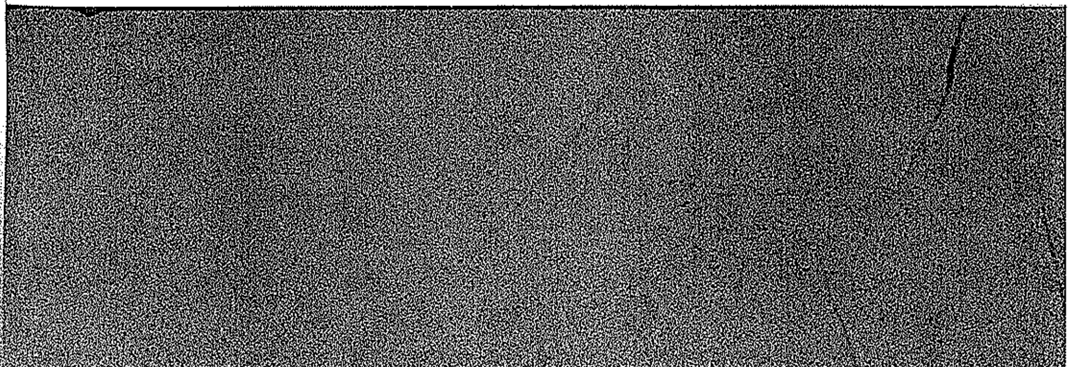
Problem Solving Therapy Haley

# 2

# Giving Directives

I recall a man in his late twenties who wished to be a great novelist but could not bring himself to sit down at the typewriter and write. He was just unable to produce. The young man was also afraid of women. Although he could associate with prostitutes, he had never had an ordinary date with a woman. He came to therapy asking to solve both problems: he wished to write and he wished to have dates with women. The therapeutic strategy was obvious: when posed with two symptoms, the therapist should use one to cure the other. I asked the young man how many pages per day he should write, and he said he should write one page per day of 250 words. I directed the young man to write six pages per week (he negotiated one day off). If he did not follow the directive, then the following week he had to ask young women for dates until he went out with three women that week. The next week, if he did not write six pages, he must arrange three dates again. Rather than ask a woman for a date, the young man sprang to his typewriter and methodically wrote a minimum of six pages per week. Later the problem of dating young women was resolved. By taking this approach, the therapist inevitably wins: if the patient wrote, he solved one problem, and if he did not write, he had to go out with women and so solved another problem. It is, of course,





essential that a therapist know how to give directives so that they are carried out. It is a misfortune that most clinical training has not included this skill. A therapist must largely learn it on his own unless he meets a master therapist, such as Milton H. Erickson, and can receive some instruction. Most of what is said in this chapter on directives is derived from Erickson.*

### Purpose of Directives

Giving directives, or tasks, to individuals and families has several purposes. First, the main goal of therapy is to get people to behave differently and so to have different subjective experiences. Directives are a way of making those changes happen.

Second, directives are used to intensify the relationship with the therapist. By telling people what to do, a therapist becomes involved in the action. He or she becomes important because the person must either do or not do what the therapist says. If the directive is something the people are to do during the week, the therapist remains in their lives all week. They are thinking about such things as: What if we don't do it? What if we only halfway do it? What if we change it and do it in our own way? When they come back for the next interview, the therapist is more important than if she had not given a directive.

Third, directives are used to gather information. When a therapist tells people what to do, the ways they respond give information about them and about how they will respond to the changes wanted. Whether they do what the therapist asks, do not do it, forget to do it, or try and fail, the therapist has information she would not otherwise have. In fact, in the preliminary talk about the task, the therapist learns things she would not learn otherwise. For example, if the task is to do something at breakfast time, the therapist learns what happens at breakfast because the people will discuss that as they talk about how to do the task.

*See J. Haley, *Uncommon Therapy: The Psychiatric Techniques of Milton H. Erickson, M.D.* (New York: Norton, 1973), *Advanced Techniques of Hypnosis and Therapy* (New York: Grune & Stratton, 1967), and *Conversations with Milton H. Erickson, M.D.*, 3 vols. (New York: Norton, 1985); E. L. Rossi, *The Collected Papers of Milton H. Erickson, M.D.*, 4 vols. (New York: Irvington, 1980).

## What Is the Directive?

Some therapists are uncomfortable about giving directives because they feel perhaps they should not take the responsibility for telling someone what to do. It is important to emphasize that directives can be given directly or they can be given in a conversation implicitly by vocal intonation, body movement, and well-timed silence. Everything done in therapy can be seen as a directive. If an individual or a family in an interview is talking about something and the therapist says, "Tell me more about that," she is giving a directive. If the therapist only nods her head and smiles, encouraging the speaker to continue, that is also a directive. If someone says something the therapist does not like, she can tell the person not to say that anymore—and that is telling him what to do. If the therapist turns her body away from the person and frowns, she is also telling the person that he should not say that sort of thing.

Whatever a therapist does is a message for the other person to do something, and in that sense she is giving a directive. If someone says, "I feel unhappy," and the therapist replies, "I understand, you feel unhappy," the reply does not look like a directive. But it can be defined as one, since the therapist is indicating that she is interested in such statements and the person should say that sort of thing or that it is all right to say that sort of thing. Since the therapist may not have responded to something else the person said but has responded to this statement, her response tells the person that this statement is important. The therapist's response also implies there should be more talk about such important things. Once a therapist faces the fact that whatever she says or does not say is telling a person to do something, or is telling him to stop doing something, then she will find it easier to accept the idea of giving directives. In fact, even when a therapist tries to avoid giving directives by pointing out to the client that the client is trying to get the therapist to direct him what to do, the therapist is directing the client how to behave.

There may be times when a therapist does not want the responsibility of directing someone's behavior. For example, someone might ask, "Should I quit my job?" or "Should I

divorce my wife?'' Here, it might be best to respond by saying, ''That is something you have to decide yourself.'' However, if you have any opinions about that decision, those opinions are going to be communicated to the person by what you say or imply, by the tone you say it in, by the way you move. But you can still put the responsibility for the decision on the client if you do not want to take it yourself.

The question of who is responsible for what in therapy is a complex one. A therapist may believe that she herself decided on a directive and was responsible for a course of action, but closer examination of the interchange may indicate that the client led the therapist into that directive. Often, too, the responsibility taken by the therapist is given by the client in more direct ways. A mother may ask that a therapist bring up a sensitive subject so that she and her children can discuss it, and the therapist may choose to cooperate by taking the responsibility for bringing up that subject. At times, one may want to relieve the client of responsibility, and at yet other times one may want to have the client feel that one is accepting responsibility when in fact one is not. This chapter does not deal with the intricacies of who actually determines a course of action in a therapist/client encounter but, rather, with how to give directives when the therapist assumes that she herself is initiating what happens.

