Redefinition in Family Therapy

One of the principal objectives of therapy is the relief of the state of suffering for which an intervention has been sought. But suffering, psychiatric symptoms, and madness take on different meanings according to the way we consider them. If we consider them mental disturbances inherent in individuals, we will inevitably study the nature of the patient and seek within him the causes of distress. Consequently, therapy will consist in the administration of drugs or of those physical or psychological treatments thought most appropriate to the particular case. But if the same signs of suffering are seen as a signal of a larger disturbance that affects and is in turn affected by other factors, then we will look for the interactional significance of the disturbed behavior and its implications for the family and the social context in which it has appeared. In this case, therapy will consist of helping the identified patient overcome his difficulties in a changed context whose own latent therapeutic capacity has been rediscovered and activated. In this altered context, the disturbance will no longer be experienced as a stigma but as an incentive to the growth of a group that shares a common history.

Therapy centered on the individual and delegation of responsibility to an expert are the cornerstones of the psychiatric approach based on the medical model of disease, which assumes that the object of therapy is a sick individual. This model is generally accepted by both mental health workers and the majority of persons who utilize their services in public as well as private facilities.

Clients and therapists have complementary roles and functions: the former are supposed to furnish information concerning the problem, whereas the latter are expected to identify the causes and to intervene accordingly.
It is easy to predict how a relationship of this kind—usually called *therapeutic*—will be defined: the patient expects to receive therapy—that is, the resolution of *his* problems—by an expert who is willing to treat him. In fact, the expert is expected to resolve the patient’s problems for him, *by substituting for him*. If the patient does not harbor these expectations, either the family or an agent of some institution (a school, a medical center, etc.) will probably try to convince him that an intervention, which *they* have requested, will be useful to *him*. This procedure is almost invariably followed in the case of children and psychotics, who are too often deprived of self-determination. Therapy undertaken on this basis is inevitably ineffective and encourages passivity. It provides stereotyped responses to needs that are not fully understood and that are often quickly transformed into diagnostic labels.

The apparent conformity between the request of the client and the response of the mental health worker supplies the rationale for maintaining forms of treatment based on a rigid medical model of disease. It also perpetuates a *stereotype of the relationship between the people who have the power to cure, because they are sane, and the people who have the right to be treated, because they are sick*. As a result, the symptom becomes the object of the therapeutic relationship; it is classified and forced to conform to a rigid scheme; and it becomes increasingly irreversible. The therapist’s modalities of soliciting and giving information, his attitudes, his ways of speaking and moving in the therapeutic sessions, the choice of intervention—these will all be influenced by the basic assumption that the person who demonstrates disturbed behavior is “sick.” In this situation, every aspect of the intervention will take on a specific significance (Haley, 1975).

Even the space in which the encounter takes place is designed to emphasize the differences between the participants’ roles and functions. Desk, couch, white coat, clinical record, prescription pad, and drugs help to establish a *safe distance* between the person who dispenses the service and the client, and to underline the distinction between the sane person and the sick one. This way of structuring therapeutic space reflects the conventional social image of mental illness in which “the image of madness is inversely symmetrical or complementary to the image of normality” (Jervis, 1975).

**Redefinition of the Therapeutic Relationship**

When we consider the therapeutic intervention from a systemic perspective, where the aim is to restore to the group in question the