Getting and Giving Information: Analysis of a Family-Interview Strategy

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This paper reports on a videotape study of particular aspects of the two-part interview developed by Selvini-Palazzoli et al. (8, 9). The first segment is a "search for information," the second part the application of an intervention based on the information gathered in the first part. The study focused on the strategies of information retrieval on the premise that they are significant for the quality of information gathered and for the criteria implicitly conveyed by the therapist that in turn have their own substantial impact on the system. We have employed theories of communication, particularly conversational analysis, that are a departure from the epistemological premises of systems theory and communication pragmatics proposed by Selvini-Palazzoli et al. as the theoretical underpinning of their interview technique.

In this paper we examine the preliminary results of a videotape study conducted during the past two years. The object is to clarify specific aspects of the interview technique by therapists using the model proposed by Mara Selvini-Palazzoli et al. (8, 9). In such a model, the interview is that part of the session known as the "search for information," in the second part of the session, known as the "conclusion," the therapist makes an intervention based on what information he or she has been able to gather during the first. The way in which he gathers his information is far from irrelevant. On the one hand, it determines the quality of the information he obtains from the family; on the other hand, every strategy of information retrieval is inevitably based on certain criteria the therapist conveys implicitly and that themselves constitute an important impact on the system.

Recently, Selvini-Palazzoli et al. have defined their principles of conducting family interviews, demonstrating the legitimacy and consistency of these principles in the light of the epistemological premises of systems theory and of communication pragmatics. In this report we have ignored these theories in favor of theories of communication, particularly conversational analysis, that have not yet been tested in therapeutic practice.

Methodology

Our approach may be compared to that of a spectator trying to learn the rules of a game by watching the behavior of the players and by isolating regular features of that behavior in order to discover which have a significant bearing on the game. The choice of observational categories is of crucial importance in deciding which phenomena are privileged and which can be neglected.

We have chiefly used categories derived from linguistic theories and, above all, from theories of conversation1 (2, 4, 5, 6). We have done so for two reasons. First, the interview can be considered a conversation from the moment the therapist and the family meet and, in particular, sit down to talk. Second, the "talk exchanges"2 we observe can be considered conversations just as soon as any participant refers to the contributions of others¾a conversation is not comparable to the completion of a questionnaire.

We shall first of all try to define the interview by distinguishing it from other types of conversation, e.g., from informal conversations of the kind that take place when acquaintances meet in a bar, in a waiting room, in a friend's house, etc. That type of conversation proceeds according to generally accepted rules, inasmuch as everyone "knows" how to converse, albeit that knowledge is not necessarily explicit. We have also distinguished the interview from such types of talk exchanges as roundtable meetings, debates, or other forms of therapy.

More marginally, we have made use of other theories, particularly the theory of speech acts (1).

To become significant, the differences thus discovered must be repetitive, i.e., regular, and must satisfy the following criteria:

1. They must be obvious to a trained observer¾one of us devotes himself to conversational analysis.

2. They must have direct relational implications, indicating not only the speaker but also the interlocutor¾another of us is a psychiatrist with relational training.

3. They must refer to concrete verbal behaviors, thus facilitating the decision as to whether a behavioral datum is observable.

On this basis it was possible to postulate "rules of the game"3 for the interview. The crucial criterion for any such rule was not the external view of the observers but the common implicit consent of participants: that is, that all the participants behaved "as if" they had agreed to observe the rule, not only because they usually followed it but also because they asked permission to break it or apologized for having done so. Moreover, whenever the rules were systematically violated, the therapy was terminated or the session suspended.

The rules of the game thus postulated describe the moves each player can make in turn and those he cannot make. They are comparable to the rules of chess. In addition, our analysis has demonstrated the existence of other important regularities. In particular, by adopting various criteria, we were able to distinguish other groups of rules of different hierarchical level. Thus, we distinguish, apart from the rules of the game, certain "technical rules" and others that we have called "laws." Here we shall merely discuss some rules of the game, namely those governing the organization of a therapeutic conversation.

Our attention has been chiefly focused on the therapist's verbal behavior; his nonverbal behavior has not been taken into account, except marginally and occasionally. Nor have we dwelt on the analysis of pathological communications, nor on other communicative idiosyncrasies of members of the family, always and exclusively considered as the therapist's interlocutors. We have observed sessions conducted by therapists of varying degrees of experience, each working with various families. This was done for two reasons. Since our object was to outline the salient features of a certain interview technique, we felt that the observation of a therapist working with different families made it possible to exclude regularities stemming from special stratagems adopted for a particular family. Again, by observing several therapists, we were able to distinguish the regular results of a particular therapist's style from the regular results achieved by the "school." Only the latter, i.e., the common results achieved by all therapists working with any families, are of interest to us.

