

by
CLOÉ
MADANES

Remembering Our Heritage

LIKE MANY THERAPISTS TODAY, my career had its start in the '60s and '70s. I was fascinated with the new vistas opened up by the systems approach, communication theory, and family therapy.

**HISTORICALLY,
THERAPISTS HAVE
STOOD UP FOR THE
UNDERDOG**

I believed in self-determination and in our mission, as therapists, to unleash the unlimited power of human potential. ■ I began my career at the Mental Research Institute in Palo Alto under the influence of Gregory Bateson, then continued at the Philadelphia Child Guidance Clinic under Salvador Minuchin. I was stirred by the work of those in the field who dedicated themselves to protecting the human rights of patients, like R. D. Laing, and the antipsychiatry movement. My guiding lights were therapists who not only had great clinical skill, but also remarkable character and courage—therapists like Viktor Frankl, who wrote *Man's Search for Meaning* in Auschwitz, and the endlessly inventive Milton

PHOTO MONTAGE © MIRI KRAMER

Erickson, who triumphed over polio and other painful afflictions throughout his life.

In those heady days, many therapists were convinced that we were going to change the world. After all, we were developing the tools to understand the paradoxes of human communication and analyze how human systems really work. At last, it seemed that we were able to understand the complex cross-currents of power, hierarchy, love, and protection within the family—the microcosm of human conflict captured so well in the Greek tragedies—and that the key to fully understanding and transforming all kinds of larger social organizations and systems was practically in sight. As therapists, we were going to replace philosophers, priests, ministers, and rabbis, bringing peace first to the family and then to the world.

But things change. Over the past 20 years, I believe that therapy has lost its way and its sense of social mission. Today, it's much harder for young therapists coming into the profession to find the role models that were available in such abundance when I started my career. One reason for this is the dominance of managed care, which took the best of brief therapy and strategic therapy and turned it into the worst possible practice. Managed-care companies took the idea that therapy could serve people better by being brief, problem focused, and practical, and used it as an opportunity to make enormous profits by bringing therapy down to its lowest possible common denominator. They reduced the number of sessions and paid so little that the more skilled, experienced therapists were driven out of practice, to be replaced by less expensive, less trained therapists, who could be managed by bottom-line oriented businesspeople with no knowledge of the mental health field. With the ascendancy of managed care, much of the therapy field has become controlled by profit-driven corporations lacking any commitment to a wider vision of the public good.

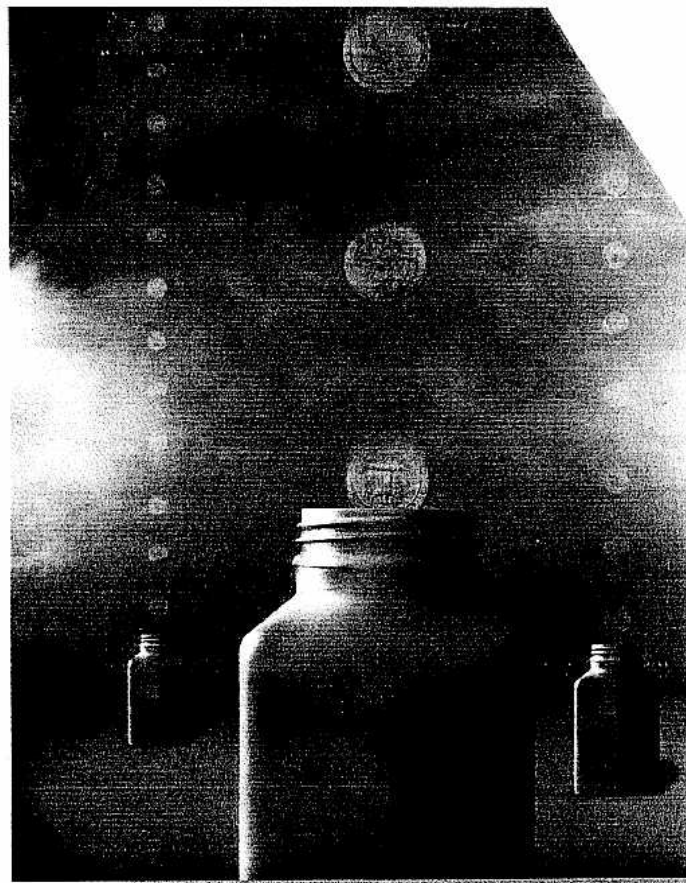
Meanwhile, the influence of psychopharmacology grew and played right into the profit-making goals of managed care. Now, even a few sessions with an unskilled therapist were no

longer needed—the magic pill would solve all. The American Psychiatric Association is dominated by the pharmacological companies, which pay an average of \$13,000 in gifts and perks per year per psychiatrist to push their medications. At the recent annual meeting of the American Psychological Association, two world-renowned psychiatrists, Aaron Beck, now in his eighties, and Albert Ellis, in his nineties, strongly warned psychologists not to follow the path of the psychiatrists and sell themselves to pharmacology. It remains to be seen whether their colleagues will heed their warning.

