Scripts and Legends in Families and Family Therapy

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Protective family scripts prescribe interaction that the family believes is needed to avoid potentially dangerous scenarios. Certain family legends provide moral tales that illustrate these dangers and hence reinforce these scripts. Together they contribute to family mythology. In the absence of adequate research data about specific effects of particular interventions, the therapist has to rely on his or her own beliefs about what works to change unhelpful family beliefs and interaction patterns. This essay examines the interplay between the two belief systems by exploring one of the author's own family legends and then seeing how its injunctions have been played out in his family therapy practice, thereby illustrating how myths and protective practices may be set up within the field of family therapy and its training.

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When myth meets myth, the collision is very real.

—Stanislaw Lec

MYTHS are elusive. Now you see them; now you don't. It is easier to see someone else's than one's own. This is hardly surprising as myths are woven into the tapestry of self-perception and self-deception. The most powerful way to maintain self-deception is to remain surrounded by those who see things in a similar light (11).

Shared beliefs are tenacious—nowhere more so than in families. Family myths can be defined (2) as the set of "role images which are accepted by the whole family together as representing each member. This gives each an allotted role in a particular pattern of interaction. The images of interaction are, however, either distortions of, or only a segment of, observable behaviour. The integrity of the role images is not irrevocably challenged from within the family" (p. 244). The danger is that a family myth may become a closed belief system that cannot integrate new information. This is particularly likely to happen if the family feels that a challenge to its beliefs threatens family survival. If the myth becomes closed, family interaction loses some of the advantages of the beneficial stability gained from the myth, and becomes rigidly unadaptive to changing contexts.

Groups of therapists also create shared beliefs about how to help families—their shared construction of reality. Research has only shown that certain completed therapies are effective in certain conditions; it has very little to say about precisely what each particular intervention achieves within those therapies (12). Until

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it does, interventions are going to have to be based on beliefs supported by clinical observation.

Therapists who are not rooted in any coherent conceptual viewpoint may run an increased risk of being conscripted into the family's view of itself—something difficult enough to avoid as it is. Many family therapists use a team of like-minded professionals to counteract this powerful phenomenon. Occasionally, on the other hand, a particular mode of intervention—in itself—becomes of paramount importance in maintaining a therapy group's identity and, hence, its own survival. There is then a danger that feedback about the effect of the interventions on the family becomes screened out in order to maintain the therapeutic team's beliefs and retain the coherence of the group. At this point, the therapist's mythology becomes a closed system in much the same way as a family myth becomes closed. Therapists need to maintain vigilance for beliefs and practices that can become self-confirming.

THE PLACE OF FAMILY SCRIPTS AND LEGENDS IN FAMILY MYTHOLOGY

Family Scripts

Ferreira (9) describes how family myths provide blueprints for actions that are necessary for every family. The concept of family script (6, 7) is similar to the idea of a blueprint. Family scripts prescribe the pattern of family interaction in particular contexts. Each member of the family has a mental representation of family relationships—in the same way as each member of the cast of a play has a copy of the script. There is, however, only one pattern of family interaction at any one time, just as there is only one play. To put it another way, each mental representation of family relationships is a subsystem of the family script, which is itself a subsystem of the overall family system.

The concept of script was popularized by the transactional analysts (21), but it is also used by developmental psychologists (16), cognitive scientists (18), sex therapists (10), and others.

Scripts are usually learned through repetition over many years. Each member of the family builds up a mental representation that predicts sequences of interaction in particular situations. Every action is cued in by the previous one and acts as cue to the next in repeating cycles of interaction. The context defines the shape of the pattern, say a mealtime. Nelson (16) points out just how efficient this is in terms of getting family tasks done. The roles can be performed almost automatically and often interchangeably.

Children of course learn how to be parents from their parents. One generation later this can lead either to replicative scripts in which the same style of parenting is adopted, or to corrective scripts in which an attempt is made to correct the mistakes that were felt to have been made by their parents. Exploratory interaction is not scripted.

