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Therapeutic modalities centered in interpersonal processes, in structural phenomena, and in reality constructions—the three core orientations in the field of family therapy—are here defined as mutually nonexclusive "translations" of the systemic paradigm into clinical practice. This definition does not attempt to blur the distinctions among these models but seeks to show their common denominator and thus expands the conceptual and clinical repertoire of the systems-oriented family therapist.

The backbone that provided identity and oriented the development of the field of family therapy has been the progressive formalization of a set of core models that became identified as orientations, or schools, around which a good part of the writing and thinking in the field was organized. These models provided a conceptual substratum for the pragmatic discussion of strategies and techniques for family change.

The study of the specific set of models on which this paper centers, i.e., those that operationalize premises of the systemic paradigm in terms applicable to the practice of family therapy, reveals, on the surface, a rather discontinuous picture. As any sample of the family therapy literature can easily demonstrate, each of these models tends to be presented by their proponents as the, and not a, translation of the systemic paradigm, as the privileged set of observables and hypotheses. Perhaps this is the undesirable effect of an unavoidable pedagogical device: The student of a given model or "school" may need to retain—for a while, at least—a compartmentalized view in order to explore the confines of the model in question and acquire a sense of mastery. Perhaps there are also reasons of marketing on the part of the teachers—each of us may wish to feel and convince others that our model washes whiter, so to speak, in order to sell it more. One way or the other, the result has been a domain marked by intermediate constructs, each of which is presented as the golden path in the field of family therapy.

It should be noted, however, that those models, core as they may be for specific schools of family therapy, are mid-level constructs placed in-between general paradigms and applied techniques. They are "translations" of the broad systemic paradigm into hypotheses, variables, and observables that are specifically relevant to the area of family therapy. These intermediary models are the actual net, knit with threads of the systemic paradigm, with which so many family therapists catch their observables and construct their clinical reality.

Understanding these models as intermediary, as operationalizations, allows us to redraw the map. The state of the art in the field of systems-oriented family therapy can be described then in terms of several nonexclusive collections of variables and constructs, i.e., a finite set of those intermediary models, all of them clearly rooted in cybernetics and thus having the potential of being richly articulated with one another.1 Each of these operationalizations, in the course of evolving its own premises and isolating its own specific sets of observables and variables, has developed its own jargon and generated its own set of therapeutic interventions. The latter thus make sense either when seen from the perspective of that specific intermediary model or when analyzed from the larger perspective of the common systemic paradigm.2

Models that share a systemic root are those that focus primarily on process, primarily on structure, and primarily on world views.

Process-Oriented Model

The model emphasizing process states that symptoms, conflicts, and problems, i.e., behaviors of a repetitive nature that are upsetting or unhealthy to people, are retained and anchored in larger recursive interpersonal loops or patterns, i.e., are pieces of interactional sequences that tend to perpetuate themselves. These sequences or loops are composed of symptomatic behaviors as well as of behaviors that are definitely defined as nonsymptomatic by the participants. These self-perpetuating patterns, these variety constraints that increase dramatically the chances that a given sequence of behavior will occur, are called, when detected by observers, family rules. After a given behavior B, of the many possible alternative behaviors that may follow it, what "happens" in a given family is D and then, of all the alternatives, G, and then again of all the many options, non-B. If we observe the reiteration of this pattern in a given family, we may state that the family operates following the rule "if B, then D and G and then non-B." We may even infer from that a complementary cycle and the rule "if non-B, then non-D and non-G and then B." Needless to say, families operate with a vast amount of predictable sequences,
of rules, that are not symptomatic. In fact, regularities are a natural systemic attribute that makes for the "familiarity" (i.e., the sameness) of a family in the presence of an ever changing social context.

Therapeutic interventions are focused on those recursive loops that contain symptomatic or problematic behavior. Strategies aimed at disrupting those specific patterns are devised and implemented by means of symptom prescriptions and/or prescription or proscription of nonsymptomatic behaviors belonging to that sequence. The disruption of the "necessary" nature of the sequence frees the behaviors, symptomatic or not, that were captured by the orbit of this "game without end." Symptoms disappear, and the family recuperates a set of alternatives previously lost when the pattern came to be. From the point of view of the observer, a family rule has changed.

Notions that are crucial to this viewpoint are pattern, punctuation of the sequence of events, and family rules. Some of the questions regularly pursued by therapists who operate from the perspective of this model are what sequence of behaviors of self and others is triggered or suppressed by the symptom and what set is defined as preceding the symptomatic behavior. By that route, interactional patterns may be reconstructed for purposes of devising pattern-disrupting strategies.

