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CHAPTER 11

Clinical Road Maps for Prescribing Rituals

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This chapter describes some of the clinical road maps I have been using to do brief therapy. The idea seems overwhelming for several reasons: First, it is difficult to transfer successfully right-hemispher maps into left-hemispher language. The fear is that the very act of thinking about them may detract from the experience.

A second fear is based on the well-known disparity between what therapists say they are doing and what they are actually doing. Another disparity involves what therapists are not writing about, but what they are actually doing that makes treatment successful.

Having stated these concerns, I also acknowledge that I am stuck with the scientific side of me which believes strongly that therapy has a procedure, a sequencing, a puzzle to be solved, and a logic. And, although some of it is quite emotional, spiritual, and personal, it is far from magical or unknowable; some of it can be communicated to others.

For me, brief systemic psychotherapy in its highest form is an art form. And as an art form, it requires a certain balance of thought, feeling, and technique. Any excess of one over the others will distract from its poetry and perhaps its effectiveness. So without further procrastination or self-protecting precautions, let me try to share some thoughts on the clinical road maps I have been quietly drawing somewhere in the back of my

mind while doing brief therapy. I have named the three maps "affect," "language," and "resistance" respectively.

AFFECT MAP

The map I use when beginning therapy is an affect map. I start with this map because it's the one I generally use in life. You have to know about the predominant feelings going on in you, as well as in the people around you. This helps you focus on where you are and what you are going to do. It's one of my more primary life maps, and I know quite well where it comes from and how it developed.

When I say I use an affect map, it does not mean that I ask people what they are feeling. Rather, while I am gathering information about the presenting symptom, learning how the family is organized around the symptom, and thinking about how the occurrence of the symptom is related to any possible shifts in a three-generational family system, I am listening closely to the feelings aroused or expressed by the patient or family. The affect will highlight or underscore certain information. It will signal how such information is more related to the presenting problem than is information presented without this accompanying affect. One of the tricks in doing therapy is knowing what's important and what's not important. The family's feelings, aroused or expressed in the session, punctuate what's important, and direct clinicians toward asking additional questions in this affect-laden area.

There is also a sub-affect map to this larger affect map. This submap tells me whether or not the feelings being expressed in the session seem primary. I contrast primary feelings to secondary feelings (what I call Yiddish Theater or melodramatic feelings) where affect is exaggerated. Also included as secondary feelings would be hysterical feelings, as well as reactions such as self-pity, as when one feels badly about feeling badly. If my submap indicates that these expressed feelings are not primary, I am inclined to give the information accompanying such feelings less importance.

This affective submap is "powered" by the right hemisphere and is also based on disparities between verbal and nonverbal communications. When there is considerable disparity between these two forms of communication, I am inclined to take what I am hearing differently than when the affect "coming down" seems primary, with little disparity between verbal and nonverbal modes.

The right hemisphere is simultaneously picking up nonverbal information on many different channels which the left hemisphere knows less about because it processes information differently. When feelings

are not primary, I pick up overtones and other nonverbal signals that tell me something is not right. I respect these signals and treat the information I am gathering as different than when the signals are congruent. Incongruent signals are the same ones a person gets when being sold a bill of goods or when being lied to.

So my first map, which determines the value of incoming information related to the presenting symptom, has to do with whether the information is accompanied by what I call primary affect.

For example, I have difficulty using it with patients or families who come in with substance abuse problems. Since alcohol or drugs often mask the affect or dissociate the primary affect from the problem or information related to the problem, treating these patients is much more difficult, since it keeps me from using this primary map.

Sometimes, when it is difficult to detect the affect needed to highlight the incoming information, I may provoke the patient or family to produce the affect. This is tricky, because the provocation is done to highlight and generate important clinical information, and not to frighten a family out of treatment. Provocation should be used with caution.

LANGUAGE MAP

A second map, also a right-hemisphere map, entails remembering the family or patient's language. By language, I am referring to Milton Erickson's use of the word "language," that is, listening to the way in which the patient conceptualizes his or her world, and also problem(s) (Haley, 1967). Using this map requires getting under the skin of patients and learning how they organize and conceptualize their world. This map is drawn by me while the drama in the session unfolds.

My language map is important for two reasons: first, to understand or appreciate the patient's world view; and second, to then use that language to ask a patient at the end of the session to do something. When you use the patient's own language to ask them to do a task, you increase the chance that they will understand why you are asking them to do it. This understanding will, in turn, increase chances that a therapeutic prescription will be acted upon.