The pattern of interaction also defines the rules of the relationship through who does what to whom and when. The sequence encodes the family's epistemology by specifying the consequences of each action. Some interaction patterns can be seen to be present in all contexts. This casts members within a set of characteristic roles. These may be defined as mythological if another pattern of behavior is observed that is at variance with these role images. For example, in one family the supposedly mentally subnormal boy was noted to be making the most astute remarks.

Normally there is an ongoing dialectic between family members' beliefs about how things are and their observable behavior patterns; the contradictions between the two build up until a new synthesis emerges in which the family identity accommodates itself to include some of the

previously unacknowledged behavior. An example would be the tension that builds up between replicative and corrective scripts until, say, a father suddenly, to his horror, realizes that he is treating his child exactly as he had vowed he never would—just as his father treated him. If owning that behavior is seen as too threatening to individuals or their relationships, then the dialectic may be blocked, turning the mythology into a closed belief system. A protective family script is then established that, by prescribing stereotyped, redundant patterns of interactions, bolsters the otherwise threatened self-perceptions. Behavior then becomes more responsive to identity than to the changing circumstances of the family.

Scripts can also be learned in one dramatic episode, such as a tragic event. These episodes transform the families' understanding of how certain things happen and they change their behavior either to accommodate or to avoid a repetition. Accounts of the episode may form the basis of a legend.

Family Legends

Family legends have a particular place in family mythology (4). They are those colored and often colorful stories that are told time and again—in contrast to other information about the family's past, which fades away. Although they are osten-ly told because they are interesting, the they are told frequently indicates how family *should* behave—a form of moral Within each telling of the story the -ent rules of the family are encoded. about blood relatives have compel- -messages about how one is likely to out, and they can script future roles. -nds also often illustrate how the fam- has arrived at the state it is now—a -rmation of those myths that the fam- currently has about itself.

What neither narrator nor audience are -lly aware of, however, is that legends are continually being re-edited by altering the metacommunication or reshaping the content in order to build up a story that fits present family attitudes. The past is usually seen as creating the present, not the present molding the past.

Legends share some of the same features as scripts because they each portray a sequence of events from which the current rules of the family can be encoded. Scripts prescribe sequences of interaction whereas legends convey a sequence in the way the story unfolds. In each, the attitude to the events conveys the meaning to be attributed to the overall plot.

The Family Therapist's Own Family Legends

The Admiral Byng Legend

I set myself some rules before exploring one of my own legends. I would think of a family story and then go through my life chronologically to see how the theme of the legend fitted with what was happening at each stage of my life. I would then attempt to discern the moral behind the legend. The result was startling. The journey I went through is written up in detail (4). I will convey only the essentials here.

The first surprising thing was that the first story that came to mind was 222 years old. This seemed innocuous enough. The second surprise was how powerful it proved to be. I tried to remember the story as it was first told to me as a young boy.

> Admiral Byng was an ancestor of yours. He was sent underequipped to relieve Minorca, which was under siege by the French. When he got there, the French fleet was so much larger than his that he did the most sensible thing, which was to keep out of range, exchange a few shots, and sail home again. Unfortunately he was then found guilty of cowardice and shot on his own quarterdeck.

To my surprise, I found that this story, which I had considered to be merely a

curiosity, linked convincingly to many areas of my life. For instance, I had wanted to join the Navy despite living 300 miles from the sea. As a 12-year-old, I had spent some time on board a British Navy Cruiser. There I had an experience that had always puzzled me. I had stood on the quarterdeck feeling terrified, while watching the second in command very intently in case he noticed that I was scared. The legend suddenly made sense of this. Sailors were shot on quarterdecks for showing cowardice.

Even more puzzling had been an occasion when, as an 18-year-old, I had been on a fishing boat off the East African coast and had spotted a shoal of sharks. I found myself diving overboard and swimming toward them. I went on until the local fisherman beckoned me to come back. I realized on reflection that this had been my way of ridding myself of the fear that I was too much of a coward, like Admiral Byng, to put myself in range of danger. I felt that the fisherman would give me a true indication of whether or not it was really dangerous.