Clearly, when the symptomatic or problematic behavior is that of a cyclical or fluctuating nature, all the other (nonsymptomatic) behaviors that are a part of the pattern also fluctuate in resonance and are thus relatively easy to trace. Patterns may be a bit more elusive to detect when symptoms are stable and nonfluctuating, as all the other behaviors of the interactional pattern that anchor the symptom or problem will also not fluctuate and thus may be difficult to detect; in the same way that still figures are much more difficult to detect against a still background than mobile ones, so fixed behaviors do not emerge as figures from the interpersonal background. Under those conditions, however, the operator may be able to infer the rules that regulate certain interpersonal processes to which symptoms are anchored by means of activating another intermediary construct, the one centered on structure, with specific reference to issues of boundaries and hierarchies.

Structure-Oriented Model

Process is to structure as verb is to noun. In the same way that verbs deposit temporarily in the noun the substance of the action, processes can be temporarily reflected in structures. The correlates of the interactional rules on certain systemic attributes can be described and mapped in terms of specific structural variables, namely, boundaries (i.e., rules of participation) and hierarchies (i.e., rules of power). Therapists guided by a structural intermediary model explore and map indicators of boundary management and infer the rules that govern that management. Special attention is placed on certain normative qualities of the transactions between subgroups within the family as well as between the family and the exo-group: (a) whether the rules that govern boundaries are clear or mystified; (b) whether they are predictable or too variable; (c) whether they are adaptive, too rigid, or too loose; this may also be formulated as (d) whether the boundaries are selective but permeable, or excessively permeable or impermeable; (e) whether the rules are appropriate for the tasks corresponding to the specific developmental stage of each specific family; and (f) whether the resulting design is balanced or skewed.

It is assumed that symptomatic behaviors, fixers and reminders as they are of family patterns, contribute to the maintenance of interactional rules about boundary management. Dialectically, the stereotypes about boundaries contribute in turn to maintaining the symptomatic behavior. The family's design in terms of boundaries can be discussed also in terms of distribution and management of power and authority, variables that require and reflect specific boundary infrastructures.

The modification of rules on boundaries and on the management of power and authority in a family has a profound impact on a variety of substantive transactions, including the disruption of those interactional patterns that contain and maintain symptoms. As mentioned above, the focus on structural variables may be most pertinent when a first search for interactional patterns leads to rather invariant, acyclic, stable traits, since relatively fixed symptoms evoke relatively fixed patterns of maintenance. Interactional information emerges from difference, not from monotony. Structural mapping, on the contrary, is based on invariance.

But the repertoire of models does not end here. There is a third intermediary model, related to a third set of variables, that, in spite of belonging to a different domain from the other two, completes and intertwines ultimately with them and further enriches the theory and practice of family therapy. It is the one centered in systems of belief, or worldviews.

World-Views-Oriented Model

It leans on the notion that each of us is a blueprint of the world,—i.e., each of us carries within himself and herself Weltanschauungen, belief structures that not only organize the "raw" reality but organize our behavior on the basis of assumptions, some of which are clearly crystalized into ideologies, some into convictions, and many more into attributions that fuse perceptions and preconceptions into "that is the way things are." In fact, as Cronen, Johnson and Lannemann (3, p. 95) postulate, "systems of meaning and action are persons' cognitive constructions of their social realities and not best
assessed as reflections of external realities.” Thus, all communicative acts (discourse and actions alike) provide direct access to the world views of the actors, as the world view organizes the interface between the individual and his environment. This relationship is seldomly acknowledged in everyday interaction, however. Our (occidental) culture being content-oriented, “reality” is perceived as intrinsically valid and “out there,” and process/structure is sensed as subsumed under a reality that shapes them. The dialectical nature of the interrelation between world views, perception, cognitions, and communication in human interaction is rescued by what is known in philosophy as the constructivist view (cf., e.g., von Glaserfeld, 6).

The parameters and norms for reality construction are anchored in each macro-and micro-culture by means of a specific set of key words, symbols, and histories that condense prescriptions and proscriptions of behaviors, orders, and regularities, agreements about punctuations and boundaries, and interpersonal rules in general. They are encompassing envelopes that add levels of meaning and provide continuity to all interactions. These condensations or symbols are, in the case of a nation, its flag and anthem, certain gestures of its leaders, its heroes and foes. In the case of the family, interactions are always framed by a rich, rather stable symbolic context, specific to the human condition, that reminds the participants how reality should be constructed and creates, anchors, and reminds of, family rules. In fact, each member of the family is defined as such, as a member of a particular family, because he or she shares with the rest a rather specific way of organizing reality, an ideology. The family members' sense of belonging to a collective derives from the experience of consonance emanating from shared reality-organizing constructs. This set of constraints provides ideological support to the interactional patterns shared by family members.6 Recursively, the performance of any interactional pattern evokes the underlying world view. These agreements are synthesized and actualized over and over again by self-perpetuating interactional regularities, by consensually validated beliefs, by family-shared styles and rhetoric, and indeed by their sharing that construction of reality known as family history.

