Dan's

Talking Points

Memo

Wilcoxon, Remley, & Gladding;
Chapter 5

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1. Expert Power (page 90). A very delicate subject. Most of us who were raised as "individual therapists" have some disdain for the notion that a therapist must have "power" to be effective. We generally like to think of our role as that of being an "equal partner in patient growth and development," and assert that therapist power would only be manipulative, or a deterrent to patient autonomy. Family therapists, on the other hand, must have power, and in subtle ways, lots of power. They need to be agents of change, to push a bit, to direct change, to literally require changes in the system. The family therapist is going up against a dysfunctional system of long standing … sometimes the system has been dysfunctional for generations. Without power, a family therapist will be chewed-up and spat out in a therapeutic nanosecond! We need to talk about how a therapist can move between both worlds, one where s/he advocates for and models equality, and the other where s/he wields power for the sake of change. Frankly, I think this is one of the most confusing role dilemmas in all of therapy, and an area where it is critical that we have an understanding of our role and function, and can articulate the dilemma and defend our position. We'll chat about this for quite a while . . . be ready. Wow, this is HEAVY stuff. According to our text (later), Jay Haley suggests that the "MFT should function as a trained expert, not an equal partner."

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2. I love the notion by Salvador Minuchin (1974) where he said, "The power of the therapist is considered to be the primary means of bringing about change." This is a huge topic, and one that we need to forthrightly discuss. Carefully examine pages 90 through 94, INCLUDING the three case examples.

3. Convening treatment has its own level of intrigue. Do we start with one family member and hope others attend? Do we demand that all relevant parties be on board in an all-or-nothing sort of sentiment? Have a sense of the term "Battle for Structure" (that has already appeared several times in the text) and how it applies to convening treatment sessions (p. 95, etc.).

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4. Understand the systemic principles of *enforcing* and *enabling* as articulated by Teismann (1980). What do you think about getting referral sources/ agents involved in proactive enforcing of your wishes for patient participation? (p. 96).

5. What do you think about the Wilcoxon and Fennel (1983) letter to the non-attending spouse? (p. 97)

6. In this business, you would be well advised to know the arguments on pages 96-97 which support the systemic intervention vs. traditional individual interventions. I'd probably be able to cite these in the future . . . if not to me (Dan), to your patients who have questions regarding the merits of family vs. individual treatments.

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7. Paradoxical procedures (p. 98). One of the most powerful tools of the MFT is also the least understood and perhaps the most dangerous. For paradoxical treatments to work, they cannot be explained. Once explained, they are no longer paradoxical. Since they are applied in the absence of explanation, are we running afoul of our ethical obligation to define for patients the exact nature of their treatment? Per the book and according to Jay Haley (1976), "ethical prescriptions requiring MFTs to disclose to patients everything they sense about them are naive and that therapists who are unwilling to draw a boundary between themselves and their patients and insist on sharing all not only risk failure but also risk doing harm."

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- **Paradoxical intention:**
  - A therapeutic strategy in which clients are instructed to engage and exaggerate behaviors that they seek to change.
  - By prescribing the symptom, therapists make clients more aware of their situation and help them seek to change.
  - By prescribing the symptom, therapists make clients more aware of their situation and help them achieve distance from the symptoms.
  - For example, a client who is afraid of mice may be asked to exaggerate his fear of mice, or a client who hoards paper may be asked to exaggerate that behavior so that living becomes difficult. In this way individuals can become more aware of and more resistant from their symptoms.

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8. Would you do this, *a la* Hoffman (1981, p. 99)? Tell your depressed patient (wife) to become more subservient to her husband in anticipation that she will rebel in defiance to your directive and then become more autonomous and independent. Do you like this approach? Do you see any risks here? No? Please see me after class.

9. On page 100 is another letter to a non-attending spouse, this from a paradoxical perspective. Do you like it any better than the one on page 97?

10. I like the statement on page 102 which reads, "Consultation with peers is advisable when one encounters …a unique circumstance with couples or families." You can also call CAMFT.

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11. Hey, here is a wild one. I (Dan) think one can do really powerful systemic treatment with only one person present in the session … in fact, having everyone in the system "in" on the treatment can even foul it up. Perhaps I'm goofy on this one, but it is something I've been contemplating (and practicing) for a long time. I wonder if I'm being "ethical" by practicing systemic therapy in the absence of the system? Convince me that I'm wrong here! I dare you. Some of my notions about this may be found back on my web page (where you got these talking points) down below under an item entitled "Some thoughts on the counseling process." Take a look and get back to me on this.

The End