Later, I was on active military service but was allowed to leave early in order to enter Cambridge University. While sailing to Britain, I slept on deck as the ship traveled through the Red Sea. One night I developed pain in the back and my legs became paralyzed. Before polio was diagnosed, I had a powerful fantasy that I had been shot in the back. I could now see that this fitted with the legend's image of being shot on deck for running away from the scene of the battle.

I explored the historical evidence surrounding the fate of my ancestor. Luckily there was a great deal written about it from 1757 until the present day, and from various perspectives. Voltaire wrote in *Candide* how the hero, while in Portsmouth, sees an admiral being shot and asks why. He was told that the English Admiral was not close enough to the French admiral, to which Candide asks a good systems question: was the French admiral also not close enough to the English one? Voltaire finishes with the famous remark, "Dans ce pays-ci est bon de tuer en temps en temps un admiral pour encourager les autres" ("In this country it is good to kill an admiral from time to time to encourage the others.")

I went to the British Museum to find the original documents. This was truly fascinating. I had the help of Howard Feinstein, a psychohistorian who is also a psychiatrist. His observations were valuable. As we unearthed document after document that showed Byng was not a coward, he noticed that I was extraordinarily resistant to giving up this belief. There were pictures showing that Byng did engage in battle; ships were dismasted. There were verbatim accounts of his cool and brave behavior during battle. Byng's court martial did not even find him guilty of cowardice. Eventually I was convinced. Now I know something of the tenacity of a belief that is transmitted to children in the form of legends.

The Byng legend proved particularly fruitful to investigate. I was able to trace the editing of the story from generation to generation, inside the family and outside, in Britain and in France. By the end, I had discovered that the *only* piece of my original version of the legend that did seem to be true was that Byng had been shot. Interestingly, the public versions had been extensively edited over the years. Every piece of falsification could be seen to have a purpose: to save Prime Minister Newcastle's political career; to protect George II's throne, and so on. But above all, it served as a universal cautionary tale for all warriors. If you do not join in battle—even if it is suicidal to do so—you are likely to be publicly shamed and lose your life anyway. It is particularly interesting that Churchill, in his *History of the English Speaking*

Peoples gave a version similar to my original. Above all, he stood for fighting against all odds.

What did I learn? I learned that one function of family legends is to provide guidelines for behavior when there is an unresolved dilemma. If there was not a tension between alternative ways of behavior then no rules would be required. The Byng legend illustrates this rather well. There is the notion that he had to get close enough for it to become dangerous or run away. Either of these actions, according to my childhood version, would be disastrous. He would be killed either way. The legend seems to have scripted redramatizations depicting different resolutions to the dilemma: first, my standing very still on deck; then finding that I could get close to "dangerous" sharks, which expunged some of the fear of cowardice—a corrective script; but finally discovering that the worse fears about "running away" did seem to be confirmed—a replicative script. I also found that understanding the context in which the story arose and re-editing it within my current family gave me a sense of freedom from its injunctions (4).

Taken from another time perspective, it is interesting to note that when my life was dangerous the cowardice/bravery theme was being re-enacted; later, when conflict within relationships was a central part of my work, I have edited the story to emphasize the dilemmas surrounding distance. I have been preoccupied in my theorizing with "too close/too far" relationships in which there is no comfortable position, because if one is distant enough to avoid fears of getting too close then one is also too far away (3). In the legend this was Byng's dilemma.

FAMILY THERAPY'S MYTHOLOGY

A feature of family mythology is that each parent's protective scripts have to overlap sufficiently if the couple is going to stay together—a new homeostasis is born. Although a therapist and a family do not select each other on the same basis, nevertheless, a shared protective script may eventually be distilled and an impasse in therapy reached. The therapist may, however, select his or her professional group on the basis of shared protective practices. There is then a need to see how the therapist's—especially the trainer's—protective family scripts may articulate with what is happening in his or her modes of intervention.

