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THE CORE VARIABLES OF SYMBOLIC-EXPERIENTIAL THERAPY: A QUALITATIVE STUDY

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Symbolic–experiential therapists have been criticized for not adequately operationalizing symbolic theory and empirically validating their methods. Although pioneering researchers have noted that the task of studying and evaluating humanistic therapies is complex, we agree that all therapists need to be held accountable for their interventions. In this article we identify the core variables underlying symbolic–experiential therapy that emerged from a research study using grounded theory. The inductively derived conceptual framework for symbolic–experiential therapy included: (a) Generating an interpersonal set; (b) creating a suprasystem; (c) stimulating a symbolic context; (d) activating stress within the system; (e) creating symbolic experience; and (f) moving out of the system.

In their review of marriage and family therapy (MFT) more than a decade ago, Piercy and Sprenkle (1990) recommended that practitioners of each model of therapy identify and evaluate the core variables within their approach. Before studies can be conducted on the effectiveness of an approach, the core treatment variables need to be clearly defined. Behavioral marital and family therapy has made the most progress in terms of identifying core treatment variables (Dunn & Schwebel, 1995; Dutcher, 2000; Jacobson, 1984; Jacobson & Addis, 1993; Todd & Stanton, 1983). Structural (Kerig, 1995; Minuchin, Rosman, & Baker, 1978; Nichols & Fellenberg, 2000; Northey, Griffin, & Krainz, 1998), strategic (Carlson, 2001; Carlson & Kjos, 1998; Stanton, 1981) and other brief, symptom-focused therapies (Bertolino & O'Hanlon, 2001; Koss & Butcher, 1986; Levy, O'Hanlon, & Goode, 2001; Smyrnios & Kirby, 1993) have also been operationalized without much difficulty. Researchers have agreed, however, that this task becomes increasingly complex with psychodynamic and humanistic approaches (Gurman & Kniskern, 1981; Keeney & Sprenkle, 1982; Sprenkle, 2002).

Experiential therapies are difficult to operationalize. In comparison with behavioral therapies, there has been less research to support the effectiveness of experiential methods. In general, there have not been many outcome and/or process research studies conducted on the experiential approach (Gurman, Kniskern, & Pinsof, 1986; Sprenkle, 2002). An exception is the work of Greenberg and Johnson, proponents of emotionally focused therapy (EFT), who have empirically validated the effectiveness of their methods with specific problems and client populations (Greenberg & Johnson, 1988; Johnson, 1996; Johnson, Hunsley, Greenberg, & Schindler, 1999). In his discussion related to the current state of the field, Sprenkle (2002) reports that evidence across family therapy models is uneven and certain approaches remain empirically underdeveloped. To date, there has been no empirical research conducted on symbolic–experiential therapy.

Some have advocated the use of treatment manuals as a means of identifying core variables of treatment approaches (Luborsky, Woody, McLellan, O'Brian, & Rosenzweig, 1982; Sprenkle, 2002). Gurman and Kniskern (1981) have also recommended that treatment manuals be developed in the field of MFT. However, they predicted that the possibility of creating useable manuals would vary widely across different family therapy methods. Gurman et al. (1986) have suggested that a treatment manual devised for

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symbolic–experiential therapy might even interfere with this method of therapy. Researchers conclude, however, that at least broad intervention principles can be explicated within such approaches (Gurman & Kniskern, 1981).

At the 2000 American Association for Marriage and Family Therapy conference, during a presentation on bridging the gap between research and clinical practice (Northey & Schwallie, 2000), Northey posed the question, "Is it unethical to teach students anything that's not empirically based? With managed care demanding that we provide empirical evidence regarding which methods work best with what type of problems, why do we teach symbolic-experiential therapy?" Schwallie, the copresenter, suggested that our training programs would become 90% behavioral. "If we don't teach students symbolic–experiential therapy, they won't know it enough to research it."