Our analysis bore on two groups of sessions. The first group consisted of a fixed number of sessions (ten sessions so far), which were run by five different therapists (each session run by one therapist): T1, T2, T3, who were the director and members of the staff of the Family Study Centre, Milan, and T4, T5, pupils finishing their training at the Centre. These sessions, recorded on videotape, were transcribed for detailed analysis. The distinction between sessions conducted by "highly experienced" and "less experienced' therapists accords with our main criterion for distinguishing between two separate groups of rules. Our assumption was that, although all the therapists knew the basic rules of the game, not all of them had equal skill in applying the technical rules needed for devising highly complex strategies.

The second group consist of an indefinite number of sessions, observed by one of us from behind a one-way mirror. Whereas the detailed analysis of the transcriptions of the first group served mainly to postulate the rules, our study of the second group served to verify the general validity of these rules. The second group of sessions, too, was run by different therapists of various degree of experience, each session run by one therapist.

Our analysis was unable to take full account of the level of nonverbal communication. However, several factors help to reduce the effects of this limitation. Above all, our inquiry bore chiefly on the therapist, and all the therapists we observed displayed, apart from differences in style, a substantial consistency between their verbal and nonverbal communications. Moreover, they all seemed to follow a technical rule debarring them from commenting on, or even from revealing, what happened in a session on the nonverbal level of behavior. The conversational sequence is therefore self-contained¾there are only exceptional references to the nonverbal behavior of participants.

As we said earlier, here we shall discuss only some of the rules of the game, namely, those concerning the therapist's "direction." Our account of these will be preceded by a few remarks on the organization of the therapeutic setting.

The Therapeutic Setting and Its Rules

By therapeutic setting, we refer to the spatio-temporal environment in which the interview takes place and to communicative exchanges between family and therapist. Some of these are constant or codified (8) and can be briefly described as follows.

The first contact between the family and the therapist is made by telephone; the therapist asks a number of standard questions and fixes the date of the first appointment. Save for rare exceptions, he asks the entire nuclear family to attend the first session.

In all the sessions observed by us, the therapist is consulted in his capacity of family therapist, regardless of any other professional (psychiatric, psychological, etc.) qualifications he may have. The family turns to him for the specific purpose of family therapy, following advice received from other sources. The therapist, having fixed the original appointment, explains that the sole aim of the first session is to establish whether family therapy is indicated. The therapeutic contract is concluded at the end of the first¾and more rarely the second¾session, provided the therapist agrees to treat this particular family. A maximum of ten sessions is stipulated with an interval of one month between each session. The contract also stipulates the voluntary acceptance by everyone of several definitions: the therapist and the family agree, at least overtly, that the problem is a family problem, whatever meaning is attached to that term; that the therapist is an expert in family therapy; that the aim of their relationship is the solution of a problem and a change of attitude.

The room in which the sessions were held was equipped with identical chairs, greater in number than that of the participants. The family members enter the room first, taking any chair they wish, and wait for the therapist. The therapist arrives and takes one of the chairs left empty. The room is linked, by means of a one-way mirror and an acoustical device, to an adjacent room in which one or more therapists act as supervisors. A session can be interrupted at any moment at the behest of the supervisors to enable the team to discuss and decide the appropriate action in the absence of the family.

The session has two distinct features; the first, the information gathering interview, is the only one we shall examine here. It is separated from the second¾the conclusion¾by a fairly long interval

during which the team elaborates the final intervention. The sessions are videotaped for study purposes. All these operations are explained to the family during the original telephone call or at the beginning of the first session. During the original telephone call, the family are told the cost of each session.

Since our present analysis is solely concerned with the interview, it neglects, even though it does not completely ignore, what happens behind the mirror: the formulation and elaboration of the hypotheses, of the investigative strategy, and of the final intervention. These aspects are treated as so many data influencing the progress of the interview. The family do not know what happens behind the mirror, but knowing that something does happen they may try to influence the supervisors. Similarly, the family do not know how the information the therapist collects will be utilized, but knowing that the information will affect the conclusion, they try to affect it one way or another. Finally, the family do not know the therapist's hypotheses, but can easily discover that, far from working at random, he tries actively to elicit certain facts rather than others.

The Rules of Direction: The Therapist's Conversational Prerogatives

Every game has a set of rules governing the moves players can make in their turn. On the basis of these rules each player elaborates strategies and tactics that may be described as an orderly combination of elementary moves towards a fixed goal.

The interview is essentially a conversational game,4 but an asymmetrical one, inasmuch as certain moves are open to the therapist alone, and are thus his sole prerogative. By and large, they grant him the exclusive right to direct the conversation. More precisely:

1. The therapist has the exclusive right to decide what topic may be discussed, that is, to choose the succession of conversational topics, their articulation into subtopics, and the moment when a particular topic must be dropped and what other must be substituted.

2. The therapist has the exclusive right to decide who may speak at any given moment, that is, to decide the succession (allocation) of turns in the conversation. The therapist indicates a member of the family and the next interlocutor often in an unequivocal way, much more so than would a participant in an "informal" conversation.