Family therapy mythology is largely scripted by what teachers do, how they demonstrate their practice, and how they structure their training. These scripts when carried out confirm and hence protect the beliefs of the group. Therapists each bring their own myths about families to the work and add to the store of legends by writing up their (edited) cases.

A Story of Family Therapy Mythology: A Dialectical Process

I will now explore how the distance dilemma revealed by the Byng legend has been played out in my family therapy interventions and teaching. My therapeutic distance dilemma is this:

> If the closed belief system of family mythology prevents change, must therapists be drawn temporarily into the family's protective script before the family will feel safe enough to explore new ideas? Or is this a trap? In which case, should therapists avoid joining the family system by remaining outside—or meta to it? But if they do, will they be experienced as outsiders whose alien beliefs have no relevance? In short, should they join or not? And if so, how?

I will now go step by step through each phase in my family therapy career. (As most of the senior proponents of each school of family therapy have passed through London, this may have some rele-

vance for a range of therapists.) I will for each phase:

1. State my major beliefs about the degree of therapeutic distance required for change.
2. Note any practices either in therapy or training programs that act to confirm that belief, especially by reducing the possibility of testing hypotheses about effectiveness. These could be called protective practice scripts that support family therapy mythology.
3. Tell any stories or legends that support these myths.
4. Trace any dialectic.
5. Have some "Byng" courage to say what I think.

Should the Therapist Be Active or Not?

I will start with my psychotherapy training in the late 1960s at the Tavistock Clinic where the belief system was psychoanalytic object-relations theory. Change was seen as coming through the interaction between patient and therapist. Pathology showed itself in transference of unconscious fantasies about parent/child relationships onto—and into—the therapist. In response to the patient's behavior, the therapist would experience in the countertransference a fantasy and often an impulse to act out a role in that fantasy. (I now see this as interesting evidence about how someone is recruited into a script.) A similar process, called projective identification, occurred between family members, in which they conscript each other into the repudiated roles of their inner worlds.

Practice was confined to interpreting the unconscious transference so as to make it conscious; action on the part of the therapist was seen as evidence that the fantasy had been acted out (recruited into the script) and hence not understood. Evidence of change was increasing awareness, not necessarily altered interaction. The basic script for therapy was "don't act; interpret the transference."

The therapeutic distance adopted here is interesting: intimately tuned into fantasy and emotional impulses, but at the same time distant, restrained, and formal in terms of interaction with clients—rather like my "standing still" solution. For me this was a too close/too far position in which, it occurs to me now, I felt paralyzed.

A group within the Tavistock has continued to develop the psychoanalytic approach (1). For me and a number of colleagues there followed, in the early and middle 1970s, a gleeful spree of activity aided and abetted by American schools of family therapy. We had sculpting, role play, genograms, rituals, and every other conceivable sort of experiential exercise. If family-system hang-gliding had been invented, we would have done it! It was a glorious release.

In retrospect, I have to ask what the release was from. Most obviously it stopped a practice that made therapy less effective. Families dropped out if the approach was less active. We seemed to be notably more successful. On reflection, however, it also took us out of an uncomfortable emotional experience; to pause long enough to know the full family conflict by experiencing it internally can be very disturbing. But what was the price we paid for this move into action? I have recently been working with a member of the original group of psychoanalytically oriented family therapists (Anna Halton). Observing her work leaves me in no doubt that we lost touch with some of the richness of human imagination and experience. Systems theory may be intellectually exciting and profoundly important in the shift from an individual to a contextual perspective, but it can be unhelpful if it is also used as an intellectual defense against perceiving emotional conflict.

The two ends of the spectrum of activity might be characterized, on the one hand, by allowing the family to recruit the thera-

[pist] into their emotional world but not into the world of action; the therapist also helps the family to stop acting on emotional impulse. On the other hand, through avoiding too much empathy and inappropriate sympathy with their conflicted feelings, the therapist retains the freedom to actively push the family members into a new experience.

