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KEEP IT SIMPLE

WHOLISM

In the search for solutions to clinical problems, the concept of wholism stands out as a useful lens to use when looking at the complexities involved. Simply stated, "systems theory" as applied to human systems and their difficulties suggests that families (or any group of people with a history and a future) are not just an aggregate of individuals. Rather, a human system is more than the sum of its parts. It is not only the individuals included in the description but also the relationships between and among those individuals. Thus, a systems view necessitates a certain complexity. However, since a system is a whole, "every part of a system is so related to its fellow parts that change in one part will cause a change in all of them and in the total system" (Watzlawick et al., 1967, p. 123). This allows us to, on the one hand, minimize, and on the other, utilize the complexity so that solutions can be found. Only a fit is necessary; otherwise the solutions, to be effective, might need to match a reality as complex as the human system plus the systemic problem.

For our purposes, "problems" can be defined as those things clients complain about to therapists and about which the therapists and the clients can do something. If the complaint is something they cannot do anything about, then the complaint is not a problem – no matter how painful and severe it may be. Of course, to therapists some of the things clients complain about may seem trivial and just a part of life

and some of the things clients do not complain about may seem worthy of complaint. Nonetheless, the "complaint" is a problem as long as client and therapist can do something about it.

The "system" under consideration can be defined as client-plus-complaint-plus-therapist. Just as the "client" may be a family or a couple or an individual, the "therapist" may also include a team behind the mirror and a videotape machine, etc. When a team approach to therapy is under consideration, the "system" includes: (1) the client, (2) the complaint, (3) the therapist, (4) the setting (mirror and VTR), (5) the team behind the mirror, and (6) the interactional relationships between and among these elements. In accordance with the concept of wholism, change in the therapeutic system might be punctuated as starting anywhere in the system (de Shazer and Molnar, 1984a). For example, the team might need to change its membership and/or its view of things before the solution can be found, the apparent relationship between the therapist and the rest of the team may need to change in some way, or the team may need to change who is filling the role of therapist in the room, etc. Although the therapeutic system with a team is more complex than the client-complaint-therapist version, the variety of options available for initiating change and thus solving problems outweighs the possible confusions.

Clients' complaints may take the form of a wife or husband complaining about the marriage, or a parent or parents complaining about their child or children. Sometimes, during the course of therapy, only one person shows up for the appointment when the therapist was expecting more. If it were not for the concept of wholism, having just "part" of the client system might seem to be a handicap in finding a solution. However, the person who comes to the appointment is frequently the one with the most pressing complaint and, therefore, the one who wants to work with the therapist toward getting something different to happen within the troublesome area. As Weakland (1983) puts it:

> In simplest terms, [the interactional view] proposes that if interaction between members of a social system is seen as the primary shaper and determinant of ongoing behavior, it then follows that alteration of the behavior of any one member of a system of interaction – particularly a family, as the most ubiquitous, encompassing and enduring kind of system – must lead to a related alteration in the behavior of other members of the system (p. 2).

The idea that a system is more than the sum of its parts can be problematic for systemic therapists (and other "family therapists"), since their unit of description is the family group. For instance, Ferrier (1984) discovered that "it has not been clear whether the systemic approach developed by the Milan Associates is susceptible to adaptation to work with these abbreviated families" (i.e., single-parent families, particularly those with very young children). Fortunately, Ferrier found that "not only is it possible to make this adaptation, but that it [the techniques and methods] can be effective within a fairly brief time." Ferrier concludes that even though it is "easier" and perhaps more efficient to work with the group that lives together, "it may well be more efficient in the long run, in those cases where only one or a few members are readily available, to accept whatever unit comes as information about the system and to proceed from there." This is close to the position suggested here: Solving the problem is the clinical task.

Szapocznik, Kurtines, Foote, Perez-Vidal, and Hervis (1983) compared "conjoint" family therapy and "one person" family therapy (sessions with just the "identified patient"), using a structuralist approach. They found that "both conditions were equally effective in improving family functioning and reducing symptomatology in the IP at termination" (p. 898). Interestingly, one-person family therapy was found to be "somewhat more effective" in maintaining continued improvement in the IP's symptoms. Since the population in this

study was limited to drug abusers and their families, we might speculate that the *more currently important* system was the drug-oriented peer network. It is possible that the one-person format is more effective in promoting changes in the peer system.