3. The therapist has the exclusive right to cut anyone short and even to interrupt those whose turn it is to speak. This rule gives the therapists the exclusive right to censure the behavior of others and to establish what anyone may or may not say. It is important to stress that the term "censure" does not have a negative connotation: by cutting someone short and censuring him, the therapist simply labels a certain form of behavior as "not useful" to the inquiry at that particular moment. Since the therapist does not communicate his or her own hypotheses, he or she alone is able to decide what is relevant to their verification.

4. The therapist has the exclusive right to stop a conversation. Only the therapist can decide when to break off or how long to continue. The interview has no set duration.

5. The therapist has the exclusive right to put questions, to sum up, and to make organizational glosses. Such glosses render the organization of the conversation manifest¾by stressing the hierarchical relationship between topics and subtopics, by explaining that an argument must be considered closed, etc. Such glosses, accordingly, are not comments by the therapist on the content of what has been said, but references to the organizational structure of the conversation. It must be stressed that, with few exceptions, the therapist does no more than that during the interview:

nothing but asking questions, summing up and organizing what has been said. The family, of course, tries to impose another set of rules on the therapist. This question will be treated below.

Needless to say, there are nonverbal forms of behavior that complement, or substitute for, the therapist's verbal indications¾e.g., the therapist may lean toward the designated interlocutor or may look straight at him. It must be stressed that the consistency of the messages sent over both channels is of crucial importance, since otherwise, the therapist's indications are easily disregarded. Most important of all is the direction of the therapist's look¾e.g., a simple glance may be interpreted as a sign to speak up. It should also be stressed that the therapist is not always forced to designate a particular interlocutor: at times the therapist may leave it to members of the family to choose successive turns, allow several members to reply to a given question, or allow others to speak after the designated interlocutor has finished.

In the transcription of sesions, we have adopted a relatively complex notation covering the greatest possible number of significant communicative acts. In the examples included in this paper, however, we have used a simpler system of notation. Words written in capitals indicate that the speaker has emphasized them by a change in intonation. The approximate length of short pauses is indicated by a succession of dots; longer pauses and omissions, etc., are given in parentheses. Words uttered simultaneously by different speakers have been superposed and italicized. The last two types of notation show how a turn is ceded or taken¾a pause in the middle of a phrase may be a move offering to surrender one's turn; a superposition a move to take one's turn while another is speaking. Two successive interventions not separated by pauses are indicated by "=" signs placed at the end of one turn and at the beginning of the next. They involve an exchange of nonverbal signals to surrender and to take one's turn.Properly speaking, however, here we do not include excerpts from transcriptions, but translations of them (in fact, the sessions were originally held in Italian).

Example 1

The therapist is in the first session with a family in which the mother has been diagnosed as a depressive.

T: What ELSE do you think is upsetting your mother?... For example, what does your father do ... APART from that ... we know that already... something else

S: Oh! In ... on the sofa... Father does this (mimes a movement)

T: So ... when your mother is sitting on the sofa, and your father is sitting there as well ... he continues to do that, your mother gets cross, but your father doesn't stop?

S: No, because he is nervous

F: Outwardly

T: Because he is nervous outwardly and so feels a need to change position all the time

S: My mother is nervous inside.

T: Ah! ... I see ... your mother keeps still, but is nervous INSIDE ... your father fidgets, and is nervous OUTSIDE but calmer INSIDE ... So much ... for number two. Now for number three, Nico.

It may be useful to specify the exceptions we have mentioned, i.e., the verbal behaviors of the therapist, which are not however, exclusive to him¾for example, reinforcing comments. By this we mean those brief comments that the therapist uses to monitor his interlocutor's contributions. Such comments have a positive or a negative effect.

Example 2

F: I ... rose up from the ranks, so to speak ... I looked ... was looking for a job because my sister was in service in Rome ... the Fascists were there =

T: = Yes, yes =

F: = Seven ... eight years before.

The therapist's "yes, yes" means "I understand, hurry up and come to the point." It serves as a negative reinforcement. On the other hand, sometimes the mere repetition by the therapist of certain statements made by a family member serves as a positive reinforcement: "It's all right, carry on, I'm interested." This type of intervention may be considered a simple substitute for, or a reinforcement of, nonverbal signs. We have pointed out that the therapist is not always obliged to follow or impose the various rules but can temporarily override them on his own initiative or on request, as if he were observing the following metarule:

1. Therapist can depart, and grant departures, from the rules of direction: However, the therapist never states these or any other general rules explicitly but follows or imposes them implicitly, as if he were following a second metarule:

2. Therapist should not enunciate general rules, comment upon them, or refer to them in any way.

Implications

Despite their simplicity, the five rules of direction govern the entire progress and general organization of the therapeutic conversation. They set the "legal framework" of the interview, that is, stipulate all the acceptable moves the participants can make to influence the course and organization of the conversation. Everything else follows the rule of "everyday" conversation.