When doing brief systemic therapy, you have a better chance of being successful when a patient acts on a particular prescription. While you can learn important information when someone doesn't do a task, you get more change out of people when they follow your instructions and *act* differently.

RESISTANCE MAP

As much as some of my purist systemic colleagues wince at the word "resistance," I still use it because I find it helpful. While gathering information about a presenting symptom and the context in which a symptom occurs, one also must keep track of how much anxiety, discomfort, or pain is associated with change or with the elimination of a symptom. More often than not, nonverbal cues best indicate how frightened, rigid, or oppositional the patient, family, or system is to therapeutic change, or to the suggestion of change. The way one frames information-gathering questions will not only provide content information about a family system, but will also help elicit the family's affect associated with these answers. This begins the determination by the therapist of how difficult it will be to change behavior in a family system.

As previously mentioned, I use provocation to generate an affect map when affect is not available by asking provocative questions. This has two purposes: one, to get clinical information about how a family is organized around a symptom, and two, to get affective information about how resistant a system will be to change. Here are examples of provocative questions: "What will the danger in this family be once your anorectic daughter begins to start eating again? What will be the danger to this family once Johnny stops drinking or hallucinating? Who, your mother or your father, will secretly be a little unhappy, once your marriage starts working again? Who among your siblings will be the next drug addict once Johnny stops protecting your parents with his drug abuse?" The family's emotional response to such questions begins the process of drawing a resistance map.

Part of this resistance map will plot anxiety, another term some of my systemic colleagues don't like much. How upset the family or patient is during the session will determine, in part, how much opportunity there will be for change. When the anxiety level is high, or of crisis magnitude, then resistance usually is low, and there is more opportunity for change. When there is little or no anxiety involved, then resistance will often be high and change thus less likely to take place.

Sometimes both anxiety and resistance are high. When this occurs, resistance is not necessarily determined by anxiety in the session (or lack thereof), but more by an impressive history of prior treatment failures. In such situations more therapeutic leverage will be needed. Here the treatment is tricky, and outside help may be needed in the form of a cotherapist or a team behind a one-way mirror. In such cases the therapist can deal with the anxiety and the prospect of change while

the team gives a totally contradictory message and prescribes the resistance or the homeostasis operating in the family system.

GATHERING SYSTEMIC INFORMATION AROUND THE PRESENTING PROBLEM

Most presenting problems have to do with separation. When a couple comes in for treatment, they are unhappy because while they are legally married, they can't "get married" emotionally, partly because each partner is still more married to the family of origin than to the partner (Bowen, 1978). When an individual patient comes in depressed and lonely, I wonder, "To whom is this individual still married in his/her family of origin?" Once this is determined, the separation work between the patient and the family of origin can begin.

Symptoms also may be related to making the necessary transition from one developmental stage to the next. Sometimes these developmental transitions are related to separation issues. Sometimes they are not. For example, a son who is struggling to act like an adult is stuck in his attempts to separate from his mother; a wife is stuck because she is giving up too much of her sense of self in her marriage; someone is lonely because he can't make himself available to be with a partner; a young woman is anorectic because she can't leave home; or a young man is psychotic because he can't leave home.

Since I see most symptoms as having to do with separation, I believe the task of the clinician is to find out how a patient is stuck, and from whom he or she is struggling to separate. The therapy then powerfully focuses on helping this person separate. Separation is constructive for the patient as well as for the person(s) from whom he or she is separating.

Symptoms can be seen as metaphors. When you look closely at a symptom metaphorically, it often has to do with keeping someone from getting closer to someone else. As long as a symptom maintains some distance from another person, it also maintains closeness and loyalty to someone in the family of origin. To reduce or eliminate the symptom will, for example, increase closeness in the couple and, as a consequence, produce more separation from the family of origin. The increased distance from the family of origin enables a different kind of relationship to evolve with that family.

To summarize, an affective language and resistance maps are developed or constructed. The clinician finds out what the presenting symptom is; how the symptom is related to developmental transitions; how the symptom is related to separation; and from whom the separa-

tion will be. From all of this information, therapists generate a clinical hypothesis as to why and how a particular symptom is related to an interpersonal system, one which is usually undergoing some developmental transition. Once a clinical hypothesis is developed, we can start thinking about therapeutic change.