The idea that the whole family needs to be involved in the therapy stems from the view held by some therapists that the family is the patient and, therefore, it is not therapeutic to see only some members of the family. However, as Szapocznik et al. show, the assumption behind this perspective is questionable.

Solving clients' complaints need not, and frequently does not, involve seeing the whole family. Watzlawick and Coyne (1980) describe a case in which the participants in the sessions complained about how they had not dealt well with father's predicament—recovery from a stroke. They describe this therapy as "treating the depressed patient only through contact with his family" (p.17). However, the "problem" was not Mr. B's depression; rather, it was the complaints of the other family members. Therapy created a solution to those complaints. The effects upon Mr. B provide a good illustration of how one part of a system changes as a result of changes in other parts of the system, once again suggesting that the *problem*, rather than either an individual or a family, is the patient.

In fact, Coyne (1984) goes further and suggests that there are good "reasons for not interviewing both members of a couple with a depressed person together, at least initially" (p. 55). For instance, the nondepressed spouse may be on the way out of the marriage and is just waiting for the depressed person to improve enough to handle a divorce. Or, each spouse may have some magical ideas about what the marriage is going to be like or should be like once the depressed partner is better. Furthermore, it can be easier "to get clear information about key incidents from one in the absence of the other. Together, they tend to lapse into a pattern of inhibition and withdrawal or, alternatively, emotional outbursts, characterological criticisms and accusations" (p. 56). Of course, this

sort of information may be relevant, but a report from each separately is just as useful in finding a solution to the problem.

*Case Example: Tit for Tat**

This case illustrates the application of the systemic concept of wholism to the solution of a marital difficulty which was presented by the wife when she came to therapy. At no time was the husband included in the therapy; in fact, he was not invited. The changes in the husband's behavior can be seen as a result of the differences in the wife's behavior and in how she framed the situation.

Mrs. Johns was feeling desperate and in a panic about her marriage. She complained that her husband frequently went out at night without her, then stayed out as late as 4:30 a.m. or did not come home at all. He told her he was going out with his single, male friend, and she believed him. Whenever she expressed her resentment, her huband comforted her about their relationship and assured her that there was nothing to worry about. Consequently, she continued to accept his going out and even kissed him good-bye and wished him a "good time," because she felt he would go out anyway, no matter what she said or did.

Meanwhile, she stayed at home and suffered stomach pains, diarrhea, depression, crying bouts, headaches, and recently thoughts of suicide, which she rejected because of their two children, aged four and six. However, her priorities were clear: She wanted this particular marriage and was willing to do almost anything to make it work.

She had tried talking to him about it; she had tried passively accepting it; then she had talked to him some more. Since nagging and suffering had not worked to keep him home, she now wanted to know what to do to change things. She clearly saw that any changes to be made were hers, since he

*Further explication of this case material appears in de Shazer and Berg, 1984.

thought everything was OK. If she could not stop his going out, then she wanted to be able to accept his going out without becoming emotionally upset. She saw that as part of her job as "wife" and as the price she had to pay for this marriage. Mrs. Johns had repeatedly modified her behavior in hopes of modifying his behavior, which indicated that she would probably be willing to try more new behaviors – to do something different.

Mr. Johns was a detective, and detectives usually love mysteries. This fact, along with the fact that he did not know his wife was coming to therapy, prompted the whole design for solving the problem.

The therapist complimented Mrs. Johns on her fairness and her patience in this trying situation and also complimented her on having tried everything she could think of to solve the problem. However, it seemed she had not been mysterious enough. Every marriage needs some mystery, and since Mrs. Johns described herself as an open book, the therapist suspected that her detective husband, who needed more than the average amount of mystery, was out of a job.

The therapist then listed a variety of things Mrs. Johns might do to make things mysterious, such as getting all dressed up and going out before he left the house without telling him where she was going or not being at home when he got there at 4:30 in the morning without leaving word where she was.