It may be useful here to examine the main implications of the rules, the better to exemplify the concrete development of a conversation.

The Rights of Family Members

The rules of direction are implicit definitions of the rights and duties of the family members either in their confrontation with the therapist or when conversing among themselves.

1. Rule 3 makes it the therapist's sole prerogative to cut anyone short and, in general, to censure the behavior of others. Every member of the family, however, has the right not to be interrupted by anyone other than the therapist and the duty not to interrupt others.

2. Rules 1 and 3 make it the therapist's sole prerogative to choose the topic for discussion and to allocate successive turns. Family members, however, have the limited right to propose themes for discussion or to offer themselves as the therapist's interlocutor, on the clear understanding that the therapist is entitled to accept or reject their proposals.

3. No member of the family has more rights than any other member.

The Central Role of the Therapist

The rules of direction account for one of the distinctive characteristics of the interview in that they make no provision for direct verbal interactions between members of the family. The conversation is organized by means of a series of one-to-one interchanges between the therapist, who puts questions, and selected members of the family who reply in turn. All verbal messages from the

various members of the family are addressed to the therapist¾at least officially. Thus, whenever family members address themselves to other family members, unless this behavior is accepted by the therapist they violate Rule 2. The verbal interaction is therapist-centered. The therapist asks questions, sums up to check and to show that he has understood the answers, organizes the reports he has collected, and does not pass judgment or make comments on what the family members tell him. The latter, for their part, can report facts, pass judgment, make comments, but cannot ask questions.

The Therapist as the Source of the Rules

The two metarules ensure that the directive rules do not restrict the therapist's sphere of action. The directive rules set the legal framework of the conversation, but the therapist can temporarily suspend them and decide whether he should agree to the adoption of various local rules suggested by members of the family. He does not present himself as a rule-enforcement officer whose duty it is to impose certain regulations¾for instance, the rules of healthy communication or of family therapy, etc.¾for, though he observes and imposes the rules, he does not enunciate any of them. As a result, he leaves the way open to possible infringements and to the stipulation of different rules at his sole discretion.

Typical and Atypical Sequences

The directive rules determine the typical sequence of turns: T-A-T-A-T-B ... where A, B refer to two different members of the family and T to the therapist. By putting questions, the therapist conveys or can convey two distict instructions. He may indicate that it is the turn of a particular member of the designated family to answer or he may indicate the topic, i.e., the permitted subject of conversation. In a regular sequence, these instructions and these alone are respected.

Example 3

This is a third therapy session for a couple in which the wife has been diagnosed as anorexic.

T: So ... according to you ... how did she [mother] react to what was being said?

I.P.: I didn't altogether understand ... she stayed neutral ... like before, in fact ... I don't really know.

T: Mm ... in fact she had no reaction.

I.P.: No, at least I didn't see any ... afterwards she... just.

T: And you ... according to you ... (omission) was your mother-in-law happy to come... or.

H: She was quite pleased ... but ... as soon as she got here ... she started to behave quite differently, in fact.

The interaction can be subdivided into a series of "events," each of which begins with a question by the therapist and ends with an answer from (at least) one member of the family. Usually the basic conversational unit seems to be the adjacency pair, that is, the minimal exchange of two utterances, e.g., question-answer, greeting-greeting, offer-acceptance or refusal. This minimal unit can be expanded in many different ways. What we are maintaining here is that basically this therapeutic conversation is made up of a series of exchanges of two utterances or moves, the first being the therapist's and the second a member of the family's. An "event" may thus be considered an elementary unit of the interaction¾all the elements present in it, verbal and nonverbal, are considered in strict correlation. What the therapist is able to extract from each "event" is not, in fact, limited to the reports5 contained in his interlocutor's reply but also comprises all the nonverbal acts

of other members of the family. These influence, and are influenced by, the therapist's questions as well as by his interlocutor's replies. An "event" made up of two turns only, as in the above example, may be considered typical.

The analysis of the interview, however, shows that there can be numerous variants.

Example 4

Here the identified patient is an autistic girl.

T: And so, you think that it's something to do with the brain =

F: Yes ... the brain =

T: = And not the nerves ... nerves... right?

F: right

T: and what does your wife think?

F: Well ... my wife probably thought the same as me... but when the psychologists started to say: no, nothing of the kind... it is all due to her nerves.

T: Nerves?

F: Yes... that's... what all the psychologists we saw told us.

In this example the father intervenes during the therapist's turn, and vice versa. These interventions serve as reinforcing comments and do not alter the form of the principal exchange: question and answer.

Example 5

F: May I ... perhaps ... may I perhaps give an example or would you prefer...

T: No no no, you just tell me.

This "event," consisting of the paired move "request for permission¾permission granted" cannot be considered unlawful, despite the fact that a family member breaks the rules by putting a question to the therapist. By asking, "May I?," the father in fact acknowledges the binding character of the rules from which he asks to be temporarily released in order to make a supplementary contribution. In this way, family members can exercise their right to make proposals, to which the rules entitle them. At the same time, it suggests that they have accepted the rules.