PRESCRIBING RITUALS

When you are prescribing an action, rather than a feeling or a thought, and that action is performed in some interpersonal context in which you think a symptom is embedded, that action forces the interpersonal context to change quickly. And when the clinical hypothesis is correct, the prescribed action begins to change the interpersonal context that created and sustains a symptom (Watzlawick, Weakland, & Fisch, 1974). To prescribe a new action is powerful because it produces change so quickly. It's also important to the patient, since it initiates a sense of hopefulness and ends the demoralization cycle that has taken place because of the patient's history of prior treatment failure. When a therapist gives a patient a ritual, inherent in this task is a message that there are possible solutions and that everything is not hopeless.

Prescribing powerful rituals requires creativity and depends on the therapist's personal style. For me it means using as much humor, absurdity, and playfulness as I can (Bergman, 1985). This communicates to the patient, "Let's have some fun and play here while we are helping you get out of this serious business."

I am also saying other things with humor and playfulness. I am saying that life is basically absurd. I am saying that sometimes the problem is not so much your problem as it is your seriousness about your problem. When I laugh with a patient about a problem, I also signal to the patient that there is a solution.

Using humor in treatment is also a powerful way of reframing a problem. Sometimes humor reframes a painful symptom into a more positive situation. And when a symptom has a new positive affect associated with it, it takes on a different meaning. Changing the affect associated with a symptom from negative to positive also reduces secondary negative reactions such as self-pity and demoralization, which after a while if unchecked may take on a life of their own.

Humor also provides the patient with some emotional distance from the presenting problem. And, with some distance and less negative affect associated with the problem, there is more opportunity for change.

Using humor to reframe a symptom also gives me the opportunity and freedom to prescribe a symptom at absurd levels to the point where the

symptom begins to lose its original meaningfulness to the patient. Positive reframing takes some of the seriousness and negativity out of the symptom and provides the therapist with more opportunity and freedom to use a larger variety of therapeutic interventions.

I will briefly present two cases to illustrate some of the things mentioned above:

CASE ONE

I once had a young man come into treatment obsessed over his girlfriend's calves, which he thought were too fat.

The task at the end of this consultation was as follows: I told this young man that he indeed had a problem and that he really was not ready to deal with his problem at this particular time. The solution had to wait until he was ready to hear it. I then told him that he had basically two choices: He was either to join Overeaters Anonymous or work part time in a woman's shoe store; and that once he did one of these two things for a while, he could come back to see me.

About a year later he called and asked whether he could come in with the woman with "fat calves." The crisis now was not focused on fat calves but on the possibility of breaking up with this young woman, who recently decided that she was moving back to Philadelphia from New York. On one hand, he couldn't be with her; but on the other, he didn't want her to leave New York. So, the problem was now relational and no longer anatomical.

The couple came in, and the woman turned out to be a delightful and beautiful 22-year-old, with perfect calves from my perspective. The patient's presenting problem was that the woman did everything he wanted her to do and showed no resistance to what he wanted. This made him distrustful about how "real" her deference and compliance were.

I ended the session by telling this young man that if he loved and wanted this woman, he was to do whatever he had to do to keep her in New York. I further noted that if he did this, his current concern over her being so compliant and needing to please him would certainly change by itself over the next 10 years.

The tone or coloring of prescribed rituals will come from the therapist as well as from theory. The more one does brief therapy, the more one uses one's own strengths and style, and the more the coloring of the ritual will reflect qualities that the therapist brings to the treatment. Another thing to keep in mind when prescribing rituals is to keep the therapeutic moves simple and small. Therapists must work to ensure

that they are not bringing more complexity into the treatment than is necessary. One reason for keeping the individual moves small is to ensure initial success for the patient as well as for the therapist. It is important to keep in mind that a major reason patients begin treatment is because they are somewhat demoralized over prior failures to solve problems. Patients also have lost some perspective along the way. Often, they see their problem magnified and are no longer able to see the difficulty within a larger framework.

Keeping things small and in perspective reminds me of an unusual case I was involved with a few years ago:

CASE TWO

The patient was a 35-year-old artist, who was talented, accomplished, and well known in his field. His presenting problem was his terror over his live-in girlfriend finding out that he was a cross-dresser. Sometimes, when she was not home, he would go to a hidden box of clothes, take out some women's clothes, and dress himself in these clothes. Then he would tie himself up into a chair, very tightly, and become sexually aroused by this ordeal. He was terrified of his girlfriend walking into the bedroom, where he performed this ritual, and finding out what he was doing.

My initial advice to this artist regarding his terror of being discovered was that he should lock his bedroom door whenever he was "doing his thing." He looked delighted over this advice. My second suggestion was that if and when the girlfriend asked him what he was doing behind the locked door, he was to casually say that "he was tied up for the moment, and would be out shortly." My patient and I then laughed together.