She was cautioned to not do too much too quickly, but she might want to just think about these sort of things so that she had a plan ready. Mrs. Johns thought the suggestions were good ones and recognized that they were the opposite of what she had been doing.

At the start of the second session, Mrs. Johns said, "I suppose, in a sense, I've reached my goal. My husband did not go out this week!" For the first time in two years, a week had gone by without his going out alone. Since she now had a plan, she felt in control of her situation. On the third evening after the previous session, Mrs. Johns went out by herself (tit for tat), returning about 1:00 a.m. He was there waiting, but they did not talk about it at all.

Although her behavior might not have stopped him from going out, it did have that effect that week (at least as she punctuated it). Therefore, she had at least the illusion of controlling his behavior by taking more control of hers. This successful change was enough to breed further confidence, which prompted further changes and consequent solution to the problem.

The therapist complimented her on what she had done differently and on what she planned to do on future evenings when Mr. Johns went out alone and she did not want him to. The therapist also suggested that she urge him to go out one night, on his night off, and to insist that he stay out until one or two o'clock. Mrs. Johns particularly liked this idea since she felt it would shock him as much as it shocked her.

In the final session, Mrs. Johns reported that everything was just fine. She had used the therapist's ideas and found out that they worked. In the first week after the previous session, Mr. Johns had gone out, and she knew far enough in advance to make plans. She hired a baby-sitter, went shopping, and rented a motel room. When she returned home at 5:00 a.m. he was there. He had returned at two. He never asked her where she went or what she had done, and she had not volunteered the information. However, he did not go out again.

Four weeks later, he asked her permission to go out. (He had never before asked.) She answered, "You have to do what you feel you want to do." He decided to go out and invited her to spend the evening with his friend's girlfriend. "I decided that wouldn't work because then he'd know exactly where I was and what I was doing, so I said, 'No, I've already made plans to go out.'" Several hours later he said, "Let's both cancel our plans and spend the evening together." That was what they did. The change in his behavior was exactly what she wanted to have happen and, therefore, the goal of therapy was met.

Case Example: Creating a Thirst for Change

This case example again illustrates treatment influenced by the principle of wholism. The therapist decided that no good purpose would be served by mother's dragging in her reluctant daughter or disinterested husband.

Mrs. Webster came to therapy complaining that Mr. Webster would not join her and neither would her daughter Colleen, age 16, who was, after all, the trouble. She and Mr. Webster had disagreed about how to handle Colleen for years. Now things were getting out of hand and Mr. Webster still could not see the need for help because he thought, "she'll grow out of it." Mrs. Webster decided to come for therapy after reading about our "radical" approach in the local newspaper. She really wanted to bring her daughter in for therapy, but she knew her daughter would not come because Mr. Webster would side with her against coming.

Colleen's troublesome behavior, as described by Mrs. Webster, included: not going to classes, always sleeping late and missing the school bus; getting poor to awful grades; leaving clothes and garbage scattered around the house; not doing her assigned chores; harassing the four younger children; being disagreeable; going out when grounded; lying; stealing; and smoking in her room. She reported that Colleen felt that the only thing wrong was that she (mother) was unfair and overdemanding. Mother thought Colleen needed to realize these were her problems and that Colleen needed to be in therapy to solve them.

The team gave Mrs. Webster the following message:

> We are impressed with your concern about Colleen's going to hell in a handbasket and your decision to act before things get so critical that the bottom falls out. Sometimes it is hard to know when to act, when to, do something different, when there's chaos and confusion. In spite of this, you were able to clearly describe your situation and, therefore, we have a beginning picture or a start toward getting a handle on it.
>
> We are sorry that we don't have anything "radical" to suggest, tonight, although we well may in the future. We do, however, suggest that you keep your coming here a secret—if she doesn't already know.

> In order to be able to help her straighten around, you need to get her into a position where she is thirsty enough so that, when you lead her to water, she'll have to drink.
>
> We suggest you give some serious thought to how you are going to turn the tables on her, how you can start to get her thirsty.

Mrs. Webster realized that we did not want her to drag Colleen in with her, but agreed that if Colleen were given some trouble, then she might want to come in.