Example 6

B is the brother of the identified patient.

T: And where does he go, to a cafeteria?

M: Near us.

I.P.: Yes... I go to a cafeteria... and to the club, too, ten yards up the road... or else to the Town Club... it's another, social.

B: Yes, I often go with him

I.P.: We go there together sometimes

This example shows that an "event" can be made up of more than two turns: that the therapist's question need not necessarily contain precise instructions on whose turn it is to answer. Moreover, even if it does, the therapist may indicate by a nonverbal signal¾for instance, by turning to another member¾that this member may make a supplementary contribution if he wishes.

Often, however, the therapist makes it perfectly clear whose turn it is to answer the first question of a series; subsequent questions aim at clarification or expansion of the first, and the therapist keeps looking at the the same member. In that case, interventions by other members are considered infractions of the therapist's instructions. Quite often, such "atypical events" consist of long sequences: the therapist giving general instructions as to the theme or the sequence of turns. Several members of the family may intervene successively, even taking several turns in one and the same "event," with considerable thematic freedom. In short, the therapist behaves as if he had decided to "let the family speak," the various members addressing all their answers exclusively to him.

Rule-Breaking: Moves Rendering an "Event" Invalid

By rule-breaking we refer to breaches of the rules of direction. Let us now (a) define them in brief and (b) look at their repercussions.

(a) Any infraction of the five rules by any member of the family leads to a potential rule-breaking (P.R.B.)¾i.e., to a move that the therapist can censure. By virtue of the two metarules, however, the therapist is not compelled to censure any breaches of the rules; he will do so only if he thinks it expedient. Faced with a P.R.B., he thus has two choices. He can treat this behavior as if it had been authorized, thus accepting it and all its effects; alternatively, he can censure it and thus declare it unacceptable¾naturally without saying so explicitly. The repetition of the same move, however, after it has been explicitly censured, must be considered an effective rule-breaking (E.R.B.), that is, an attempt to undermine the rules of the game.

This definition follows directly from the five directive rules and from the two metarules.

(b) A P.R.B., is considered an "equivocal" move, that is, a move that may give rise to misunderstandings. It is ambiguous inasmuch as it is impossible to say whether it is a clear infringement of the rules. Let us take an example.

Example 7

T: Ah! You took your degree AFTER MARRIAGE?

F: Yes, I did, yes...later, I...a year later I enrolled in the university...I was living in a little village, you know...I decided to jump a step

M: he...is a primary school teacher, but he had no patience with the children...NONE AT ALL.

In this example, the conversational move of M can have two distinct meanings in terms of the rules. It may be considered a request for permission to speak, with the question "May I" omitted. In that case, it would mean, "I am proposing this intervention, but I am ready to withdraw it if the therapist does not consider it useful." But it may also be considered an infraction of the rule by which the therapist alone is given the right to decide who may speak. In that case, it would mean, "I can speak regardless of the therapist's consent." Naturally, there are some nonverbal behaviors that may fall clearly into the first category¾for example, a facial expression and an interrogative tone or a signal, such as raising one's hand. On the other hand, nonverbal behaviors may fall clearly into the second category. In the majority of cases, however, there remains a margin of doubt, allowing a member of the family to redefine that move later¾explicitly or otherwise¾as falling into one category or the

other. The therapist for his part, renders the move unequivocal by censuring or accepting it, taking charge of it by implicitly communicating "I allow it" or "I do not allow it." It must be stressed that the occurrence of an E.R.B. is highly significant. In our study, there were only two such occurrences out of the ten sessions analyzed. These appeared in sessions conducted by two highly experienced therapists (Dr. Selvini Palazzoli and Dr. Boscolo) who fully exercise their "censuring functions." Of the two families, one was refused further treatment, and the other was considered a treatment failure. Generally at the beginning of the first session, the family and therapist will establish a set of rules, an agreement that does not give rise to the adoption of fixed rules until later. An E.R.B. is a breach, at least temporarily and locally, of that agreement. The family realizes fully that the therapist does not discuss his own conjectures with them; no one knows precisely why he asks what he asks. For that reason he alone can decide what is useful to his inquiry at any one moment, that is, what must be considered cooperative. The members of the family have the right to suggest to the therapist anything they may consider useful¾and every P.R.B. may, indeed, be a cooperative contribution. By committing an E.R.B., the members of the family, by contrast, make it known that they feel entitled to decide what is useful, at least for the moment, even if it runs counter to the wishes of the therapist.

It may be helpful to illustrate by means of several examples the various ways in which the therapist can censure or accept a P.R.B.

Example 8

T: (Omission) Did it bother you?

I.P.: Yes...it bothered me...I rather...I don't know why I didn't say anything to the doctor in charge of the case...I had faith in him, so why not tell him?