Some people are comfortable in giving a task. In fact, some therapists rush in and give a task prematurely before they understand the situation. However, many therapists experience an inertia when they try to do an active, directive therapy. Sometimes this is because their training was in nondirective therapy, and it was instilled into them that they should only interpret and reflect, not direct people what to do. Sometimes therapists seem to feel that telling someone what to do takes too much responsibility for a person's life, and sometimes they simply believe they have not had sufficient training and therefore they should continue to say only, ''Tell me more about that.'' More than these practical reasons, there seems to be a natural inertia about intruding into some stranger's life and telling him or her how to behave. Overcoming this inertia is part of becoming a directive therapist.

One way to arrange an obligation to give directives occurs when a therapist sets up a situation where he or she *must* tell someone what to do. For example, one can talk to a family or an individual about change. "Would you like to change?" one can ask. The answer is often "Of course, or I wouldn't be here." But it does not follow that the client is there to change; clients can be there for many reasons. One can also ask, "Would you rather change slowly or quickly?" Or a question can be "Would you rather know what I am doing to change you, or would you rather just find out you changed and not know why?" Some people certainly want to know everything you are doing, and others do not really care. You can also say, "Are you willing to make a sacrifice to have a change?" Often the answer is "What sort of sacrifice?" The reply can be "Any sacrifice that is necessary to get over the problem." In the process of talking about change in this way, two things are happening. One, the idea that the client is going to change is being accepted—the only question is how. (This is like saying to a hypnotic subject, "Would you rather go into a trance now or later?" and so setting aside the question *whether* the person is going into the trance.) The second thing happening is that the client is accepting the idea that you are going to do something to change him. If he agrees to a sacrifice, for example, he turns to you expecting you to offer one. In this way a therapist can arrange to overcome the inertia about giving directives and proceed to do so.

## Types of Directives

There are two general types of directives: (1) straightforward directives, given when the therapist has power to get people to do what he or she says, and (2) indirect directives, given when the therapist has less authority and must work more indirectly to get the change desired. Another way to put it is that with straightforward directives the therapist wants people to do what is asked, as in good advice or coaching. Indirect directives are used when the therapist does not want the client to do precisely what he says because he wants the change to occur more "spontaneously," as when the therapist uses the indirect technique of restraining change.

First, we will discuss giving directives when the therapist wants people to do what he says. The emphasis here will be on giving directives to whole families during an interview, but the procedures are essentially the same when interviewing a person alone.

When a therapist wants people to do what he or she says, there are two possible approaches. One can try to change behavior in a family by telling one or more members to stop what they are doing. For example, if a mother intrudes when a father and son try to talk to each other, the therapist can tell the mother not to intrude. Whether the therapist puts it nicely or forcefully, the therapist is asking her to stop what she is doing.

To ask someone to stop doing something is one of the most difficult directives to enforce. It can be done, but it is not easy. Usually one needs high status or a reputation as an expert for someone to stop usual behavior simply because he is told to. With minor problems or educational situations such direction is easier. If someone drinks too much, sometimes it is a good idea to tell him not to drink. He might stop. But if the problem is severe, he is likely to drink more, and a therapist does not usually have the power to enforce the directive. In the same way, some mothers in families with minor problems will stop intruding on father and son if told to stop. But if the family problem is severe, the mother may very well not stop but, rather, may debate the therapist about how he does not understand or appreciate her. A directive to stop needs to be accompanied by other messages. A therapist may have to repeat the directive often or magnify it by standing up and waving his hands at her to stop. Or he may have to put the mother behind a one-way mirror and have her watch father and son talk. Sometimes he needs to get the cooperation of the father and son by asking them to prevent her from interrupting.

If the therapist tells someone to stop usual behavior, he must usually go to an extreme or get other family members to cooperate and change their behavior to support him in this task. Often it is like trying to stop a river from flowing; one can try to block it, but the river will go over and around the block and the therapist will drown.

In telling someone to do something different, the therapist is trying to change behavior in a family by telling the family members to behave in a way that is different from their usual behavior. The therapist is asking them to try new ways. Instead of trying to block the river, the therapist is diverting it into a new pathway.

There are two ways to tell people to do something different: (1) good advice and (2) directives to change the sequence in the family.

Telling people that they should treat each other better is usually not useful to them. For one thing, they have had good advice from other people and have not been able to follow it. For example, if a mother fights with her daughter about what time the daughter comes in at night, good advice to them is usually not helpful. The therapist may say, for example, that they should listen to each other with respect, be nicer to each other, and find some compromise they both like. In most cases the therapist gives this kind of advice when he thinks they have not realized they should do these things. The therapist thinks he is telling them something new. Actually, they know how they ought to behave; their problem is that they cannot behave that way. Every time they try to be nice and respectful they get into a runaway fight.

Unless the therapist is dealing with someone who is quite unintelligent, or unless the problem is a mild, educational kind, good advice is not usually helpful. If the therapist is tempted, he can ask the family a question like this: "If I were to give you some good advice, what would I say?" The family members will then tell the therapist all the good advice that he has considered, that they have been given in the past, and that has not helped.

Giving good advice means the therapist assumes that people have rational control of what they are doing. To be successful in the therapy business, it may be better to drop that idea.

The directives that will be talked about here are ones in which the goal is to change the ways the family members deal with one another by introducing action. There are many ways to accomplish this goal. For example, if a mother and daughter

are in a continual fight about when the daughter is to come in at night, one can direct the father to take charge of this problem. This directive will change the sequence in the family. Or one might use many other kinds of directives in this situation. How to give such directives so that they are followed is a matter of skill and practice.

### Motivating a Family to Follow Directives

To motivate someone to do something means to persuade the person that there is some gain in it for him. When a therapist wishes to motivate family members to carry out a task, it is necessary to convince them that the task will achieve the ends they want for themselves individually and for one another and the family. How to motivate a family will depend on the nature of the task, the nature of the family, and the kind of relationship the therapist has with the family. But one can talk about general ways to motivate people.

The direct approach, a common approach for persuading family members to do a task, is to say to them that you know they want to solve their problem and that you want the same thing. When they agree on a goal, the task is offered in that framework of achieving what they want out of therapy.

When the family members are in conflict over their aims, it is sometimes necessary to find some gain for each of them in the task. For example, the therapist can say that the mother wants to be sure her daughter behaves properly, the daughter does not want this constant arguing with her mother, and the father does not want always to be called in as a referee. Therefore they should do the task.

In the direct approach, the therapist takes what has been learned about the family members in the session and uses what seems most evident and matter-of-fact as the basis for persuading them to do the task.