What's most inhumane about the practice of psychopharmacology today isn't just the toxic effects of the medications, but that they're typically prescribed after a 15-minute interview. It's become common practice to make enormous leaps of faith regarding the biological causes of all sorts of emotional distress, with no consideration for the underlying human relationships involved. No one takes the time to get to know the person receiving the prescription or pays attention to the social context surrounding the presenting problem. It's a shameful commentary on our clinical standards and the integrity of our scientific community that the studies showing the dangerous consequences of the use of antidepressants on children and adolescents had to come from Great Britain and Italy, not from the United States.

Being All That You Can Be

Given all the influences that are eroding clinical standards in the field and making it harder and harder for therapists to maintain their idealism, it's more important than ever for us to be clear about the values we wish to embody in our work. We all have a system of personal values; we can't *not* have one. And we all have a system of professional values. What's amazing is



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that most of us never consciously set this system up. It's been downloaded over the years from teachers, peers, and the general culture.

The beliefs about life and therapy that grow out of our values direct our decisions, both inside and outside the consultation room. That's why it's important to have the right kinds of beliefs. The worst set of beliefs that a therapist can have, that we should never indulge in, is learned helplessness. With too many failures, however, therapists may begin to experience their efforts as futile and ultimately develop the terminal discouragement of learned helplessness. Psychologist Martin Seligman has described three patterns of beliefs that cause us to feel helpless. As applied to therapy they are:

■ Believing in the permanence of a problem. A typical example is the thought: "This person is chronically mentally ill. Like a diabetic, he'll always suffer from this condition."

■ Believing in the pervasiveness of a problem: "This is a bipolar disorder." Such thinking causes us to lose sight of the human being and just see the diagnosis.

■ Believing that the problem has to do with our personal nature: "As a therapist, I'm not strong enough or knowledgeable enough to change this person."

Holding these limiting beliefs is equivalent to gradually poisoning yourself as a therapist. As therapists, we must constantly question our beliefs to make sure we're not setting ourselves up for failure, and our patients, too.

This inquiry process is at the heart of what we do as change agents. Successful therapists ask better questions and get better answers. My favorite statement by Milton Erickson, and one that has influenced generations of therapists, is: "Don't ask *why* the patient is the way he is, ask *for what* he would change." For example, even if we don't understand the root cause of a woman's depressive patterns, we can change these patterns if we know that she'll overcome her depression to help her child.

Ask your clients the right questions and they'll reveal themselves in a whole new light. Ask a terrible question and you'll get a terrible answer. My favorite

terrible question is: "Are you depressed?" Simply asking the question triggers the depressed state. It's like asking: "Are you thinking of the color blue?" You automatically visualize blue.

Questions immediately change what a person focuses on. Questions can bring back what we deleted from our memory. Some people have the tendency to forget everything that's positive. The right question can bring back empowering memories. Questions also change the resources that are available to us. That's why the good systemic therapist asks about all kinds of relationships, looking for the connections that can be used to change a person's life.

Words have tremendous power when chosen wisely. By changing someone's vocabulary, especially the words that are consistently used to describe emotions, you can change how a person thinks, feels, and interacts with others. For example, if instead of saying you were angry or enraged when you were really upset at someone, you forced yourself to say "I'm feeling a tad out of sorts," or "I'm a bit peeved," wouldn't this make you laugh? Wouldn't this change the nature of the interaction?

Changing the metaphors that people use to view their lives can instantly transform them. There's a big difference between thinking: "Life is a game" and "Life is suffering." To succeed as a therapist, you must understand the metaphors that people link to their lives and know how to change them.

All these statements of general principle may sound reasonable, even commendable, but how exactly is a clinician to put them into practice in the face of the challenges of our practices? In what follows, I'd like to give you some idea of how I try to bridge the inevitable gap between my values and beliefs and the creative challenge of clinical work. Along the way, you'll get some idea of the way I work: the questions I ask, the words I use, and how I change metaphors.