Purpose of the study

The purpose of this study was to identify the core variables underlying symbolic–experiential therapy and to provide an organizing framework for Whitaker's symbolic method. We present findings of a 2-year research project in which grounded theory methods were utilized to derive a conceptual framework for symbolic–experiential therapy inductively. The research questions that guided this study were: (a) What symbolic interventions reflect the domain of symbolic-experiential therapy?; and (b) which interventions occur most frequently in the assessment, initial, middle, and termination stages of treatment? The framework may be helpful for clinicians interested in learning more about the approach and provides a model for educators who are interested in teaching the approach.

Primary Goal of Symbolic–Experiential Therapy

Symbolic–experiential therapy is rooted in a phenomenological existential conception of human development, which emphasizes that one can learn most effectively through experience. A basic tenet underlying this model is that families cannot change their process of living by being taught. Symbolic–experiential therapy is a growth-oriented psychotherapy approach that is "not based on intellectual understanding, but rather upon an interactive process, metaphorical language, and personal interaction" (Keith, 1982, p. 331).

Symbolic–experiential therapy evolved from the clinical work and writings of Carl Whitaker. During his work with individuals diagnosed as with schizophrenia in the early 1950s, he wrote about the importance of a powerful unconscious-to-unconscious personal contact within the therapist–client relationship (Whitaker, 1952). Although he incorporated many psychoanalytic concepts into practice, Whitaker believed in the personhood of the therapist, rather than transference, as the primary curative ingredient of therapy (Neill & Kniskern, 1982; Whitaker, 1944, 1946).

The goal of symbolic–experiential therapy is to enrich, expand, and, at times, alter the family's symbolic world (Connell, Mitten, & Whitaker, 1993). Humans create symbols to represent each other, objects, ideas, and experiences. Symbols evolve as a result of experience. Anything that is experienced can become symbolic. In dysfunctional families symbols become fixed and rigid, thereby inhibiting growth. The task of the therapist is to provide experiences for the family that will reshape dysfunctional family symbols. The symbolic–experiential therapist accesses the family's infrastructure, induces primary process relating, and creates corrective emotional experiences. The therapist relies on self as a catalyst in the change process. The family's participation and involvement in the treatment process may generate new information, which is fed back to the family's unconscious, nonrational processes. In this way, dysfunctional symbols are altered and new ones created. Families are able to reorganize themselves around these new symbols.

METHOD

This study was conducted in three phases: (a) Development of a theoretical schema derived from the literature; (b) observation of videotapes of Whitaker and revision of the conceptual framework; and (c) interviews with experts in symbolic–experiential therapy and further revision of the conceptual framework.

Phase One

Phase one of the study involved a review of the literature conducted by the first author. Books frequently used by instructors when teaching this method of therapy and articles describing symbolic–experiential interventions were reviewed. Sources included: (a) *From Psyche to System* (Neill & Kniskern, 1982); (b) *Dancing with the Family* (Whitaker & Bumberry, 1988); and (c) all articles published by Whitaker from the 1940s through the 1990s. Open coding was used to identify as many symbolic interventions as possible. Each line of books and articles was closely examined for words that seemed to describe symbolic interventions. Key words were underlined. Each example was recorded on a note card and sorted into categories grouping together similar types of interventions. Cards were again sorted into categories based on the stage of therapy during which they were most likely to occur (assessment, initial, middle, and termination). A preliminary conceptual framework was derived from the data.

Phase Two

Phase two involved observation of eight videotapes of Whitaker's work. Again, open coding was used to identify as many symbolic–experiential interventions as possible. Two tapes were purchased from AAMFT including: (a) *Learning Edge Series—Carl Whitaker*; and (b) *Parallel Play: The Journey Inside—Carl Whitaker and Randy Jaffee, AAMFT Conference 1993.* Prior to his death, Whitaker gave videotapes of his work to those who trained with him. The second author and Dr. David Keith selected six tapes considered to be representative of Whitaker's work from the tapes they had been given. Tapes included consultation sessions and Whitaker's work with a family member diagnosed as schizophrenic illustrating specific techniques throughout the course of therapy.