Was there a new synthesis to be made out of these apparent contradictions? Here are two stories:

I watched a leading exponent of structural family therapy supervising from behind a one-way mirror. He gave an instruction over the telephone, "Get father to explain to the girl [aged 6] what her mother's multiple sclerosis will mean in the future." There were sound reasons for this move within the theoretical framework of structural family therapy. A great deal of active support was needed to keep the father to this painful task. Finally it was done, and the relief at having spoken the unspeakable was enormous. Now what was preoccupying everyone, including the girl, could come out into the open. For me it was agonizing to observe the family confronted by such a grim future—and also very moving. I was close to tears. Out of curiosity, I asked the supervisor how this made him feel. Very little, he said; for the therapist to be caught up in distress would block his capacity to make the necessary intervention.

The second story comes from work that I did in cotherapy recently with Anna Halton. The father in the family we were seeing had reached an advanced stage of multiple sclerosis and could have died at any time. The eight-year-old boy had shown his preoccupation with death in his play and stories.

We met before the session to discuss what to do. We both agreed that it was important to be able to talk openly about father's possible death. We found it uncomfortable even to think about broaching the topic and realized that we had been blocking the subject from emerging despite plenty of evidence that this was currently haunting the family. We had become very fond of the boy and also worried how the five-year-old sister would manage the discussion, quite apart from our own discomfort with the topic of death.

The session started with a story about how a pet rabbit had died. The father said that pets dying provided an important opportunity for children to learn about death. It seems he had less trouble with this topic than we did. In a gentle to and fro movement in which he and then we got closer and closer to what everyone was thinking about, the topic of his impending death was eventually raised by father himself with surprisingly little embarrassment. This was deeply moving in a rather serene way, as opposed to the acute distress of the first story. The new synthesis came in the recognition that it was the overlap of protective scripts that was blocking change, and the therapists had to deal with their own blocks as well as take active steps to make sure that something happened in the session.

One-Way Screens: Closer or More Distant?

Live supervision using a one-way screen closes the gap in space and time between supervisor and trainee as compared to reporting a session later (23). But what does it do to the therapy that is taught? In some ways it enables greater intensity to be generated in the room. The supervisor can press trainees to go beyond the point at which they would normally stall. Structural moves such as the one described above in the first story do this. The use of the earphone from behind the screen can be highly effective in encouraging trainees to say the things they would normally find too difficult (15).

Observing how the screen was used, however, can paint different pictures of the

ethos of the training. As always, what supervisors do is more important than what they say. Visiting some training programs revealed behavior behind the screen that sent a clear message about what was really important. Talking, laughing, and joking about the family, even if there is much distress, and supervising with frequent interruptions (either on the telephone or by going into the room) that cut across whatever was being talked about, are all powerful ways of indicating that content and affect are less important to therapy than changing family process. This is correct for structural family therapy. The interruptions may, however, act as protective scripts if the discussion is never allowed to develop to the point where the importance of the topic, and the feelings about it, are revealed.

The therapist can usefully move in close and then draw out again (14). This combines the advantages of entering the system without being swallowed by it. But there is a difference between proximity and emotional closeness. Watching some practitioners suggested to me that proximity was being used to create intense interaction; but if this was divorced from empathy and respect, the opportunity was occasionally used to be quite cruel, which in turn might represent an enactment of either the family's problems or the therapist's.

I have had to struggle with all these issues myself and I continually have to monitor my own practice. In my supervision, I try to avoid interrupting the process of the trainee's work, allowing themes to unfold in a way that is more like a normal session. For me, the earphone is best because a short comment can be enormously helpful without the family even knowing it has been made (5). In this way the supervisor can also avoid usurping the role of the trainee therapist. In terms of supervisor/trainee/family distance, there is this strange situation of the supervisor being inside the head of the therapist while remaining a strange, unheard presence for the family. It is curious how quickly everyone gets used to it, but the advantages seem to be so considerable that I may be choosing to overlook the problems. Loewenstein and Reder (13) give some interesting comments from the trainee's perspective.