A few sessions later, I learned that this patient had an intrusive mother. She was totally focused on, and concerned about his entire internal and external existence as a child. He was her life, and as long as that was the case, he had no identity of his own. In my mind, the cross-dressing, or more important his secret about the cross-dressing, was a metaphor for his small sense of self, or for an identity separate and distinct from his mother's incessant intrusions.

The cross-dressing served a similar function when he got involved with his girlfriend. Later on in the therapy, I was able to coach him to be more overtly himself in his girlfriend's presence so he would not have to be so secretive. This involved coaching him to speak up more for himself so he could be less tuned into pleasing her and less reactive to her unhappiness. This enabled him to develop experiences of being more

tuned into himself, which he missed and postponed as a child as a result of being so tuned into his mother's unhappiness.

As it turned out, later in the treatment, I learned that the girlfriend also was a cross-dresser! The couple eventually got married. His mother did not attend the wedding ceremony. And there were indeed *two* ceremonies. One was the conventional one with the bride wearing the gown and the bridegroom wearing the tuxedo. The second ceremony was more private and involved my patient wearing the gown and the girlfriend the tuxedo.

This case illustrates a few things. The conflict was first reframed with humor, giving this patient the message that all was not so tragic and that a solution was at hand. In addition, the initial interventions were kept small and simple, with the therapist maintaining a perspective on things, particularly when that perspective had been lost by the patient.

Also, in a brief therapy model, you stay with where the client is and work backward. There was no reason to wait in the treatment until I figured out why he was cross-dressing to help him with his problem. I found that out later. And I found it out later because I stayed focused on the presenting problem, which was that if his secret was revealed, his girlfriend would leave him. After his panic over being found out was reduced, he and I had more freedom and therefore more access to the information about what led up to his problem.

WHY AND HOW RITUALS WORK

Prescribing a ritual has many purposes, one of which is to change the ongoing game that sustains a particular symptom. Since symptoms can be seen as evolving out of interpersonal contexts one must understand the interpersonal game that leads to symptom onset. The symptomatic game then has to be replaced with a new game, a "therapeutic game."

Prescribing a therapeutic ritual begins the process of replacing a family game with a therapeutic game because the very process of the therapist prescribing a ritual adds the therapist and thereby changes the context. By joining the patient or the family and prescribing a ritual, the therapist changes the interpersonal context.

Now there are rituals and there are rituals. Some rituals, when presented in the presence of all of the major players in the old game, may be comprehensive enough to change the structure of the family sufficiently so the old game becomes a self-sustaining new game, which no longer requires the presence of a symptom. These are the most powerful rituals, requiring all or most of the major players, and are based on an accurate understanding about why and how the old game produces and

sustains a symptom (Palazzoli, Cirillo, Selvini, & Sorrentino, 1989). These rituals may be sufficient for changing the family structure and sometimes constitute the entire therapy needed.

Other rituals may be sufficient for breaking up an old game without necessarily immediately replacing it with a new game or structure that is self-sustaining. Here, additional rituals or nonritual therapeutic work may be needed to help the family develop a new structure.

Now, as we well know, often in therapy, all the major players are not available. When this occurs, therapists must work with the players who are willing to play. This too can be therapeutic, because when the therapist is working with an individual, this new context is a smaller game, a scrimmage directed toward changing the individual's behavior within the larger game, namely, the family. This works too, although less quickly and less powerfully than when one has all the major players in treatment.

One reason family therapy is powerful is that when all of the major players are in treatment, the therapist is able to change the old game faster. It's not by chance that change occurs more readily in this order: treating families, treating couples, and lastly treating individuals. The difference between these treatments has to do with the inclusion of the major players who are participating in a family game.

Rituals are also action-oriented. By encouraging a patient to do a ritual and act differently in the interpersonal context that sustains a symptom, one can produce positive change quickly. Once the patient sees the positive effect of these new behaviors, these positive consequences end the demoralization cycle, encourage the patient in continuing to act differently, and increase the patient's willingness to try additional new behaviors. The momentum for change has begun, and this momentum provides the patient with more opportunity to take new risks and try new behaviors.

There are probably many other legitimate explanations for why rituals work, the scope of which is too great to include in this chapter. I suspect that as I continue to prescribe rituals in my clinical practice, and continue to think about why and how they work, some of these clinical maps for prescribing rituals will become clearer and more refined.

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