At the time of this first session, Mrs. Webster had so many complaints that she was unable to focus on one deserving our initial attention. So, although the complaints were rather specific, none of them led to a goal specific enough to be useful. She wanted Colleen to straighten up totally and was unable to accept a small change as a sign of progress. Therefore, the team decided on a "think task" which might help Mrs. Webster focus on something specific in the second session. The team also was attempting to redefine the situation as one about which Mrs. Webster herself could *do something other than complain.*

In the second session, mother reported that Colleen's behavior had gone from bad to worse. This prompted Mrs. Webster to think about dropping out of college for the time being in order to "baby-sit" Colleen. This was the only alternative Mrs. Webster could imagine. However, she did not want to do this and hoped we had something else in mind. The therapist assured her that he had something much smaller in mind.

The therapist agreed that Mrs. Webster's dropping out of college well might work to get Colleen up on time and off to school; however, it was the kind of sacrifice that Colleen had seen her mother make before. The following statement was made:

> We think that since you never know what to expect from Colleen, but she knows what to expect from you,

> this needs to change. We think you need to do things that Colleen can't expect you to do which will make her thirsty enough to change.

The therapist then told a story about a mother who solved a morning difficulty. What she did was to sneak into her daughter's room after she was sleeping and set the alarm for two hours earlier than normal. The next day daughter bitched, but mother maintained her silence. The following night, she reset it for three hours later than normal. Again the daughter bitched. The third night mother did not change the alarm, and the daughter got up on time the next day and most days thereafter.

The therapist told another story about a mother who was angry at her daughter for not picking up dirty clothes, etc. One day, while the daughter was gone, mother stole all her makeup. The mother did not mention picking up dirty clothes. The daughter complained a lot about the missing makeup. A few days later, when the clothes were still not picked up, mother stole all of her daughter's left shoes. When daughter complained, mother simply told her that she knew what she needed to do to earn her shoes back. Daughter not only picked up dirty clothes, but did some other chores. Mother, knowing the girl had an "important date," gave her the worst left shoe. Daughter did not complain and chores were no longer an issue.

Mrs. Webster chuckled throughout these true stories and clearly had figured out the kind of things we were suggesting. In the following weeks, she used some of these techniques and invented some of her own.

In the final session, Mrs. Webster reported that the changes in Colleen's behavior had spread from home to the school. She even brought homework home for the first time in two years. She was going to classes regularly and doing most of her chores on time. Even Mr. Webster had remarked about these changes, saying, "See, I told you she'd grow out of it." Mrs. Webster did not tell him about her therapy and how she got her daughter thirsty enough.

*Case Example: The Retired SOB**

This case illustrates how deliberate changes made by one person can affect not only the marital system but also a larger surrounding system. The husband was disinvited because the complaints seemed more readily solvable through working just with the wife.

Two months prior to the initial appointment, Mr. C, 72, who was a nursing home resident, had had an unexplained fall which left him very frightened and with some continuing pain. The doctors concluded that there was no physiological reason for his not having recovered to his previous level of functioning. His condition became increasingly worse, he lost 21 pounds, refused to get out of bed, lost interest in former activities, became irritable, rejected the ministrations of the nursing home staff, and, in particular, demanded the constant presence of his wife.

Prior to this, Mrs. C, who still worked full-time, would visit her husband in the evenings and on weekends. On those rare occasions when she could not visit, he had accepted this, as long as he had been told in advance.

When Mr. C first became demanding after his fall, Mrs. C had complied with his wishes, thinking that this would speed her husband's recovery. Instead he seemed to get progressively worse. The more she tried to please him, the more demanding and irritable he became. At this point she felt totally trapped. If she did not visit daily and do all the things Mr. C demanded, he not only became angry with her but also made trouble for the staff. The staff, in turn, complained to her and made her feel guilty. Since she was about to retire and was afraid her husband would demand her presence even during the day, she agreed to some therapy.

Mr. and Mrs. C met at BFTC for the first session. Mr. C had been brought by a nursing home van since he was in a wheelchair. From the moment he was wheeled in the door, he appeared to be extremely angry. He denied having been told

*Further explication of this case material appears in de Shazer and Lipchik, 1984.

the purpose of the meeting, and when he was informed of it, he said, "Are things that bad?" He rejected all of the therapist's attempts to establish rapport and removed his hearing aid or wheeled himself away from the group when he did not like what he heard.