Family Therapy as Drama

The setting of a family struggling in conflict is the very essence of drama. Add to that a one-way screen (or videotape) and an audience and we have theater. This is not necessarily bad. The energy generated can mobilize change. To play to the audience of professionals rather than to the family can be one way of holding to a therapeutic stance in the face of enormous family pressure to conscript the therapist into their protective script. The primary task, however, can all too easily shift to showmanship, especially if a reputation has to be maintained or a huge conference audience kept enthralled.

Superstar Events: Our Living Legends

Family therapy has perfected the technique of boosting the morale with hyped-up events that provide all the excitement of the circus. The visiting maestro performer is given an extremely difficult family to interview. He or she proceeds to walk the tightrope without using a safety net by seeing the family "live" in front of a packed audience. Anything might happen. Despite all this, he or she pulls off a spectacular session in which success is not only achieved but also done with that particular flourish that is the maestro's signature "tune." The audience is enthralled and inspired. Next day families all over the region are being treated to a replica flourish.

The importance of these events is not to be underestimated. They provide an important stimulus to try a new way of working. Far more effective than endless talking! The whole message is of potency

and effectiveness. A demonstration is easy to copy—the tyro will discover what effect it has. Some techniques will "take," others will not. I found them very useful in the early stages of my career.

The circus lost its magic for me when I discovered that even I could pull it off sometimes. After all, almost every first session is a winner; you are a prophet in another country; the adrenalin does flow, and so on. More significantly, however, I found that my client families left behind by visiting performers frequently did not benefit. Lions are not tamed for the lion's sake.

The edited videotape can also be used to convey a great sense of potency by selecting the most dramatic and effective moments. Video, however, has had one unfortunate effect on the field of family therapy. Interaction and movement are conveyed well. The intensity of what is happening is clear, but when people turn inwards to their imagination, say during a genogram, they become still and their facial expression is often not caught by video. The whole session appears to "go off" the boil. The audience is less involved. Yet the emotional intensity may become very high, and families often report these as the significant moments. This deficit in video may have contributed to the fact that fewer "historians" than might be expected are to be found on the performing circuit. The whole field becomes a little more distant from the emotions of families.

Another version of public mythologizing is the "Ticker-tape parade of Grandees." Here a vast galaxy of famous "names" are paraded in front of your very eyes, often at such speed that you hardly have time to recognize the signature tune before the next is wheeled on.

The tendency to hero-worship charismatic figures in the field, and to provide a suitable stage on which they can perform, sets them up as powerful role models. Families can be so powerful that a certain bravura is required to challenge them. Here are the super-confident heroes with whom to identify. They helped to give me the courage to step out and try new ways.

The myth of eternal potency is of course dangerous because it depends on the counterpart role of impotence (often conveniently allocated to individual therapists). The protective script supporting this myth of eternal potency is largely one of omission. The faltering reality of everyday therapy with all its hiccups and mistakes is just not seen. I find that one of the most useful teaching experiences is regular observation of ongoing therapy.

A good setting for teaching can take the form of a dialogue between two peers. They treat each other's work with respect but do not lionize it. Seeing what family therapists *actually do,* however, is the most advantageous because the gap between the performance and a retrospective account of that performance lends itself to even greater myth making.

Dancing with Family Structure, or Flirting Strategically with Symptoms?

Initially I followed structural family therapy tenet that the correct distance to enable change was to become close at times, then moving out to gain an observer position before moving in once again. Protective practices included never allowing any sequence of family interaction to develop unfettered to a point where I was caught up in their drama; the family had to follow my dance as much as possible. This tended to be self-confirming because observable changes within sessions were rapid as compared with previous approaches. Families learn the therapist's dance remarkably quickly. But do they go on in the new rhythm at home? I ask them, and it seems as if they do—to some extent. So structural techniques remain a basic part of my work with families. But I found that structural work took me only so far and no farther. My repertoire was limited.

Like many others, I turned to strategic approaches.