Recently I was asked by a businessman friend to do a consultation with one of his clients, who'd told him he was planning to commit suicide. In our first appointment, I asked this over-

weight, sad-looking man how I could help him. He told me that he came from a poor, uneducated family and he'd been the first one in the family to get a college education. Success and hard work had always been central in his life. Then he explained that he'd been laid off a year ago and was in such despair over not being able to find work that he was considering suicide.

"You're going to have to explain this better to me because I don't understand it," I said. "You're saying you're going to kill yourself because you're not working? That's strange. Could you please explain?"

He looked puzzled and replied, "Work's very important to a person's self-esteem. I feel worthless."

"You're going to have to explain that better," I said, "I still don't get it."

He smiled a little, not sure whether I was joking.

"I'm serious," I said. "I'm quite a bit older than you—a child of the '60s. In my generation, nobody wanted to work. We were proud of *not* working. We wanted to tune in and drop out. So what's so great about work that you want to kill yourself because you don't have it?"

He was looking at me as if I'd come from outer space. He said, "I always thought work was important. I have a strong work ethic."

"Hmm, so what was the work you did?"

"I'm an engineer, and I always worked in plants manufacturing weapons."

"Oh, great!" I said. "So the world is a better place because you don't work!"

By now he was smiling broadly. I said, "Look, eventually, you'll go back to work, that's inevitable. And then you'll look back on this period when you could have done so many things and had so much fun with regret, because you won't have time anymore to do the things you want to do. Do you have a girlfriend?"

"No," he said, "I don't have any money."

"Since when is love related to money?" I asked. "If I were you, I'd find a woman and go to the beach, the park, the mountains. Go to the zoo."

He called me the next day at my

office and said: "I just wanted to let you know that it's a beautiful day."

"Yes," I agreed.

"And I'm at the zoo," he continued, and then he paused, "with a woman."

I said: "Great! I'm at my office, working."

He wrote me a letter a year later to tell me he was happy and working and to thank me for our conversation.

If I could do this in one hour with a depressed, suicidal man—and this is something I've done time and again with many clients—what does it say about the possibilities for creating change in situations that seem grim and hopeless? Most of the time, I find that the main barrier to helping clients, even with the most serious presenting difficulties, are the beliefs and rules that limit our effectiveness as therapists.

Years ago, I used to teach at a university hospital in Baltimore, supervising psychiatric residents and psychology interns. One day, some time after I had left, the Director of Training called me asking me to take on a very difficult, VIP case. It was a 26-year-old woman with many diagnoses who was severely suicidal. Having been in mental hospitals since the age of 16, she had become the kind of patient who'd grab an ashtray, break it against a table, and slit her wrists in front of the other patients. She was also epileptic and didn't respond to antiseizure medications. Her seizures were so frequent that she was being transferred to this hospital in an ambulance because she had to be given the antiseizure medication through an IV tube. I said I couldn't take on the case myself, but I'd supervise one of the interns.

The young woman, whom I'll call Amy, was the youngest child of well-to-do parents. I gathered from the information available that the event that precipitated her first hospitalization had been her parents' divorce. I suspected that the young girl had begun to act crazy in the hopes of bringing the parents together to care for her, or perhaps as revenge against the father. Maybe the mother had encouraged this behavior to humiliate and embarrass the father. I surmised that once Amy had started her career as a mental patient, medications, the effects of insti-

tutionalization, and bad therapy had increased her problems, and she'd deteriorated further and further.

In my first conversation with the intern who took the case, Patrick Fleming, I said that we first had to do something to decrease the frequency of the seizures, since this seemed to be the most severe problem. I knew that the parents lived in different cities, a one- or two-hour flight away. I told the intern to tell the parents that they had to come to the hospital to a family session once a week, and they agreed.

I decided to use a paradoxical strategy to bring the seizures under control. Pat would say to Amy, in the presence of her parents, that the best way to stop an unwanted behavior is to deliberately bring it on. He'd explain that if you can deliberately do something, then you can also stop it deliberately. So Amy was to deliberately have a seizure in the session, and then the parents were to embrace her and comfort her. I prepared Pat for the fact that Amy would most probably respond by insulting him and refusing to do such an absurd thing. He was then to respond by labeling her screaming insults as a seizure and have the parents comfort her.

