process. Some professionals are willing to accept the idea that treatment institutions, like mental hospitals, resist change, but they do not think through the fact that this idea must apply also to the therapist. Given this view of the therapeutic situation, the supervisor, who operates more on the periphery of the system than the therapist does, has the function of helping the therapist move past change as well as helping the therapist disengage from the family. (The supervisor too is part of the system but is less involved in terms of the immediate feedback processes exchanged by therapist and family.)

To put the matter another way, therapy involves changes in relationship between the therapist and the clients. If a therapist and a family accept a helping contract, they are agreeing that the therapist should help and that the family should receive the help. All messages are in that framework and define the relationship in that way. Yet it is impossible to cure a family by helping them

if the cure involves arranging that they no longer need help. The more help the therapist offers, the more he or she is defining the family as needing help. The more the family accept help, the more they define the relationship as a helping one. The goal of the therapy is to have the therapist and the family achieve a relationship as peers in the sense that the family do not need any more help than the therapist does. Once the helping relationship is established, if either party moves toward changing the relationship, the other will react to stabilize the relationship they have.* Not only does the patient resist change in a relationship, but so does the therapist. The art of therapy includes shifting from one type of relationship to another while being part of a stabilized system. The supervisor can help in this situation by the use of a variety of techniques, including the use of recesses in the therapy, such as meeting in a month rather than next week, and even the encouragement of controlled relapses.

Once it was thought that clarifying communication in families would not only bring about togetherness and harmony but also cause basic change in family structure. But such clarification, when it means pointing out to family members how they are communicating, seems to produce little change. At the opposite extreme was the idea that the therapist should individuate family members from one another and so provide more autonomy and less togetherness. With experience it has become more clear that the autonomy of a person is dependent on how other people behave. Even the definition of autonomy can only be in relation to other people. Of course, at times both the effort to clarify communication and the emphasis on achieving autonomy can inadvertently break up habitual sequences in families and so produce change. It has merely become more evident in recent years that the therapist can focus directly on changing those sequences and so more quickly and efficiently produce change.

The particular strategy of a therapist will vary with the unique family and the context of therapy, and it will also be influenced by the stage of development of the family, since fam-

*J. Haley, *Strategies of Psychotherapy* (Orlando, Fla.: Grune & Stratton, 1963).

ilies change over time.* As children mature and parents and grandparents age, sequences and hierarchies change. In the family life cycle, there is an extraordinary reversal of hierarchical structure. Children shift from being taken care of by their parents to becoming peers of parents as fellow adults to taking care of parents in their old age. It is now being assumed that "spontaneous" change is related to developmental processes in families. Sometimes therapy is given credit for a change when a natural process has accomplished it. Yet often families do not develop and change over time, but remain fixated in a problem sequence. The therapist must intervene to make a change and cannot depend on a natural process to do his or her job.

*J. Haley, *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (New York: Norton, 1973).