I will recount a legend told at a workshop—perhaps the reader will recognize it:

> A husband and wife each had been in analysis for several years. They had a sexual problem. One day they moved their beds while redecorating, which meant that the husband had to climb over his wife to get into bed after going to the toilet. Finding themselves in contact with each other they got excited, and their sex life started to flourish.

This legend is particularly interesting because it can illustrate diametrically opposed ideas, depending on how it is told. In this particular workshop it was used to illustrate how years of trying to understand the problem had become the new problem. This led to the argument that problem resolution should focus on unraveling solutions that have gone wrong; underlying dynamics are irrelevant. An alternative strategic move was mooted, which consisted of prohibiting sex for the time being. This would reduce performance anxiety which was being aroused by the analysis. The same story, however, could just as well have been used to show how psychoanalysis creates a situation in which spontaneous improvement can occur.

Strategic moves join at the level of the symptom not at the personal level. The protective practice, for me anyway, is to avoid being tied up in the contortions of family knots by acting unpredictably (paradoxically) and suggesting a solution opposite to the one the family expects. It is a wonderful way of sidestepping the script the family has for the therapist. One myth is that the symptom is caused by the attempted solution to a problem, and so interventions do not have to be directed at any underlying, unresolved family conflicts. It is the sort of myth I would love to believe. This is of course different from strategic interventions aimed at central family dilemmas (17).

I use strategic interventions when my therapeutic efforts seem to make the situation worse or produce no change. In other words, the attempted solution—treatment—has indeed become the new problem. For me personally, the move to a strategic mode lightens the mood; I am not bound by empathy to the family's underlying pain or anger. I suddenly find that I am laughing not hating. I can flirt with the symptom instead of being overburdened by it. But a cautionary note has been raised by Wendorf and Wendorf (22) who discuss deception by therapists and suggest the need for research that examines what effect benign deception has on the therapist's own emotional development.

Milan Systemic Family Therapy

I became fascinated for a while by the Milan technique (19) in the middle and late 1970s. It was instructive in terms of understanding belief systems. It elicited family members' beliefs by questioning rather than by observing them interact, and then targeted intervention at those beliefs. These therapists did not try to change family interactions en route to altering the way the family saw itself, although at that time they were beginning to theorize that the experience of circular questioning led to a change in the way the family handled information, which ultimately did alter interaction patterns (20).

Circular questioning limited family interaction and greatly reduced the risk of the therapist being inducted into taking a role in family transactions and being recruited into the family script. How was this blocking of interaction achieved? Each member of the family was on tenterhooks, waiting to hear what was going to be said about him or her by another member of the family. A questioner is in a very powerful position, and all interaction was centered on the therapist and the person being questioned; but because the discussion was about other members of the family and

their relationships, these exchanges aroused less personal feelings about the therapist in the person being questioned. Also, each member was questioned in turn. In this way no intense or emotional alliances were built up between the therapist and any particular family member. This neutral position gave the therapist the space to think, which was greatly enhanced by lengthy consultations with the team of colleagues watching from behind the one-way screen.

Joining was at the level of cognition, it was the most emotionally distant of all the approaches I had encountered. A particularly good match would be a family who conscripts everyone into its drama with a therapist who is most comfortable with his or her intellect. But will the therapist's beliefs hold up to the family challenge? To meet this challenge, the group had to maintain a coherent conceptual framework; they needed the strength of their mythology. This put them at risk of creating self-confirming practices.

I will describe one such use to which I put the method, which I will call "The Seminal Myth." The group behind the screen, of which I was a member, watched the session intently. We then spent an hour building a systemic hypothesis. As we shared ideas, a new and fascinating image of the family emerged. Excitement rose. Finally, a beautifully written prescription was prepared in which the team's pessimism about the therapist's ability to help the family was at the center of the message. Of course we believed the opposite. The therapist returned to the family to read it. We all sat on the edge of our chairs watching intently to see how each person responded. We noted their startled looks and agreed that each member had been deeply affected. In keeping with the practice at that time, the family was sent away without being given time to counteract the power of the intervention. They also were not seen for another month so that their own solution would have been found by the time of the next session. It was clear to us that it had been a seminal intervention.