As I predicted, as soon as the therapist explained what he wanted her to do, Amy responded by screaming that he was an idiot—in much more colorful words than that—and insisted that she'd have nothing to do with him and his stupid theories. Pat thanked her, saying that it really looked like she was having a seizure, and asked the parents to comfort her. We did this for several weeks, many times during each session, and the frequency of the seizures diminished. Amy also began to respond to the medication.

We'd begun to move to a discussion of family relationships when Pat called me one day and asked if I'd been invited to Grand Rounds, where Amy's case was going to be discussed by a famous psychiatrist visiting from a prestigious university. I said I hadn't been invited, but I'd come anyway. When I arrived, the meeting had already started and a psychiatrist was explaining that Amy was schizophrenic. Then someone else spoke and said that she was bipolar. Then a psychologist explained that she

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also had multiple personalities. Finally, it was the turn of the visiting psychiatrist. She'd interviewed Amy, she said, and realized that she was the typical chronic patient that either commits suicide in the hospital or ends up living in the back wards. She was incurable and untreatable.

To my surprise, Amy, who'd been listening to all this, was invited to speak. It was the first time I'd actually seen her. She said that she'd gone to the library and looked up the side effects of all the medications she'd been given. She'd concluded that she was toxic from all the medications, and thought that maybe if they took her off everything for a while, she'd get better. I was amazed at her presence and intelligence, and totally enraged about what was being done to her. But I thought of the old Chinese proverb: If you kill in anger, dig two graves. So I said to myself: "Stay calm, Cloe. Think strategically."

The meeting ended and I approached the head of the department. I said warmly: "How are you, Dr. so and so." He said he was happy to see me. I said: "Do you know that I've been supervising the family therapy of this girl and we've succeeded in decreasing the frequency of the seizures, and she's now responding to the antiseizure medication?" He said he knew that and was impressed.

I invited him to lunch and during the meal I said: "Amy's case is so sad. It's so terrible to think about how she'll end her life." He agreed. I went on: "It must be so difficult for you to have a patient like this in the hospital—so much responsibility. I can't imagine how you can tolerate it, to think that she could kill herself any minute in the ward. It's such a burden."

He seemed to appreciate my sympathy. So I said: "Since she's most likely to kill herself soon anyway, like the visiting psychiatrist said, would you discharge her to me so she can live for a while with her mother and have some experience of family and the real world outside of the hospital? I'm willing to take full responsibility."

"You *are*?" he asked, surprised and a bit incredulous.

"Definitely," I said. "I have a good

collaboration with the intern, and we can do it."

"Okay," he said, "go ahead."

The next day, the parents picked Amy up from the hospital and came to a session at my office. I supervised Pat through a one-way mirror as he worked with them. We focused on how the parents could help Amy catch up with all that she'd missed during her long hospitalization. She'd barely finished high school and she needed to study, make friends, and learn how to behave in all kinds of situations she'd never experienced before. Both parents seemed withdrawn and distracted. However, they agreed that Amy would live with her mother and visit the father twice that week, and the father would be in charge of buying her clothes, introducing her to some friends, and arranging for her to take some courses.

Amy said that since she'd heard the psychiatrist say that she was probably going to die soon, she realized that she didn't want to die a virgin. She said she'd refused to have sex in the past because she didn't want to have her first sexual experience be in the bathroom of the hospital. So she wanted to meet some nice young men. We suggested that the father introduce her to some.

They came back the next week, and the father had done absolutely nothing. It seemed to me that he cared about his daughter, but not enough to take any action. We reviewed what he was supposed to do and gave him another week to do it. The following week, he'd still done nothing. But we were prepared for that.

The therapist said that it was important for Amy to know whether or not she had a father. Some people who don't have a father are officially known as "orphans," but they can have a good life anyway. What's confusing and difficult for a young person is to think that they have a father when actually they don't. So Pat asked the father: "Are you a father to Amy or, as a father, are you dead?"

The father answered: "I'm dead."

We were prepared for that, too. We'd pushed him to take a position by asking a dramatic question that required a dramatic answer, so that he'd stop giv-

ing contradictory messages and allow Amy to get on with her life without unrealistic expectations. Also, we wanted to do something completely different from the kind of therapy that Amy had been subjected to for 10 years.

The therapist said: "All right, you're dead. So Amy has to have her part of her inheritance from you right now."

The father said that would be impossible: he had five children, his assets were tied up, and so on. Pat said he'd call Amy's siblings to get their agreement and make the arrangements. Amy had four older brothers who were all successful professionals. They agreed willingly and were happy to do anything that would help their sister. So the rest of the therapy focused on getting the money out of the father. We managed to get enough so that Amy could have a nice apartment, go to school, get a car, and have spending money.