If it looks as if the family will not easily cooperate in the task, the therapist can go at the matter more indirectly. Often this indirect approach can be used first; later one can be more direct. In the indirect approach, the therapist leads the family

members to talk about their difficulties in such a way that they are ready to listen to someone who can offer something to do. For example, the therapist may ask the members to talk about everything they have tried to do that failed to solve the problem. This discussion yields information about what has been tried, so that the therapist does not ask them to do something that has failed already. Equally important, such a discussion gives the therapist the opportunity to emphasize what has failed before. As each failure is listed, it can be emphasized as a failure by saying, "And that failed too." After the listing is done, the family members will notice that everything *they* have tried has failed, and so they are more likely to listen to what *the therapist* has to offer.

A similar approach can be used by encouraging the family members to talk about how desperate their situation is. Rather than reassure them it is not so bad, the therapist can agree with them that it is quite bad. If the situation is made to appear desperate enough, they will listen to the therapist and do the task he or she offers. That is, the therapist uses their desperation as a motivation by emphasizing it. One can even project their situation into the future and have them talk about how disastrous the future will be if something is not done.

However, one can take a quite opposite approach if family members are talking about how things have been improving. One can agree with them and go along with that assessment. Then one can ask them to do the task as something that will help them continue to improve even more, so that what one offers is seen as a small addition to help along an improving situation.

It is possible to motivate family members to do a task at home by starting them on small tasks during the interview. For example, if a mother is asked to help her child do something in the room, and this task goes well, then she will be motivated to do what the therapist asks in directing her to help the child at home during the week. Similarly, if the therapist asks a father to intervene and help the mother and daughter while in the room, to ask him to intervene at home during the week can be seen as merely a continuation of that initial intervention. In such

situations, the task at home does not seem such a major event because in a smaller way it has already been done during the therapy session.

The therapist must fit the task to the people. While interviewing a family, one will observe what sort of people the members are and can fit the task to the family style. If the family members emphasize doing things in an orderly, logical manner, the task offered to them should be an orderly, logical task—they will be more likely to do it. If they form a casual, disorderly household, a casual framework for the task may be more appropriate. If they are concerned about money, the therapist emphasizes that the task costs nothing. One of the ways to get this kind of information is to ask the family members to do things while in the therapy room, such as move their chairs or talk about certain subjects. The ways they go about doing such tasks will give the therapist information on how to frame the outside task most acceptably for them.

How the therapist describes the size of the task is important. For some families and for some tasks, the therapist may choose to describe the task as small. For families who seem resistant, sometimes it is best to define the task as a small thing being asked of them. Families who enjoy crisis or have a flair for the dramatic can be told that this task is a major thing being asked of them. That is, some families will feel that a large task is too much for them, while others will feel that a small task is beneath them. The needs of both types must be met.

The therapist can exert authority in a number of ways. Generally, in motivating the family, the therapist should use his position as an expert on what should be done. If he acts as if he knows his business, people are more likely to do what he tells them. Usually people in trouble prefer to have a therapist know his business. Sometimes this preference can be used in an extreme way. If a family is the kind that bickers about things and unravels whatever is suggested, the members will continue to do so when the therapist tries to motivate them to do the task. In that situation, the therapist may tell the family, "I want you to do something, and I have my reasons, but I'd rather not go

into them. I just want you to do this in the coming week." The therapist can also get many tasks done by getting people to do the task in order to prove to the therapist that he is wrong or that his method will not work.

A variant approach is to say to a family, "I'm going to ask you to do something that you will think is silly, but I want you to do it anyway." Then debate is cut off, because the family cannot say the task is silly after the therapist has already said it is.

## Being Precise

After the family is motivated, the therapist should give clear instructions (unless there is a particular reason to be deliberately confusing). The directives should be clearly *given* rather than *suggested.* For example, it is better to say, "I want you to do such and such," than to say, "I wonder whether you've considered possibly doing such and such." To say, "Why don't you do such and such?" is really asking a question rather than giving a directive. It is better to be precise and clear and say exactly what one wants done. Observing the family members' responses while giving instructions will usually show whether they are clearly understanding what the therapist is saying. The therapist should not be afraid to repeat himself. Being repetitious is better than not being understood. Sometimes people will think ahead about one part of the instructions and thus not listen to another part. If the therapist has any doubt that someone understands, he or she can ask that person about the instructions and even ask the person to repeat the instructions.

One of the reasons for being precise is not only that the therapist wants the task done but also that if it is not done, he or she will want to be sure it was not left undone simply because the instructions were not clear.

However, in some situations it may not be desirable to be precise and detailed when giving a task. The therapist may want, instead, to drop in an idea so that the family "spontaneously" thinks of doing that kind of task. Nevertheless, the therapist still must be precise in his or her casual dropping of the idea.

## Involving Everyone

Just as it is important to involve all the family members in an interview, it is also important to give everyone something to do in a task. (For special reasons the therapist may leave someone out, but exclusion should not happen accidentally.) A good task has something for everyone. Even if the therapist specifically asks someone to stay out of the task, this request is still giving the person something to do.

The task should be structured like any other piece of work. Someone is needed to do the job, someone to help, someone to supervise, someone to plan, someone to check to see that it gets done, and so on.

If, for example, the task is that the mother and father are to agree on something during the week, this task should be made quite precise. The time set aside to talk about it should be decided, what each is to bring up should be specified, and the children should be assigned something to do. One child can remind the mother and father that it is time, if that is necessary; another child can interrupt them when it is time to end; and a third can report the agreement to the therapist at the next interview.

The purpose of involving everyone is to put the emphasis on the total family unit, except in special cases where the therapist wants one part of the family to do a task and wants the others to stay out of it. The therapist must also be careful not to confuse hierarchy in the family by involving children in adult tasks. But, just as no one should be left out in the interview, no one should be left out of the action designed to take place in the home.

It is important to involve the siblings in a task for other reasons than just being fair. If a sibling becomes distressed, the case can go badly. For example, there is often a hierarchy confusion among the siblings in a family with a drug addict child. In one particular case, the addict was the younger daughter. Her oldest brother also had problems. The second brother was the pride of the family because of his success in life. This brother proposed a plan for the father and daughter to do something together. It was a good plan, accepted by the therapist. It was

important to involve the oldest brother in the task because if he were left out, he might become jealous of his younger brother and increase his own problems. Should that happen, the parents could become distressed, and the daughter might consequently relapse to help her parents. Providing therapy for a particular sibling can often be seen as requiring the therapeutic involvement of other siblings so that everyone does well in the therapy.

## Reviewing the Task

In many cases, particularly if the task is very complex, it is a good idea to have the family members review what they are to do. If one member reviews, the others should be brought into the discussion by asking them to specify their particular parts in the task. This review, which can be done quite quickly with most families, is further insurance that the task is fully understood.