T: Quite...quite so

I.P.: and yet my mother why, if only...if only she would accept

M: No. What I say is that from the moment

T: one moment. Let Luca speak.

In this example, the therapist's censuring move is unequivocal, clearly labeling as "not useful to the enquiry," at least at the moment, the intervention to which it refers. The therapist sometimes makes a different¾unequivocal¾censuring move on the nonverbal level; he lifts his hand in the direction of the culprit, using the "stop" sign of a traffic policeman. This type of gesture is particularly effective when the therapist continues to look at the accepted interlocutor.

On other occasions, however, the therapist's censuring moves are equivocal. They suggest that the intervention is "not useful" but do not make that fact explicit¾the family members can always claim that they were left in some doubt.

Example 9

T: Are you happy, signora, that Maria has moved to her sister's...home...or would you have preferred some other arrangement?

M: No, no...I am perfectly happy. They now keep each other company...and then there

F: there are two colleagues who are very fond of her... but she feels little for either of them...she has a purely formal relationship

T: and you (turns to Maria) how long did you stay with your older sister?

The therapist has ignored the father's P.R.B. on both the verbal and the nonverbal levels¾the therapist behaves as if he were deaf. When this type of censure is effective, the P.R.B. is canceled, inasmuch as it has no effect on the subsequent course of the conversation. The culprit may let it be known, however, that he has not grasped the censure implicit in the therapist's intervention and persist with his behavior. He then creates a continuous "noise" of comments or explanations that again do not affect the course of the conversation. It is an open question whether this type of behavior must be considered as accepted by the therapist when he continues to tolerate it.

Example 10

The session is the same as that in example 9.

T: Very well...there was...there was an agreement between you...to have children straightaway, or

F: He was born...he was conceived before our marriage...(omission)...it wasn't that we wanted him straightaway or that we didn't want him...he was born

I.P.: He wanted him...even Papa wanted him!

T: Even Papa wanted him?

I.P.: Yes, he did...to tie Mamma down (laughs).

In this example, the therapist's acceptance is equivocal¾he treats the intervention as if he endorsed it; it does not become clear however, who authorized it in the first place and is hence implicitly defined as irrelevant. The therapist simply accepts it, defining it implicitly as "useful to the enquiry."

In conclusion, members of the family make a number of conversational moves that are unequivocally in accordance with, or in breach of, the rules; they also make a number of "equivocal" moves¾that is, moves that are not patently in accordance with, or in breach of the rules, are Otherefore ambiguous, and can give rise to misunderstandings. The therapist has a special set of conversational moves¾censure and acceptance¾by which he can strip such ambiguous moves of their ambiguity. He may, however, prefer to censure or accept such moves in a less unequivocal way, leaving it open whether or not he considers a particular intervention useful. In that case, a measure of ambiguity remains. It should be stressed that far from being undesirable or random, such ambiguity has a systematic and structuring effect on the development of the conversation. Were everyone to grasp the significance of every single move, all conversation would probably cease or certainly become commonplace and guarded. The real problem is what should be left ambiguous and how and when. The therapist himself must decide what degree of ambiguity is acceptable in any particular sequence, i.e., best serves his ends. If he censures no interventions at all, every P.R.B. is implicitly but equivocally redefined as a "useful proposal." There can be no challenge to his authority because he refuses to wield it. In that case, however, it remains an open question whether the therapist enjoys any real authority.

Interaction-Control Moves

The rules of direction grant the therapist the exclusive right to make certain moves, thanks to which he is in control of the interaction, that is, of the content and course of the conversational sequence. However, members of the family, too, can exercise a measure of control and are often keen to do so. They exchange messages between themselves, and these may be considered implicit negotiations

about what anyone may say to the therapist; moreover, every member of the family sends messages to the therapist that may be considered more or less direct attempts to influence his inquiry. Because of the therapist's central role, however, the members of the family have only a limited number of "acceptable" moves to achieve these ends. More precisely:

1. When his turn comes round, a member of the family can send the therapist messages¾verbal or otherwise¾that may influence his subsequent questions or can make indirect suggestions¾promises, threats, etc.¾to other members of the family that may influence their possible answers.

2. When it is someone else's turn, every member of the family can, by various nonverbal messages, try to influence his answers to the therapist's questions or try to influence the therapist himself.

3. A member of the family can offer a supplementary contribution of his own in an attempt to correct what others have said, hoping that the therapist will authorize him to speak out of turn. If all these means fail, a family member can try a P.R.B., he can speak out of turn without permission or, when it is his turn, introduce a different theme from that chosen by the therapist. A P.R.B. informs the therapist that the culprit is prepared to "pay the price" for exercising some form of supplementary control over the conversation.

Example 11

The session is the same as that in Example 4.

T: And when your sister-in-law said that, what did you (turn to the father) think?

F: That the girl

M: Never...I thought straightaway way that my sister was wrong.