All tapes were transcribed verbatim. Both authors coded all tapes. Interrater agreement ranged from .69 to .98 on the eight selected tapes. After viewing each segment, the tape was turned off. The framework was perused while asking, "Do any of these symbolic interventions describe what occurred in this segment of the tape?" If yes, the code was recorded. The authors then discussed differences in coding. If the segment seemed to be illustrative of some type of symbolic intervention that was not listed in the framework, a description of the process and/or tentative name was given. Discussion then focused on whether or not to add it to the conceptual framework. The idea was to observe videotapes until all conceptual categories were saturated, and no new symbolic interventions were identified. The degree to which Whitaker's work conformed to symbolic interventions identified in the literature, as outlined by the preliminary conceptual framework, was assessed. Based on the findings of phase two, the conceptual framework was revised to fit the data (Straus & Corbin, 1990).

Phase Three

During phase three, ethnographic methods were used to interview five experts in symbolic–experiential therapy. Experts were chosen based on reputational case selection. A list of therapists who trained with Whitaker was compiled. Experts were ranked and contacted in order based on the number of current publications/presentations related to the approach and years of training with Whitaker. Face-to-face interviews were conducted with David Keith (Syracuse, NY), William Bumberry (St. Louis, MO), and David Kniskern (Cincinnati, OH). Telephone interviews were conducted with Russ Haber (Columbia, SC) and Randy Jaffee (Santa Barbara, CA). Experts participated in a 2-hour interview and were reimbursed for consultation fees.

Based on data collected in phase two, a total of seventeen 2–4 minute segments were selected as the best illustrations of symbolic–experiential interventions. Experts were shown a 65-minute videotape titled, "Symbolic–Experiential Therapy: The Works of Carl Whitaker." After viewing each segment, experts were asked to describe in their own words what Whitaker was doing. Experts had no knowledge of the preliminary conceptual framework. Doctors Haber and Jaffee received the videotape via express mail and agreed not to view the tape prior to the interview.

Data analysis revealed a high level of agreement among experts in terms of their description of vignettes. Although experts used somewhat different terms to describe what Whitaker was doing, they described the process and purpose of each vignette similarly. For example, after viewing Whitaker using

amplification deviation, one expert indicated that he was "making it a little worse." Another expert said Whitaker was "stimulating some anxiety." Other responses included, "trying to amplify," "provoking and challenging," and "giving a strong provocation that ups the anxiety." Experts did not disagree regarding the purpose of any of the 17 vignettes. Experts offered elaborate descriptions of symbolic–experiential interventions. Their detailed responses, including new words and phrases, were used to expand conceptual definitions and further revise the conceptual framework.

This process of continually returning to the data to revise the existing taxonomy is referred to as the constant comparative method (Conrad, 1978; Glaser & Straus, 1967). In phase one, core constructs (or concepts) underlying the approach were identified and organized into categories. By comparing videotapes with the literature in phase two, additional properties and dimensions of constructs were identified. In phase three, responses of experts provided in interviews were compared with the findings from the literature and videotape review. Experts' descriptions of videotaped segments provided yet another way of looking at and interpreting the data. Each phase of the study added more depth and meaning to the constructs until theoretical saturation was reached (Glaser & Straus, 1967) and the data seemed to form an integrated whole—a conceptual framework reflecting the domain of symbolic interventions.

Triangulation is one way to increase the validity of a qualitative study. Triangulation involves using different methods and/or different data sources in a study. Different types of data provide "cross data validity checks" (Patton, 1980). Triangulation of the data occurred in this study since sources included a literature review of relevant concepts, intensive study of videotapes, interviews of experts, and the lived experience of the present researchers. Several data sources were used to grasp the gestalt of symbolic–experiential therapy.

RESULTS

In the final data analysis, selective coding was used to rearrange categories of interventions until they seemed to "fit the story" of symbolic–experiential therapy (Straus & Corbin, 1990, p. 127). The following question was asked, "How can these categories of symbolic interventions be organized in a way that describes the process of symbolic–experiential therapy from the beginning of therapy to termination?" In answering the question, six core stages of symbolic–experiential therapy emerged: (a) Generating an Interpersonal Set; (b) Creating a Suprasystem; (c) Stimulating a Symbolic Context; (d) Activating Stress within the System; (e) Creating Symbolic Experience; and (f) Moving out of the System. Refer to the Appendix for a list of specific interventions within each stage of therapy.