The latter merits a special comment because it has been used in family therapy with a variety of presuppositions. Embroidered in the overall tapestry of macro-social variables—culture, socioeconomic events, etc.—the family anecdote or history can be described as a common construct or mythology, an agreement about the order and meaning attributed to the events of joint experiences; i.e., it constitutes an ad hoc organization of moments or anecdotes rendered memorable because they encapsule past and present agreements about present reality, contractual issues, consensus about values, goals, labels, etc. Part of it may be prehistory, that is, elements of the members' own original family histories that persist through time as they keep symbolizing and actualized standing agreements, re-presenting them, i.e., keeping them present. Thus, the shared history is one of the reservoirs of interactional rules and a coding manual of how to construct a reality that is activated whenever a corresponding fragment of that history is activated.

Symptomatic behaviors tend to be quickly incorporated as part of the overall organization of the family's reality, and their activation readily activates or defines (rules about) roles. Symptoms and the corresponding complementary behaviors of nonsymptomatic members thus constitute powerful markers that contribute to represent, reconfirm, and reactuallize family agreements about punctuation, views, values, and norms. They are also powerful additions to plots and anecdotes. It is in this sense that one may speak of a fit among symptoms, family style, and family history. This fit, and this bidirectional relation between the hic et nunc and the past, allows also to explain why a therapist-induced change in the value attributed to a present symptomatic behavior (from “negative and mean” to “positive and heroic,” for instance) has the power to jolt a whole segment of family history built on the basis of those values, and why a strategically selected change in the order of elements or the value of a meaningful fragment of family history may in turn disrupt a symptom-maintaining interactional pattern that was lodged in, and supported by, the previous belief system of the world.

The German poet Goethe warned us: “The past is frail; treat it as if it were a red-hot iron.” As a red-hot iron, it also proves to be highly malleable. Without even touching the concrete building blocks of the shared jigsaw puzzle of the family history, the order of pieces, as well as the normative corollary of events, can be altered dramatically with appropriate family intervention. The past frames the present, and vice versa.

Therapeutic interventions based on the construction of alternative realities capitalize on well-known systemic properties. The therapists' interventions will aim at selectively changing the organization of specific fragments of the family's reality that provide ideological support to those interactional patterns that contain the symptomatic behaviors in order to jolt the pattern and dislodge the symptoms. This is usually done by means of (a) positively connoting (reframing) certain behaviors or events labeled by the family as negative—for instance, praising a symptom in terms of its collective value, thus destroying the value or function of the symptomatic behavior as rule reminder, e.g., boundary marker; (b) positively connoting behaviors previously connoted as positive by the family themselves, thus altering polarization of behaviors as positive and negative and, as a result, breaking patterns of punctuation of reality organized between “victims” and “victimizers”; and (c) proposing alternative, equally plausible, organizations of past or present reality in a way that makes the retention of the symptomatic behavior unnecessary. This style of therapeutic intervention is frequently delivered by the therapist as a “discovery” (rather than as a construct) or as a self-evident way in which all the data provided by the family organize themselves.
Conclusion

This review of the three intermediary models leads to the inescapable conclusion that symptomatic/problematic behaviors can be said to be contained and anchored by their own participation in circular, self-perpetuating interactional patterns, by their function as reinforcers and reminders of structural traits, which recursively contribute to maintain them, and by their participation in world views that in turn provide the ideology that supports them. This statement should not obscure the fact that process and structure are a dialectic pair, whereas the construction of reality, connected as it may be with the other two, refers to a different semiological—and logical—level. However, each level of analysis allows the description of a recursive loop that accounts for the maintenance of a symptomatic or problematic behavior.