The therapist should anticipate difficulties while reviewing the task. When the therapist gives family members a task, while he or she is talking they are sometimes thinking of ways to get out of it. If this situation seems possible, the review should be followed by a discussion of ways they think they might avoid the task. Usually, family members will bring up what they have thought about. If not, a few suggestions may be helpful. For example, the therapist can ask: "What if somebody forgets?" or "Suppose someone gets sick?" Such suggestions are helpful, particularly if family members have indicated that such things often happen. When the therapist does this, the family members have blocked themselves off from getting out of the task and are more fully committed to it.

## Examples of Tasks

A few simple examples of tasks may be helpful at this point in the discussion.

1. In an actual case in which the grandmother is siding with her ten-year-old granddaughter against the mother, the

therapist sees mother and grandchild together. The girl is instructed to do something of a minor nature that would irritate grandmother, and the mother is to defend her daughter against the grandmother. This task forces a collaboration between mother and daughter and helps detach daughter from grandmother.

2. In another case, a husband is asked to do something for his wife that she would not expect, and she is asked to receive it graciously. He must not do something routine, which she would expect, and therefore he is encouraged to initiate something new in the marriage. He also must think about his wife carefully to decide on something she would not expect.

3. A father and son are asked to do a minor thing that the mother would not approve of. It will be difficult for the mother to arrange what they do when the thing must be something she does not want.

4. A mother who does not differentiate among children of different ages may be asked to set and enforce a different bedtime for each child, even if the times are only fifteen minutes apart. This task forces her to differentiate on the basis of age.

5. A father who is siding with his small daughter against the wife may be required to wash the sheets when the daughter wets the bed. This task will tend to disengage daughter and father or cure the bedwetting.

6. Among the many tasks that can be done inside the interview room are those that involve changing pathways of communication. Father and mother may be directed to talk without including daughter, or mother and son may be told to talk without father interrupting. A son may be physically moved to sit beside a male therapist while they observe the women in the family making a decision about something, thereby drawing a gender boundary. A family in which everyone constantly interrupts may be told to pass a coat or hat around and only the person holding it may talk. Or a "speaker's chair" may be set and only the person sitting in it may talk. All these tasks shift the pathways of communication.

7. A mother and father who need an excuse to be affectionate with each other may be asked to show affection to each other in an obvious way at set times to "teach their child" how to show affection.

8. A husband and wife with sexual problems may be required to have sexual relations *only* on the living-room floor for a period of time. This task changes the context and so the struggle.

9. When there is an intense triangle between a mother, a teenage daughter, and a father, the father may be asked to take the daughter out to a nice place for lunch to give her experience in behaving well in public. Mother can be asked to dress the daughter for the occasion or choose the place. Such a directive may seemingly involve father and daughter more intimately but actually draws a generation line in the result.

10. A man who is afraid to apply for a job may be asked to go for a job interview at a place where he would not take the job if he got it, thereby practicing in a safe way.

11. Among the many tasks a supervisor may give to a therapist is one to help him disengage from a family. The supervisor can have the therapist tell a couple near termination of therapy that they will probably have a major disagreement. The couple will be inclined not to want such a fight, and they will pull together against the therapist to avoid it, thereby extruding him.

12. When a mother is behaving helplessly with the children and so keeping the father involved but exasperated, the father may be instructed to educate the mother in how to deal with the children (beginning by practicing in the room). To get the husband off her back, the mother will become more effective with the children, and the couple are then likely to begin quarreling more openly.

13. An individual or family may be told that during the coming week they will spontaneously get an idea that will improve their situation. They may be told they are at a stage where they are responsive now to ideas from within themselves. This task helps patients initiate changes.

14. To get more distance and objectivity between a mother and child, the mother may be asked to hide something where the child will take no more than ten minutes and no less than five minutes to find it. She must repeatedly attempt this task until she succeeds. The mother must think through just how her child thinks, and how he thinks differently from her, to succeed.

15. Some tasks involve compromises that satisfy everyone. For example, one husband was always concerned about his health, and he regularly took his temperature, even walking about the house with a thermometer in his mouth. His wife became angry every time he did this, and they would fight about it. They could not resolve the issue. The therapist agreed that the husband should be able to take his temperature when he felt it necessary. His wife should also not be provoked by her husband's "forgetting" and walking through the living room with a thermometer in his mouth. The directive was that they break the oral thermometer that same day and purchase a rectal thermometer for his use.

16. When a husband and wife, or parent and grandparent, are at an impasse over who is correct in the way the child should be dealt with, a therapist can provide a behavior modification program. One person may be excluded by this arrangement, or they may be brought together. For example, the parent can say to the grandparent that this is a new procedure being learned at the clinic and so from now on parent and not grandparent is to be the authority on what to do with the child with this new procedure. Or parents who have fought over different ways of dealing with the child can reach agreement on this new way and so resolve a parental conflict that has been maintaining a child problem.

17. With a depressed person, the therapist can require a series of tasks that require the person to activate. The more trivial the tasks, the more angry and less depressed the person will be. To change the organization maintaining the depression, the therapist can require the family members to initiate and enforce the tasks to activate the person.

18. A task can be used to prevent something happening that a therapist does not want. For example, a mother who felt she was unable to control a twelve-year-old boy said that she was reluctantly going to put him in military boarding school, because there was nothing else she could do. The therapist suggested that the boy did not really know what a military school would be like, and in fairness the mother should teach him about one before sending him away. The mother agreed, and under the therapist's direction she began to teach the boy to stand at at-

tention, be polite, and make his bed every morning after rising early. It became a kind of game between mother and son to have her be the sergeant and him be the private. In two weeks he was behaving well enough so that mother did not think it was necessary to send him off to military school. Mother had found a way to deal with the son, and he had found a way to do what she asked.

### The Task Report

After giving a task, the therapist should always ask for a report at some time in the next interview. Generally there are three possible results: the task has been done, it has not been done, or it has been partially done.

If the family members have done the task, congratulations are in order and the interview goes on from there. If they have partially done it, an exploration is necessary of why they have not completed it. Sometimes there are practical reasons and they just could not complete it. At other times they just did not get it all done and have no good excuse.

When people have only partially done what the therapist asked, he or she should not excuse them easily. If they are let off, it is saying that what they were asked to do is not important. This message makes the therapist less important and also makes it less likely that they will do the next task asked of them. Once the therapist has given a task, he or she has started something that must be finished.

When family members have not done a task and have no valid excuse, there are two extreme ways to deal with the situation. One is the nice way, and the other is the not-so-nice way. The nice way is for the therapist to apologize. One should say, "I must have misunderstood you or your situation to ask that of you—otherwise you would have done it." That is, the therapist takes on the burden of not having acted correctly. Out of such a discussion can come a somewhat different task which they will do.