Behind the screen, it seemed clear that Mr. C was a tough old SOB who was discouraged and angry about his helplessness and dependence. When this idea was phoned in and relayed to him by the therapist, he became more animated than at any other time in the session. He denied being a tough SOB any longer, removed the hearing aid, and wheeled himself away. Mrs. C, however, agreed that she had seen him as being a tough old SOB prior to the fall. The team then speculated that although Mr. C made demands, Mrs. C's compliance made him angry and confirmed his fears of being terminally ill. The team gave the couple the following message:

> Jonathan, we are very impressed with how difficult it must be for you to have to put up with all this, and not be with Judith all the time, but despite all that, you show a lot of spirit. You still look like a man who knows what he wants and you haven't given up. You still have a lot of spirit.
>
> We are also impressed that after 42 years of marriage you still care for your wife so much.
>
> Judith, we are also struck with your efforts to make Jonathan happy and still have a life of your own. Most wives would not be nearly as caring and loyal as you are.
>
> We think you are both in a difficult situation, and the fact that you, Judith, are trying the best you can for *both* of you – not only yourself – is very impressive. Many women would not be so unselfish.

An appointment was then made for just Mrs. C. The team thought it would be more useful to work with her alone and to construct with her a problem she could do something about.

Mrs. C's attitude had changed somewhat when she returned the following week. She appeared less helpless and spoke of becoming tougher, even though she commented, "That is not my nature." She feared Mr. C's changed behavior and steady decline were either a sign that the doctors were missing something and he was sicker than they thought or evidence that he had given up. She described dreading her visits with him not only because he was so demanding, but also because the nursing home staff was so irritated with her for not making him behave better.

The therapist suggested that before Mr. C could give her more freedom, he would have to feel better about himself and become more independent. Mr. C needed a challenge, such as proving he could still do something for his wife like he used to. It was suggested that Mrs. C might have to sacrifice some of her helpful ways and even pretend to be sick, helpless, or dependent in order to get Mr. C to help her.

One week later, Mrs. C reported that her husband had had a very good week. For the first time in months he was hungry and eating solid food again. He had also agreed to go back to physical therapy and was working hard to regain his mobility. She did not really know how to account for these changes. However, she did describe a change in her attitude and behavior. She reported that she had stopped giving in to him so much. When he did not want to sit in the dining room with her while she had some coffee, she told him to go back to his room alone, where she would join him later. He did. She had decided that it was time to stop treating him like he was hopelessly ill and to stand up to him again, as she had in the past. Her husband seemed a little surprised at her behavior this week, but was not complaining too much about it.

Essentially, the remaining two sessions were devoted to promoting these changes and worrying about a relapse that never happened.

After Mr. C's fall, Mrs. C and the staff had operated within a frame which described their giving in to Mr. C's demands as "helpful," which implied that Mr. C was "helpless," no

longer strong, and therefore no longer independent. The more they tried to be helpful, the more Mr. C labeled himself as "helpless," since this confirmed his frame, which was built on his fears and his temporarily weakened physical condition. Thus, he stopped eating and confined himself to his bed to die. The less he ate and the less he moved, the weaker he got; the more "helpful" people became, the more completely his worst fears were confirmed.

The above is an example of how two labels, "helpless" and "helpful," can interact to the detriment of all. The behaviors falling under each label tend to confirm the other label and to contribute to the development of a mutually escalating pattern.

CONCLUSION

The approach in all three cases used the principle of systemic wholism as a foundation. In each case, one person in the family deliberately made some changes in behavior that prompted changes in other family members and even in larger systems. "Tit for tat" has developed as a shorthand or code name for this approach, since that is exactly what is involved. The clients started to respond in kind to the complaint-provoking behaviors of others, rather than continuing to play the victim. Since the others could no longer predict what was going to happen next, they started to behave in ways that would eliminate or minimize the retaliatory actions of the complainant.

In each case, fit was achieved because both therapists and clients constructed the problem in such a way that the individual person could do something to solve the problem in the larger interactional systems. This framing of the situation fit the clients' world view and thus solution was reached.