Generating an Interpersonal Set

When beginning to work with the family, Whitaker immediately shifted the focus from the identified patient to the family system by expanding the symptom. The idea was to distribute anxiety equally among all family members (Napier & Whitaker, 1978; Whitaker & Keith, 1981). Whitaker refused to talk about the identified patient. Instead he accessed the infrastructure of the family by identifying and amplifying affectively loaded issues and relevant themes underlying family life.

The following example illustrates Whitaker's work with a couple and their two daughters during an interview. Whitaker expands the symptom initially described as the husband's loyalty to his business by covertly communicating to the wife that her over-involvement with the children may equally contribute to the distance in their marital relationship. He encourages her to see herself as a participant in the relationship rather than feeling victimized by it.

Wife: I think we were close when we got married. Then we had the children, and we were close to them. I think that's when we started drifting. I was pretty stationary. Paul went in another direction. He went to business. I think that was the beginning of the separation and distance.

Whitaker: Did you have any sense of the children belonging to you, and he being married to the business?

Wife: Exactly! I feel like I raised the children and he raised the business.

Whitaker: Did you ever figure out what trick you used to make him do that?

Wife: You mean, "Did I turn him into a workaholic?"

Whitaker: No, not that. Do you think he was threatened by all the fun you had with the kids? Did you keep them all to yourself when they were young and cuddly?

Wife: Well, I guess I did. I could have used some help at times, but even when he was home he always seemed to get in the way. I guess, at times it was easier when he was gone.

Whitaker expanded the symptom by implying that the process was bilateral, and encouraged everyone to think about how they contributed to presenting problems. No one is to blame, yet all participate in maintaining the process. Whitaker identified and amplified affectively loaded issues within the family—father being a workaholic, mother's intense relationship with the children, and the couple's emotional distance. Symptoms were then reframed within the context of the relationship.

Creating a Suprasystem

Once the family had a sense of its identity as a whole, Whitaker joined the family system. The idea was to create a therapeutic suprasystem. Whitaker worked his way into the family system by joining with family members and engaging in parallel play. Joining and parallel play are two of the many ways in which Whitaker created a suprasystem. Although Whitaker joined the family, he did not become a part of it. He engaged in an on-going process of joining and distancing. He moved in to experience the family, stimulated movement in a variety of ways, and then quickly backed out. He was a catalyst for change, but he did not become part of the reorganization process. It was the family who needed to continue the journey.

Parallel play is one method of establishing a therapeutic alliance in which the family and therapist work side by side. Parallel play involves taking a component of the therapist's life that is analogous to what the patient is discussing and presenting it from another perspective. Parallel play requires the therapist to be responsive to the therapy process.

In the following example, the father of a son given the diagnosis of schizophrenia recounted an experience that was socially embarrassing. Whitaker normalized the experience by sharing a social anxiety story of his own.

Father: When I was younger, there was this girl that I liked. One time I was skiing with a group of guys and I said to myself, "That's her." I went over to her and she wasn't anything like her. She was blonde, which was close as it came. As I got closer to her I started bursting out in a sweat. It was terrible because I realized it was all in my head. It had nothing to do with the girl whatsoever.

Mother: Well that reminds me of when I was in high school and would say something really dumb. Then of course I'd think to myself, "Oh, I'm just nutty!"

Whitaker: Boy, you're talking about high school. I remember walking down the street once. I was so shy. I was a junior in high school. There was a guy coming in one of my classes towards me, so I practiced a smile so that when he got along I could turn it on.

Father: Were you able to pull it off when the time came?

Whitaker: Yeah, but it was still awful 'fake.'

Parallel play requires the therapist to be responsive to the therapy process and attuned to the family's story. Parallel play emerges from the therapist's awareness of self and capacity to be truly present in the moment as the session unfolds. It is not something one plans.