With the not-so-nice response, the therapist should have the attitude that the family has failed. It is not that they have failed the therapist, but they have failed themselves. That is,

the therapist condemns them for unfortunately having missed an opportunity. One way to express this approach is to tell the family members that the task was very important and that for their sakes it is too bad they did not do it. The therapist can tell them that now they cannot know how beneficial it would have been to them. If they say they did not think the task would do any good, the therapist can say they can never know that now, because they did not do it. Throughout the interview, when they bring up problems, the therapist can point out that naturally they have those problems because they did not do the task. His or her goal is to get them to say they would like to have the opportunity to try again and do the task. If they do say this, the therapist can tell them that that opportunity is gone and can never come again—they cannot do the task now. In this way, the therapist sets up the situation so that the next time he or she asks them to do a task, they will do it.

Generally, a therapist should not easily forgive people who have not done what was asked. Sometimes it is best to be hard on people for not doing a task and then later in the interview find a way to excuse them. But failure to do what a therapist asks, or only partly doing it, should never be treated lightly.

It should be emphasized, however, that the therapist should not anticipate resistance from a family when setting up a task. If the focus is on what is important to the family, the presenting problem, and if the therapist offers a reasonable explanation why a task is necessary, cooperation will be obtained. Most typically the family will simply agree and do the task asked of them.

### Metaphoric Tasks: The Use of Analogies

The metaphoric way of directing someone is important because it is not always appropriate to make explicit what the therapist wants to happen in a family or what the therapist wants the members to do. Sometimes people will be more willing to follow a directive if they do not have to concede that they have received one. Talking in metaphor is one way to give such a directive.

A metaphor is a statement about one thing that resembles something else. It relies on the analogous relationship of one thing to another. We say "high as a kite," meaning the way the person is "high" resembles the way a kite goes "high." Or we say, "The way his father talked to him, it's like he was run over by a train." A play on the stage is a metaphor about life because what happens there resembles what happens in life. Often when a therapist wants family members to behave in a certain way, he or she gets them to behave in some other way that resembles the one the therapist wants. Then they will "spontaneously" behave the way the therapist wants them to.

As an example, in one case where a boy was reported to be afraid of dogs, the therapist learned that the boy had been adopted as an infant. The boy ostensibly did not know he had been adopted, and the parents did not wish to tell him. The therapist assumed the boy did know. The therapist wanted to get the family to take a dog into the home and also wanted to deal with the adoption issue. He therefore talked to the boy about "adopting" a dog who had a problem of being frightened. He then discussed with the boy various issues, such as the possibility that the dog might become ill and have to be taken to the doctor (which situation paralleled the adopted boy being taken to the doctor). When the boy said the family might have to get rid of the dog if he became ill and cost doctor bills, the therapist insisted that, once the dog was adopted, the family was committed to him and would have to keep him and pay his doctor bills no matter what. Various concerns the boy might have had about himself as well as the parents' concerns about him were discussed in metaphoric terms in relation to the proposed adoption of the puppy.

Metaphors are not only words but actions. The ways in which a therapist deals with the children in a room can influence the ways the parents will deal with the children even if he does not point anything out to them. By how he operates, the therapist is showing them how to operate without making an issue of it. This approach is showing something metaphorically; the therapist is saying something in action that resembles something else he wants to have happen.

Another example can illustrate this approach. Suppose that a therapist wants a married couple to enjoy sexual relations more than they do. She wants husband and wife to behave differently together and to have a more pleasant mood during sex. She sees that there is bad feeling and a sense of contest around sexual relations, and she also sees that they (or she herself) have difficulty talking directly about their sexual activities.

If the therapist decides not to approach the problem directly, then she begins to think of what other situations a married couple go through together that have some processes resembling sexual activity, something that is permissible to talk about. One possibility might be for them to have a date together as they did in their courtship days. The therapist can talk about what is to take place on their evening out. Or there might be a game they play together. The therapist can talk about the way they should deal with each other during a session of the game.

One of the metaphors Erickson developed to use for this problem is to have the couple talk about eating together. The therapist can discuss how they have dinner together. Is there a time they have dinner without the children present, just the two of them? As the therapist asks the couple about this, she can talk about aspects of eating that resemble sexual relations. She can say, for example, "Sometimes a wife likes to have appetizers before dinner and start slowly, and her husband likes to dive right into the meat and potatoes." Or "Some husbands compliment their wives on how nice everything looks, and other husbands just don't notice and so their wives don't put out any effort." As she talks about these things, if the couple appear to be connecting what she says with sex, she changes to a part of the subject that does not touch so closely on the sexual topic. She does not want them to make the connection consciously. Then she moves back again to talk about how some people like dinner with the lights dim and perhaps with candles, while others like bright lights where they can see everything they want to enjoy.

At the end of such a discussion, the therapist can move naturally toward a task about dinner together. They are to choose a night, and together they are to prepare a pleasant dinner.

They are to show appreciation for each other's differences in taste and are only to bring up pleasant things and not the troubles of the day. The wife is to try to stimulate her husband's appetite, and he is to do what he can to provide what will please her. If the dinner goes well, the odds are that the mood will carry over to sexual relations.

As another example, a family was in therapy with a problem boy who improved. The mother said she would also like to improve her marriage. The father, who also appeared unhappy with aspects of the marriage, said he did not want to deal with his marriage in therapy. He was there for the boy and nothing else. At this point the therapist could choose to focus on the boy and drop the marital issues. Or the therapist could deal with the marriage indirectly so the father would not have to reveal his marital problems or discuss them with the wife in the therapist's presence. That approach was decided on, and the therapist began to talk with the parents about their two boys in a way that was metaphoric to the marriage. Mother had tended to side with the good boy, in general, and the father sided with the problem boy. In that sense the children represented them. The therapist discussed the relationship between the two boys, which paralleled the relationship of the couple. For example, the good boy was embarrassed by the problem boy in public. Mother, too, was sometimes embarrassed by the father in public. A crucial issue was the right of the problem boy to have some time to himself. Father insisted the boy should have some, and he added, "It's like when a man comes home from work, he likes some time to himself with a beer and the newspaper before his wife tells him all the day's problems." In the following week, the couple made the arrangement that father was to have time for himself when he came home, which improved his relationship with his wife. They thought they had "spontaneously" thought of that. The therapist assumed it was a product of the metaphoric conversation. A series of such conversations led to similar changes, without the marriage ever being explicitly discussed.

There is an important aspect of this metaphoric technique that is sometimes not known. Merely discussing something

in a metaphoric way does not produce change. It is important that the therapist take a position when talking metaphorically. For example, if the therapist is talking about having dinner as a way of discussing sex, it is necessary to say that enjoying dinner is a good idea. That is, when trying to change A, the therapist should take a position on B. In the case of this couple, it was when the therapist said that the boy should have time for himself that father made an issue of people needing time to themselves. Merely drawing parallels in metaphor does not cause change.