At this point, Amy's epilepsy was completely under control and she was off all medications except for the epilepsy drugs. The therapy continued for about two years. Very soon, Amy found a boyfriend who was okay, but not great. Then she found a better one and was happily married. Pat stayed in contact with her for more than five years and she continued to do well, with no hospitalizations, medications, or therapy.

If a psychology intern and I could accomplish such success, any intern and any therapist could do the same. I firmly believe that it's because of the limiting beliefs of the primary caregivers that young people wither away in institutions. If I'd believed there is such a thing as "chronic mental illness," if I'd believed in any of the diagnoses she was given, and if I'd thought I wasn't strong enough or knowledgeable enough to change her, Amy would still be in the hospital, or she'd be dead.

Beth, the 14-year-old, anorexic daughter of a famous Washington lawyer and prosecutor was referred to me by a prestigious university hospital, where she'd been hospitalized many times without success. She looked like a skeleton, ruminated, and presented the

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typical thought disorder of starvation. Father and daughter came alone to the first session. The parents were divorced and the mother was away on a trip with her charity, even though it was clear that the daughter's life was in danger. I got her on the phone, however, and she was present by the second session.

During the first three sessions, I learned that the parents had married two months after the father's father had died. The father considered the marriage to be a reaction to his grief, and they'd divorced a few months later, when the wife was already pregnant. They had joint custody of Beth and lived a few blocks from each other. The mother was the only child of Holocaust survivors. She had no living relatives, and an aunt had died of anorexia. The father, a brilliant, powerful man, was

remarried and had another child. The mother hated him and he had contempt for her.

As I tried to get them to agree on how to enforce eating on Beth, I realized the intensity of their mutual animosity. The mother was emotionally frail, insecure, somewhat disorganized, and lonely. I realized that, in Beth's mind, she'd never be able to leave home. She'd always have to take care of her mother, because the mother had no one else. Not only that, but, in her mind, she had to protect the mother from the father's viciousness, a daunting task for a little girl.

So I met alone with the father and I said: "You're very intelligent, so I'm going to be very frank and clear with you. I don't want to waste your time or mine. It's up to you to save your daughter's life, and you can decide whether you want to or not. In the endless war between you and your ex-wife, your daughter is taking all the bullets. For her sake, you can no longer have one harsh word, one unpleasant gesture toward your ex-wife. Not only that, but you must go out of your way to help your ex-wife and take care of her in every way you can, materially and emotionally. From now on, at least three times a day, I want you to tell Beth that you love her mother, not as a wife but as the mother of your child, and that you're always going to take care of her. And then you're going to do just that. Every day, you'll call your ex-wife and ask her what she needs, if there is anything you can do to help her, and then you will do it."

He said incredulously, "Then Beth will eat?"

"Yes," I said.

He did it, and Beth began to eat. Very soon, she was at a normal weight, and I helped in getting her readmitted to the private school from which she'd been expelled due to the anorexia.

The Good Therapist

I chose to tell you these three stories because they're all stories of life and death. In each one, the patient could have died. Working from a systemic point of view made it possible to save their lives. In the instance of the depressed suicidal man who didn't

have a job, the solution wasn't only instilling a doubt about the value of work, but also suggesting that this was a good time to have fun with a woman. In the case of Amy, the key was our willingness to push the issues beyond where most therapists would have left them. In the case of Beth, it was the insight that the father first had to change, and then Beth would change. None of this is rocket science.

So what does it take to be a good therapist? First of all, you must love doing therapy. You must believe in your own creative power to put things together with vision and insight. You must have confidence in your understanding of the people involved. You must love the drama and be fascinated with the sudden revelations that bring enormous changes. You must stand for truth and be able to question everything, down to everyone's secret motives.

You must love humanity and be willing to empathize with all who suffer—to get inside their skin and see the world through their eyes. You must dream and follow your imagination wherever it leads. You must love humor, for it restores balance. You must delight in language and all its nuances. You must be sensitive to life's contradictions and always suspicious that things aren't what they seem. You must be brave and audacious and tolerate ridicule. And most of all, you must love to provide the spark that bridges the gap between limitations and possibilities, knowing that there's a great deal to human beings, so a great deal can be made out of them. They don't have to stay the way they are now, and we don't have to see them only as they are now, but also as they might become. ■

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