F: And afterwards...my first thought was...that children may just be like that...seeing that her sister...her sister, too, has a...a girl who is a bit...that is

M: Who is in therapy though she is normal again now...now she has finished secondary school

F: Has finished all her all her schooling.

In this example, taken from the beginning of a session, M intervenes with a P.R.B. cutting her husband short so as to minimize the effect of his statement. When the therapist reverted to the report of the niece's illness toward the end of the session, he discovered it to be of crucial importance, as his clinical records make clear. It is significant that the emergence of an important element should have coincided with a P.R.B.

Amplifications of Contradictions and Incongruities

The fact that the interaction is organized according to fixed rules has an important effect. The members of a family, unable to interact on a verbal level, can only communicate with one another through the therapist. It often happens that contradictory interventions on the verbal plane become comprehensible on the assumption that the speaker's message was not intended for the therapist¾to whom it is ostensibly addressed¾but to another member of the family. Naturally, any message, verbal or nonverbal, is simultaneously influenced by all those present; however, the fact that the therapist is the "obligatory" addressee of all the messages forces all members of the family to use this indirect method of communication. Whenever two contradictory messages are sent over two

different channels, the resulting communication may not only be contradictory in respect to its contents but may also be incongruent. This particular way of organizing a conversation thus amplifies contradictions and incongruities. Such amplifications are of benefit to the therapist, who uses much of the information they contain to elaborate and check his own hypotheses.

Discussion

What has been said so far is the result of a detailed analysis of transcriptions of sessions attended by the first group.

The rules proposed were confirmed by observation¾carried out by one of us from behind a one-way mirror¾of the second group of sessions. This second group of sessions gave rise to more remarks.

The Hypotheses of the Therapeutic Team

It is important to stress that, at the start of every session, the therapeutic team frames a hypothesis about the family it is treating (9). In nontechnical language, that hypothesis may be defined as a conjecture about the basic premises by which the members of the family try to influence one another's behavior. The main purpose of the therapist's questions is to collect such information as enables the team to check that hypothesis. Pauses during the interview enable the team to rediscuss and elaborate it and to propose expedient strategies of investigation. In the first session, the initial hypothesis is based on information collected during the telephone call; in more advanced phases of therapy the hypothesis generally involves the presumed effects of the intervention at the end of the last session. In every case, the initial hypothesis is of a general kind and becomes more detailed and specific as new information is obtained.

Once it has framed a hypothesis, the team elaborates a program of investigation and entrusts the therapist with the task of implementing it in the session. It is important to stress that such programs are not identical with the hypothesis. The therapist does not verify the latter by submitting it to the judgment of the family, but does so indirectly. He does not offer interpretations but merely asks questions. Moreover, the hypothesis is too complex to be checked except by successive investigations of its various implications. The team's ability to frame hypotheses does not therefore coincide with its ability to formulate programs of investigation or with the therapist's ability to implement them during a session.

Learning the rules

At the beginning of the first session, the family does not know the rules of the game. If after some time the family shows that they have identified them, it is only because the therapist has taught them the rules without enunciating them. Initially the therapist simply puts questions to successive members of the family in such a way that everyone has a chance to reply, thus establishing a characteristic conversation. Soon afterward, someone is bound to break the rules he is expected to learn and identify as such. The therapist, appealing to the authority vested in him by the family, censures such behavior, defining it implicitly as "not useful to the enquiry." Such breaches then tend to become less frequent. Behavior in accordance with the rules becomes more common, thanks largely to the therapist's therapist's positive reinforcing comments. In short, the interaction is gradually organized in accordance with the rules. Hence we cannot really speak of rule-breaking until some time after the beginning of the first session, that is, until the members of the family the family show that they have grasped the rules.

Such training is usually rapid and is influenced by the way in which the therapist conducts the session, some therapist impose a tight rein from the outset, severely censuring all infractions of the

rules; others prefer to let the family speak as they like initially and impose adherence to the rules more gradually. The choice of one approach in preference to the other seems to bear less relation to the therapist's therapist's experience than it does to his "style."

General Method of Organizing the Conversation

The distinction between "typical" and "atypical" events is useful in describing the general method of organizing the conversation. Thus the approach to which we refer as "letting the family speak" can be characterized as follows:

1. The sequence is mostly organized into "atypical events." The therapist's! instructions as to the topic are general; the questions do not clearly or bindingly dictate the permissible range of the answers; successive turns are not unequivocally fixed on either the verbal or the nonverbal levels.

2. The therapist generally avoids censuring any P.R.B.'s, which are fairly frequent. He accepts them, redefining them implicitly or explicitly as "useful contributions."

3. The therapist's censuring moves are generally equivocal; he usually reverses unequivocal censuring moves for gross thematic digressions or for patent violations of the conversational rights of others. The ambiguity of the individual moves is thus high.

Example 12

This sequence is taken from an advanced stage of the same session as in the last example.

T: I see. But why was it that...her husband paid no attention when Lucia said: I think there's something wrong with Valeria?