Another important aspect of the metaphoric technique is that it raises ethical problems. The therapist is changing some aspects of a person's life outside the person's awareness, ostensibly, and without an explicit contract that this area is to be changed. It might be that the person is always aware, at some level, or he or she would not participate and be influenced. But still the therapist must approach change through the use of metaphor with a concern that special ethical responsibilities are involved.

In summary, in the metaphoric approach the therapist chooses a goal of achieving some change. The therapist selects an activity that resembles the one he or she wants to change, an activity easier for the family to deal with. A story or a conversation is used to discuss that area in order to gain information and to influence the way they think about it. The therapist takes a position on how things should be in the metaphoric area. Finally, a task might be assigned in the metaphoric area.

### Paradoxical Tasks

The directives up to this point have been the kind a therapist gives when he wants the family members to do what he says. There is another kind of directive in which he wants the members to resist him so that they will change. These tasks may seem paradoxical to family members because the therapist has told them he wants to help them change but at the same time he is asking them not to change.

This approach is based on the idea that some families who come for help are resistant to help offered. The members are

very good at getting a therapist to try and fail. The therapist is then pulling at the family members to improve, while they are resisting and provoking him to go on pulling. This situation is frustrating for both the therapist and the family.

To some extent it is true of all families that they are resistant to change if they are in a stable state. If they are in a crisis and unstable, with everyone upset, they will often follow directives easily because they are trying to stabilize. But if they are stable and a therapist asks them to change, he is asking for instability and something new, and people may react against that. Yet all families who come for help are unstable enough to have sought assistance. So it is never simply one way or the other.

Usually a family has stabilized around one family member being the problem. When the therapist moves to make a change in the situation of the problem person, he is moving to unstabilize the family, and he will meet resistance in varying degrees. Paradoxical tasks are designed to deal with this problem.

There are two general approaches with a paradoxical task: (1) an approach to the family as a whole and (2) directives that involve only part of the family.

*The Approach to the Family as a Whole.* An example of an approach to the whole family is the case described in Chapter Five. The therapist expressed his concern about what would happen if the child were properly toilet-trained and became normal. Within a framework of trying to change the family, the therapist restrained the members from getting better. The paradoxical approach always has two levels on which two messages are communicated: "change" and, within the framework of the message, "don't change."

As another example, a family may enter with a problem child who will not go to school. The therapist—within the framework of her job, which is to help the child get back to school—can talk to the family about how perhaps the child should not go to school. She can suggest that it might be better if the child just stayed home and can offer various reasons for this, depending on the particular family. She might say that perhaps the family would get upset if the child went to school like normal children and therefore it would be better if he or she stayed home.

This approach requires skill, because the therapist is communicating a number of different things at the same time. She is saying, "I want to help you get better," and she is saying, "I am benevolently concerned about you." She is saying things to the family that are on the edge of being insulting: she is saying she thinks the family members can really tolerate being normal, but she is also saying perhaps they cannot.

The dangers in this approach come about when the therapist does not communicate all these things at once. If she does not, the family members may feel merely that she thinks they are hopeless. Or they may feel that she is taking advantage of her position to be insulting—or that she does not really care whether they change or not.

When the approach is successful, the family members achieve the goal of the therapy to prove to the therapist that they are as good as other people. They "spontaneously" change. The therapist must accept the change when it happens and let the family put her down by proving her wrong. If she wants to ensure that the change will continue, she might say to the members that probably the change is only temporary and they will relapse. Then the family will continue the change to prove to her that it is not temporary. Talking about the change being temporary serves to block off a relapse. The therapist can do the same thing by encouraging a relapse. This approach can ensure that no relapse will occur. One can say to the family, "I can see you've changed and are over the problem, but I think this has happened too fast. I would like you to have a relapse and this week go back the way you were before." Sometimes one can put it, "I want you to feel as miserable as you did when you first came in."* To make this directive reasonable to the family members, the therapist might say that too fast a change is upsetting, or that they really need to understand how bad

*Milton H. Erickson was, of course, the master at directive therapy, and he had a particularly graceful way of encouraging a relapse. He would say, "I want you to go back to that time when you felt miserable, feel as you did then, and see whether there is anything from that experience you wish to salvage." Since there is usually a nostalgia for lost symptoms and problems, as well as relief, such a suggestion fits particularly well.

they felt before, or whatever else might seem reasonable to them. However, when asked to relapse, they will resist by not relapsing, which is the therapist's goal. (Even if they should relapse, the relapse is under her direction, and so they are following her directives and cooperating with her. In this way she can then get them not to have a relapse again. But such relapses do not happen if the approach is done properly.)

*Directives That Involve Part of the Family.* Often a therapist will not want to use a paradoxical approach to the whole family, but only with a particular person or a particular pair. The procedure remains the same: one asks people to stay the same, within a framework of helping them change.

For example, a mother may be overprotecting her child and hovering over him so that he has no freedom to make decisions or take responsibility for what he does. If the therapist tries to persuade her to do less for the child, she may respond by doing more, often saying that the therapist really does not understand how handicapped the child really is. One can take a paradoxical approach by asking the mother to spend a week hovering over the child. She is to watch over him, protect him, and do everything for him. A therapist might give different reasons for this directive, depending on the mother. For example, he might say she should do this so she can find out how she really feels in this situation or so that she can observe herself and the child. To use this approach well, the therapist should ask for more extreme behavior than the mother has been showing. For example, she should not only hover over the child but also set aside a definite time to spend a whole hour warning the child about all the dangers in life (an hour is a long time). Or the therapist should take some other aspect of her behavior and make it more extreme. If this approach is done well, the mother will react by rebelling against the therapist and hovering over the child less. She will not like to do what she is doing because someone is telling her to do it. She also will not like to do more of it, particularly when she also feels that too many demands are made on her by the child already. She will begin to emphasize that the child should do more for himself and take more responsibility. That is, she will begin to move to the position

the therapist would really like her to go to. Usually it is necessary to pursue this approach. If the mother hovers over the child less, the therapist should not congratulate her but should push her to do more. This approach is one way of disengaging a child from a parent without using another family member.

The same approach can be used with couples who are always fighting in an unproductive way. The therapist can ask them to go home and have a fight at a set time and for a certain period, such as three hours. The goal is to get them to fight less. People do not like to fight or make themselves miserable because someone tells them to do so.

Similarly, if a child is provoking her parents, the therapist can ask her to do that for a full week. If she provokes them, they will react differently because they have heard her asked to do so. If she does not provoke them, the therapist has changed a pattern in the family, which is what he is after.