I was talking to the general practitioner who had referred this family about another case, and he happened to mention that the mother had seen him after that session. She had been totally mystified. She asked him what pessimism meant!

The myth was that the orgasmic experience within the group had penetrated through into the family at the moment the intervention was read out. We had to face the fact that it had not been seminal; being honest, we had to admit that it had been nearer to masturbation. That is not to say that the family may not have benefited from the experience or even used the intervention if armed with a definition; but it was clear that the two mythologies did not interpenetrate at the moment that we were so convinced they had. We might never have found that out.

The protective practices involved are fairly obvious: sending the family away immediately after reading the prescription; a long gap between sessions; and not seeking information about the effect of the intervention on the grounds that either inquiry or research might prejudice the family's finding its own solution. All this helped to maintain the myth of insemination by screening out information that might contradict that notion. The Milan group has moved on since then (8). The case was used because it illustrates rather well how a closed belief system can be set up.

This experience increased my conviction that the therapist needs as much feedback about the impact of his or her interventions as possible if therapeutic mythology is to be reduced and learning continued. I see families weekly to begin with, and then tail off with increasingly long gaps between sessions, perhaps seeing them once every three months. This combination gives me information about the immediate effects of

particular interventions, but also leaves me in less doubt about whether any change was lasting or not.

My Therapeutic Distance: Close? Far? or Both?

I try to be a temporary attachment figure for the family. They tell me their story through words illustrated by interaction. My imagination is fired. The interest with which I follow and unravel this story in turn stirs their imagination. They see themselves in a new light given fresh color by what I put into their picture. I prefer the idea of joining of imaginations to the concepts of tracking, accommodating, hypothesizing, reframing and restructuring. Unless I become excited, intrigued, and challenged at a human level, I cannot help. Joining through imagination also acknowledges the mutual subjective nature of the joining process. Of course, there are technical aspects to what I do just as the family has techniques for dealing with strangers; but this has a pattern above and beyond the sum of the individual moves. A new shared script is created that has a plot and an intimacy of its own.

As families reveal their unresolved conflicts, I am partially drawn into their protective scripts. Because many of my own family scripts are about distance, it is often approach/avoidance conflicts that draw me in. I frequently become a distance regulator triangulated into their too close/too far relationships (3).

Having got into this position, I then steadily hand back the distance control to the family, this time enabling each member of the family to take responsibility for managing his or her own distance. I do this by helping them to stop triangulating in the session, but I also ask about what has been happening between the sessions. I get a detailed account of how a difficulty was handled, who did what in which sequence, who got caught in whose conflicts, and how. I then find out which moves were part of an old script and which were new. As there are almost always some fresh moves identified by the family, they start focusing on what they can do that is different. Some families start using the metaphor of old scripts and end up writing new ones.

At some stage, often about the third session, I ask for their stories about the past, which puts the current rewriting of their script into its historical context. This allows for some re-editing of their legends with a loosening of their injunctions (4).

In terms of distance, I aim to get close, become imaginatively engaged and entwined, then slowly disengaged, eventually becoming like a nonintrusive grandparent: available but not taking over. I become both close and distant at different times. A secure attachment is one in which there is freedom to flow from intimacy to autonomy and back again. The therapist as a temporary attachment figure can provide a safe base from which the family can explore new ways of solving problems.

The too close/too far therapeutic distance dilemma is revealed as an illusion of alternatives. The therapist can hold a position that is at times meta to the family system through a process of reflection, understanding, and observation—even while partially inducted into their script. Also, adopting a more formal, meta position, as in the Milan method, does not necessarily remove the therapist from the emotional ambience of the family or prevent the therapist from inducting the family—through a pattern of questioning—into confirming his or her script for them. Total neutrality is of course a myth.

Byng's dilemma was also an illusion of alternatives. Naval historians point out that he could have avoided both an all-out battle and having to leave the scene if he had patrolled the island and prevented supplies from reaching the French invaders. That would have been his best strategy.