M: Well...he...er...quite suddenly...since she [Valeria] was so lively, we...we could see her running about all over the place. He must have thought an abnormal child wouldn't have done that

T: That's it

M: And so

T: He was

F: I don't really know. Even at that age (omission) I felt she wasn't acting DIFFERENTLY from the rest...but then by and by.

M: But none of the doctors who saw her...even the pediatrician we took her to...yes...he tranquilized us (omission) I think we just didn't understand her.

T: Tell me, signora, how old were you when your sister's child was born?

M: Thirty-six...she is thirteen now.

This method of organizing the conversation has the function of letting the family speak in the hope of gathering clues to frame a hypothesis. The rules are observed, however. The therapist makes scarce use of his right of censorship, but when he decides to do so, his veto is respected. As a result, he retains his hold over the conversation¾although he allows the family to choose its own method of organizing the conversation, he exercises remote control. This method of running the conversation involves an adaptation by the therapist to the family's family's method and interactive style. The adaptation, however, is only partial; the therapist maintains a central position, in that all members of the family address their remarks to him.

A different way of organizing a conversation, to which we have referred as an "inquiry," can be characterized as follows:

1. The sequence is organized into a series of "typical "events": the therapist's instructions concerning the topic and successive turns are precise and binding. He insists on highly pertinent replies, demands definitions of details, and will accept answers only from a particular member of the family.

2. P.R.B.'s are less frequent and usually censured by the therapist.

3. Censuring or accepting moves are, more often than not, unequivocal; the therapist makes greater use of organization glosses, summing-up, and keeping a close check on the structure of the conversation.

Example 13

The session is the same as in the last two examples. Laura is the niece mentioned in the two earlier sequences.

T: Well. Who first noticed that Laura was slightly retarded?

M: Well...her. Her mamma, her mother...Me...too, when I was thirty (omission)

T: But were you thirty six or thirty when she was born?

M: No. When this one

T: No. That one...when your sister got married and when... Laura was born?

M: Ah! Twenty-nine, or thirty.

T: I see. Twenty-nine.

M: THEN, but I was thirty-six when this one was born.

T: Ah, well. There was some misunderstanding...we were talking at cross purposes...I asked you how old YOU were when YOUR SISTER gave birth (The patient interrupts, asks for sweets).

M: You've had enough sweets

T: Do sit down, come along now. Well now, I was asking WHO was the first to notice, etc.

This interaction is much more highly structured; the therapist keeps a close rein on the conversation, which is clearly organized in accordance with the rules. He allows a very small margin of ambiguity, unequivocally defining the various conversational moves as "useful" or "nonuseful." In sum, the therapist follows a narrow path and does not accept any detours. This method of conducting a session requires a pronounced adaptation by the family of the therapist.

Neither of the two approaches we have described is inherently beter than the other. In practice, both alternate in every session, with every possible intermediate variation. The first approach is particularly suited to opening up new paths of inquiry, revealing important information that the family almost invariably and often marginally and ambiguously let slip out while straying from the main thematic sequence. The second approach, by contrast, seems better suited to the detailed verification of hypotheses framed previously. In the course of the session, the therapist alternates between "long shots" and detailed questions in which other elements are temporarily neglected,

returning later to the wider topic and examining the interconnection of the details he has discovered. Our last three examples will have conveyed some idea of this procedure.

Conclusion

In our videotape study we describe and define the interview technique used by therapists who adopt the model proposed by Selvini-Palazzoli et al. We consider the therapeutic interview as a conversation which, by contrast with nontherapeutic conversations found in everyday life, can be described in its peculiar features. We have chosen conversational analysis as our main reference model, rather than other models already developed in relation to therapy, because we feel that the members of the family themselves follow a procedure of this type. They begin by thinking of the session as an ordinary conversation, but within a few minutes they grasp its peculiar nature exactly by means of comparing it to ordinary conversation. In the family's hands this comparison becomes an important piece of information they can use either to help or hinder the therapist.

In this study we discuss only one aspect of the interview, which is normally called the therapist's "direction." We define this "direction" by means of a set of rules. These rules, obtained inductively by observing the actual behavior of the therapist, describe some asymmetrical aspects of the conversational rights of the participants. Together they unequivocally define the meaning the generic term "direction" assumes in this particular context. We belive that some results of our analysis may be useful clinically.

In the first place, the "directive" behavior of the therapist and its communicative implications have been analyzed in considerable detail. This may help therapists adopting this model to achieve a greater control over their own behavior.

In the second place, the description of the therapeutic interaction by means of categories different from those commonly used by therapists allows us to bring out phenomena that might otherwise have been overlooked. One example is "Effective Rule-Breaking," the occurrence of which seems to be related to the failure of the treatment. A quantitative check of the significance of this relation is now being carried out. If confirmed, this hypothesis would not only offer a prognostic criterion but would also indirectly prove that the method used in fact allows the emergence of significant phenomena.

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