To use the paradoxical approach, a therapist must develop skill and must practice. He also needs to be able to think about problems in a gamelike or playful way even though he realizes that he is dealing with grim problems and real distress. He also needs to tolerate the emotional reaction of the family toward him, since this approach forces them to deal with him in ways they have never dealt with a helper before.

The design of a therapist's directives in this approach is relatively simple. He observes how the family members deal with each other and directs them to behave in that way. How he gives the directive, how he makes it seem reasonable, and how he reacts to a change and follow-through can require more innovation than the design of the task.

*Stages of a Paradoxical Intervention.* To summarize the paradoxical approach, the proper stages can be illustrated with a case example. A nine-year-old boy was referred to a clinic for a problem of compulsive masturbation. He masturbated at school and at home in front of his mother and sisters. The problem was so severe that he had worn holes in the crotch of his pants, and his mother reported he had been hospitalized for blood in his urine. The problem had existed since the boy was five years old. A child therapist had worked with the problem for a year

and a half with no improvement. He had tried insight into the problem, had tried some rewards and punishments, and had met regularly with the boy's mother. He referred the case hoping that family therapy would help. The family was on welfare, and the father had been dead for several years. There were three older daughters in the family, two of them living outside the home. The twenty-year-old daughter had two small children who were also in the home.

The stages of the paradoxical approach can be summarized. First, as in all directive therapy, one must establish a relationship defined as one to bring about change. This definition is usually implicit in the framework when someone asks for therapy, but it can be emphasized. Second, one must define the problem clearly. In this case the problem was defined as public masturbation. Third, one must set the goals clearly.

The goal was not to stop the boy from masturbating but from masturbating in public and without pleasure. Setting goals clearly is particularly important if one is using an effective therapeutic technique.

Fourth, one must offer a plan. It is helpful to offer a rationale to make a paradoxical directive reasonable, although one can also leave the plan implicit and merely give the directive. In this case the first step in the plan involved the mother and other family members, and the second step involved the boy. The therapist asked the mother to let him deal with the problem with the boy privately, although he also wished to see the whole family together at times. The mother agreed. In this way the therapist attached the boy to himself and made the problem an issue between two males. Later, when he saw the boy alone, he offered the rationale that his paradoxical request for an increase in the masturbation was to prevent the boy from doing it on days when he did not enjoy it.

Fifth, one must gracefully disqualify the current authority on the problem. The authority on the problem may be a spouse or a mother or some other family member. Usually someone is trying to help the person solve the problem, and that someone must be defined as not doing the right thing.

In this case, the mother had taken the boy from doctor

to doctor for years to solve the problem. The therapist suggested that she would become upset when the boy improved. The mother did not like that idea. The therapist asked her what she might do with herself when the boy was over the problem. She thought she could find something else to do with herself. A purpose in dealing this way with the mother is to encourage her to prove that she will not get upset when the boy improves. The only way she can prove this is to help the boy become normal and show she is not upset. Therefore she is working at home to improve the boy while the therapist is working in the office to improve him, and they are working together. In the therapy the mother was also seen alone to interest her in school and work so she would have more in her life than this problem son (and an even more problematic daughter).

Sixth, the therapist must give the paradoxical directive. As part of defining the problem, the therapist asked the boy to make a baseline chart on how often he masturbated. The boy came in the following week and reported the number of times. He said that he had enjoyed it most on Sunday. The therapist gave the paradoxical directive that the boy do it more on Sunday, when he enjoyed it, and not on the other days, when he enjoyed it less. He was asked to do it eight times on Sunday, twice as often, perhaps getting up early to get it done.

Seventh, the therapist should observe the response and continue with encouragement of usual behavior. The therapist should not relent for rebellious improvement or if the person is upset but should reemphasize the rationale and the plan. If the person improves and does less, the therapist should define that as not cooperating, because the request was for more problem behavior.

In this case the boy had done his masturbating on Sunday, but he had also done it on Monday, when he was not supposed to. To punish himself, he was asked to do it twelve times on the next Sunday. Masturbation was also made more of an ordeal by requiring him to undress completely, fold up his clothes, and so on.

The next week the boy came in without the baseline paper, had joined a hockey team, and was more cheerful. The therapist

insisted on more masturbation. By the fifth interview, the boy had rebelled and masturbated less than required on Sunday. The therapist condemned him for not cooperating and, as punishment, required him to masturbate once each day in the living room in the presence of his mother and sisters. It had taken five weeks to arrange that the boy do as a punishment exactly what he had been doing as a presenting problem. (Some clinicians would have difficulty being this punishing, but given the severity of the problem and the fact that the boy was only being asked to do what he was already doing, this therapist did not find it difficult.)

Eighth, as change continues, the therapist should avoid credit for it. Accepting credit means that relapses occur in relation to the therapist. Although a therapist might want to "share" with a client and explain what he is really doing, the risk is a relapse caused by the therapist's need for comfort. A way to avoid credit is to be puzzled by the improvement.

In this case, the therapist recessed for two weeks. The first week he required the masturbation program. The second week he left unclear what the boy was to do. This omission allowed the therapist to judge the amount of spontaneous change (rather than a methodical extinguishing of the behavior). If the boy gave up the public masturbation, the therapist would drop the issue. If he did not, the procedures would be reinstituted.

In two weeks the boy reported that he had done little or no masturbating the second week and seemed to have lost interest in it. The therapist dropped the matter and talked to the boy about going to camp (which had not been previously allowed by mother).

The therapist continued the therapy focused on the mother and daughter problem, with the boy present but not involved around the issue of his symptom. A few weeks later the masturbation was inquired about, and the mother said at times the boy provoked her by putting his hands in his pants while watching television. This action was not made an issue, and in a follow-up a few weeks later the problem was gone.

The mother was allowed to show that she did not get upset when the boy improved, and the boy's general manner became

more mature in a matter of a few weeks. He even made some trouble with a friend at school, which he had never done before because he was a quiet boy and a good student. The therapist and mother defined this kind of trouble as normal for a boy that age. The teacher confirmed that he was changing.

It should be emphasized that in this case the paradoxical maneuver was used within a family context. The therapist dealt with the boy about other issues, such as sports and girlfriends. He also dealt with the mother about other interests in her life. When the boy improved and became less obedient, the mother showed that she did not get too upset about the change. The shift to the daughter's problems allowed the mother to be less focused on the boy. All these aspects were part of the therapy and not merely the paradoxical maneuver. There were also stages to the therapy and not merely an encouragement of the symptom and a backing off when improvement occurred. It was necessary to follow through in a systematic way.

## Designing Tasks

When a therapist first gives tasks to families, designing tasks may seem difficult. With practice and experience design becomes easier.* A few guidelines can be offered.

Whatever the task, it should be simple enough so that the family can do it (unless the therapist has a special reason for wanting them to fail). The therapist wants successful achievement, and so he or she should only ask people to do what is possible for them to do in their situation. The therapist should be able to say with confidence, "This is something you can easily do." The task should also be adapted to the financial and time situation of the family.