Many reality-shifting interventions have been described both within the process-centered and the structure-centered models. However, the logic of those models is not based on the shifts in reality-construction, and the practice guided by those models also utilizes therapeutic interventions other than those in which alternative realities are introduced. In turn, models based on world views do not utilize processor structure-based logic. Summarizing, each of the three models provides conceptual rationale to a specific set of therapeutic interventions. Repunctuations, symptom prescriptions, predictions of failure, prescriptions of behaviors, and tasks to defeat the pattern of symptom maintenance clearly derive from an interactional view. Realignment along generational boundaries and parental empowerment, conveyed frequently through in-session enactment, can be identified with the structural view. And alternative organization of family histories and positive connotation of collective behaviors can be ascribed to the emphasis on reality construction. But, are these types of interventions mutually exclusive? Or, putting the question differently, could it be said that family changes triggered by therapeutic interventions based on different intermediary models belong to different genders, i.e., are different types of family change? If we accept the notion that process, structure, and world views are non-exclusive, dialectically related levels of analysis of interpersonal phenomena, that is not the case. In fact, each systemic change can be discussed in terms of interactional, structural, and world view parameters. Even the specific sets of therapeutic interventions that clearly derive from one of the models can be analyzed from the angle of the others. So, a change in punctuation can be discussed in terms of the way it affects the family history as well as present construction of reality, a positive connotation can be studied in terms of the way it modifies intergenerational boundaries, a realignment can be examined in terms of its power to alter the pattern that retains symptoms, and so on. Even further, in many cases one given therapeutic intervention can be said to represent two intermediary models. For instance, what process-oriented therapists define as repunctuation, world-view centered therapists will call reframing. The dialectic correspondence between sequence and context, between pattern and organization of the reality, makes it in fact possible to change actual patterns by changing the values that correlate with them, and, vice versa, to shatter certain sets of values by altering the interactional patterns that support and give credit to them.

A stance that characterizes therapists who focus on any of the systemic models is one of equidistance or neutrality. The therapist may attain this neutral position either by carefully refusing to engage in any kind of side-taking (Selvini-Palazzoli et al., 18) or by systematically siding with all the participants, even those who do not wish to be sided with (Sluzki, 20). The end result is the same: a nonalignment that increases the therapist's leverage as well as his or her ability to perceive seemingly conflicting views presented by family members (and even nonconflicting views) as interlocking choreographies of interactional patterns, i.e., as reciprocally perpetuated sequences of behaviors, as structures with clear rules about participation and authority, and as constructs rather than descriptions of realities. Summarizing, a neutral, equidistant position is necessary in order to retain a metaperspective.

The realization that these three intermediary models are rooted in one and the same paradigmatic frame does not reduce the requirement that conceptual consistency within models should be maintained. By means of defining their common systemic base, however, it vastly expands the repertoire of conceptual and technical tools of the family researcher, trainer, and therapist, as it empowers them with the choice within a wide range of mutually potentiating family variables, hypotheses, and interventions. An additional advantage of this integrated systemic view lies in its potential for demystification of some of the political, rather than scientific, boundaries that threaten to factionalize and thus impoverish the development of family theory, training, and practice.

The ethical imperative of our task is to increase for our patients the number and quality of their choices. The same ethic of responsibility—as Heinz von Foerster (5) aptly calls it—can be applied to our own development, ensuring that we explore and claim the full range of conceptual tools that guide our theory building and our practice.

REFERENCES


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1Simple as this argument may sound, an a priori position of either/or (or of both/and, for that matter) is a sound example of "deutero-learning" (Bateson, 1)—when we learn, we also engage in second-order learning by which we apprehend context and premises. In that process lies the core of a most pervasive ideological, self-fulfilling prophecy—by operating as if certain constraint (e.g., the either/or premise of mutual exclusion) is there, we create it.

2It should be stressed that to propose a unified frame does not imply to blur the useful distinctions between intermediary models. These distinctions ensure that one does not mix in the same bag processes, structures, and frames. The unified systemic frame, however, defines these discrete parameters as different dimensions of one and the same domain, that of family dynamics when viewed with a systemic lens.
3Cf., e.g., Haley (9), Watzlawick et al. (26, 27), Fisch et al. (4), Wilder (27), Sluzki (22, 23).

4Cf., e.g., Minuchin (15) and Helay (10).

5The class/member entanglement, lodged in the fact that we define this intermediate model centered in world views as rooted in
the systemic paradigm, which, as any paradigm, is simply a way of organizing reality, i.e., is a map of the world, has probably not
escaped the reader.

But, paraphrasing Watzlawick et al. (26), who in turn paraphrased Bateson (1), one cannot not have a world view (which is, of
course, a world view).

6Cf., e.g., Selvini-Palazzoli et al. (20), von Foerster (5), and Reiss (17). Recognition should also be made here of the early
phenomenological incursions of Laing (13) in this domain.

7Some authors (e.g., Haley, 10, and Madanes, 15) display in their discussion of strategies and techniques of family therapy a
pragmatic combination of interventions derived from these different intermediary constructs. In addition, there have been a number
of recent contributions in which bridges between orientations or “schools” are proposed or in which at least their mutually exclusive
nature is questioned and their common basis explored. Such is the case of Hoffman (12), Stanton (25, 26), Liddle (14), Rohrbaugh
and Eron (18), Grunebaum and Chasin (8), and, alas, others who may feel, with all good reason, unfairly unrecognized for not
being listed in this modest acknowledgment.