Although the goal is to design a task the family can do, getting the task done can be less important than the negotiations around the task. For example, if the therapist says she will not assign a task until all the family is present, she is setting up

*For a discussion of designing strategies, see C. Madanes, *Behind the One-Way Mirror: Advances in the Practice of Strategic Therapy* (San Francisco: Jossey-Bass, 1984), chap. 5.

the task properly, but she is also using the task to get the family to organize itself in a new way by the members taking charge of getting everyone to the session. Sometimes the arrangements to do the task, when accomplished, solve an organizational problem without requiring the task. Sometimes, too, a threat of a task will force changes. With the directive approach, the directive becomes something for the family to talk about instead of about their problems or their past. It provides an issue for therapist and family for discussion.

A task can be a simple one if the primary goal at that stage is to intensify the relationship with the therapist. Asking family members to make a list of problems, or to observe certain behavior during the week, or to talk together at a set time all will serve the purpose of getting families involved with the therapist.

When the primary goal is to bring about an organizational change, the task to be given requires more thought. The best task is one that uses the presenting problem to make a structural change in the family. For example, if the therapist wants mother and problem child more involved and wants a parental child excluded, and the problem child is a fire setter, the therapist can ask the mother to teach him how to set a safe fire with matches for a certain period each day. If a child is afraid of dogs and the therapist wants to disengage mother and child and have the father intervene, father and child can be asked to select a particular kind of puppy.

With this approach, the focus is on respecting and utilizing what the family considers important, the presenting problem, and what the therapist thinks is important, an organizational change.

The steps in designing a task are to think about the presenting problem in terms of the sequence in the family and to find a directive that changes both. For example, a common problem is a child who declines to go to school. The families differ in many ways, but the most typical sequence is the following.

The child refuses to go to school. The father insists the child go and in the morning pushes the child to go. The child manifests anxiety, illness, or vomiting or runs away. The mother

steps in and insists the father is too hard on the child, and the father backs off. After a while the parents agree the chld must go to school. The father insists the child go, the child manifests involuntary behavior, the mother intervenes, and the father stops insisting.

There are many variations to this sequence. It may be the mother who insists the child go and the father who becomes upset. It may also be that some physical problem overwhelms the mother as child and father get into altercations over the school issue. The explanations for why the child stays home vary, but (unless the problem is at school) they usually include the idea that the child is necessary at home for some function in the life of one or both parents. Of course, it is necessary to be sure that the problem is not that the school situation is unsafe or for some other reason the child should not go there.

To get the mother and father to work together, it is necessary to motivate them by having them agree that the child must go to school and is falling behind. Drawing them out about a child's future if the child does not attend school is also helpful. Usually parents agree that something must be done; that is why they are there. It is best to review with them all the ways they have tried to get the child to go that have failed. An important part of this motivating stage is to join the parents within their difficult problem. It is very important to avoid interpretations about why they have failed or what might be "really" behind the problem.

The directive designed must take the usual sequence into account. Various directives are possible. The responsibility might be put on the father to take the child to school, or it might be put on the mother. Or the therapist may say that mother must see that the father does it. Or it could be appropriate, if logistically possible, that both parents escort the child to class.

In a straightforward task such as this, the crucial issue is anticipating what will happen. The therapist must review with the father how he will take child to school. The parents are then asked to discuss how the child will behave—temper, upset stomach, anxiety, vomiting, or whatever might happen. The mother is asked what she will do when the child becomes upset. Her

concern that the father and child might kill each other can be examined in terms of its validity. The parents should anticipate that the child might be innovative at the moment when success is about to occur and say something like "I won't go to this school, but I will go to some other." How should the parents respond? Generally it is best to agree that the child could finish the term in this school and then perhaps transfer to another, but they should not let the child deflect them from their task.

The therapist should keep in mind, when discussing this task, that the goal is both to get the child into school *and* to resolve the difficulties between the parents to which the child is responding by not going to school. These difficulties need to be defined in terms of the child's problem. For example, if the parents say they get so upset with each other's way of dealing with the child that they think about separating, the therapist should not discuss separation. He should say that separation is an important issue but whether they separate or not, the child must go to school, and they must solve this problem together. Later, when the child is going steadily to school, the parents may bring up separation. At that time it is appropriate to deal with separation, since it is a real issue and not merely part of the previous sequence.*

The therapist may want the parents to review with the child in the therapy interview what is to happen on the morning designated for going to school. Perhaps the therapist will want them to practice the task. He can have the father insist and the child get upset and mother try to rescue the child. If siblings are involved, they should be given something to do in relation to the task.

When the family report what happened, the therapist finds that they have succeeded or not, or they have partially succeeded. Each alternative leads to different results. If the family have succeeded, the therapist should see them for a period to stabilize them with the child in school and deal with the other issues involved. If the family have partially succeeded by getting the child to school but he left school early, or some unanticipated difficulty arose, the task can be repeated.

*For designing a task in relation to the structural organization, see Chapter Five.

If the family have no excusable reason for not having done the task, the therapist must deal with this seriously, mourning this misfortune, and offer an alternative. He can begin, for example, a set of procedures designed to make it more uncomfortable for the child to be at home than at school. For example, the child is to get up at school time, get dressed, and stay in his room reading during school hours—no television or entertainment, and so on. Often the parents will do this task, since they failed at the other. After succeeding at this task, they can again push the child toward school.

This example illustrates designing a task when the problem is serious and organized action must occur. Other examples would include having an anorectic young woman be required by her parents to eat or having a family organize an extreme response to stop the use of drugs. Similarly, a threat of suicide can involve a whole family in a suicide watch, just as there can be a family consequence around preventing drinking when there is an alcoholic problem. In these cases the directive is straightforward: the therapist decides how the situation would be if therapy were successful and gets there as rapidly and directly as possible.

If the therapist does not have the authority to arrange such actions as getting a family to organize an action or getting an individual or a family to follow an ordeal,* then more indirect procedures are necessary, such as paradoxical or restraining techniques. Often a therapist can have alternative plans for backups that can be used if necessary.

When children and young people are the problem, the therapist should keep in mind that he or she is changing a repeating sequence and so is changing the structure between parents and children. Drawing a generation line clarifies parental functions and husband-and-wife issues. When one uses a directive approach, the design of tasks is greatly simplified if a clearly defined presenting problem is negotiated. The better tasks use the presenting problem as leverage for inducing change. As a therapist learns to clarify problems and to set goals, designing directives becomes easier.

*For the design of ordeals, see J. Haley, *Ordeal Therapy: Unusual Ways to Change Behavior* (San Francisco: Jossey-Bass, 1984).