Stimulating a Symbolic Context

When Whitaker experienced a sense of connectedness with the family, he began to shift from reality to the symbolic by listening "through" what was being said rather than "to" it (Keith & Whitaker, 1981; Whitaker, 1966; Whitaker & Warkentin, 1965). Two symbolic interventions relied on to access the symbolic world include picking up on symbolic bits and fragments and expanding the fantasy. Whitaker accessed the symbolic world of the family to facilitate primary process relating (Whitaker, 1957; Whitaker & Malone, 1953; Whitaker, Warkentin, & Malone, 1959). At this point, he was creating the context within which symbolic experiences could occur.

For example, rather than complaining about his lack of social life, an isolated father called himself a hermit. Whitaker, picking up on this image, went a step ahead and free-associated about the cave in which the hermit lived. By picking up on words that seemed to have special meaning, the session became livelier. The whole family became engaged in a playful fantasy regarding dad as a hermit, mom as Mrs. Hermit, and the chronically whiny kids as hermit crabs. These spontaneous side trips touched hidden aspects of their relationships that were central to their struggles for intimate involvement with one another. This random element can give the therapy process an unexpected twist while helping the family to transcend the presenting problem and perceive other options.

Activating Stress within the System

Whitaker believed that anxiety fostered growth. When families were stuck, he suggested they were not desperate enough to change. As he became a part of the family's symbolic world, he would poke at the system in a variety of ways to increase the level of anxiety (Barrows & Zeig, 1981; Keith & Whitaker, 1978; Whitaker, 1973; Whitaker & Keith, 1981). He often relied on amplification deviation as a means of raising the family's temperature. He also used his own anxiety and affect to facilitate movement, believing that the therapist's internal experiences belonged to the therapy process. He suggested that impasse occurred as a result of the therapist's inability to tolerate anxiety within the system (Whitaker & Malone, 1953; Whitaker, Warkentin, & Johnson, 1950).

In the following vignette, Whitaker relied on amplification deviation by suggesting that the couple was not desperate enough to change. Rather than exploring ways to resolve marital issues, Whitaker pushes the couple to think about what it will be like when they separate.

Whitaker: (To a couple struggling with ongoing impasse in marriage) Do you think it's probably going to go on like this for the rest of your life?
Wife: Yeah, it could unless we do something.
Whitaker: So I don't understand why are you going for therapy? Why don't you just let it happen the way it's happening?
Wife: I'm crazy. I can't go on, and he's crazy, and our poor children are going to get crazy.
Whitaker: Do you think he may do better with his third wife?
Wife: His third wife? I don't know. That's an interesting concept. They say you pick the same mates over and over so I don't know.
Whitaker: Had you thought of trying to help him find the right kind?
Wife: Find his third wife? I don't think so, but I know a lot of people who really like him so I don't think he'll have a problem.
Whitaker: Have you tried to get any help from him in choosing somebody that would be compatible with you?
Wife: I don't think he'd go for that.
Whitaker: Well, he might and knowing you he might know of somebody that would be compatible with you.

The couple presented as emotionally disengaged. Whitaker's intent was to move them in an area where they were not comfortable but needed to face. He used his own affect and frustration with their lack of investment in the process to facilitate movement in the system. By increasing the anxiety he might make them angry, make them laugh, or do something that would change their view of the situation. By talking about quitting and amplifying their situation he challenged them to either consider divorce or decide to actually be married.

Creating Symbolic Experience

Whitaker believed that if therapy was to have a lasting impact, it must become a symbolic experience (Keith, 1982; Keith & Whitaker, 1981). He often told the story of a police officer who was on the scene as a man was about to commit suicide. As the distraught man was about to jump from a bridge, plunging to a certain death, the policeman spontaneously reacted:

Officer: Hey you! Stop right there! You can't do that!
Man: What do you mean I can't? Who cares?
Officer: Your parents will be devastated!
Man: Big deal.
(In a moment of frustration the policeman drew his gun and aimed at the man.)
Officer: You S.O.B, don't jump or I'll shoot you!
(Looking befuddled, the man climbed down.)

Whitaker referred to this as the best example of symbolic therapy that he'd ever encountered. The policeman was fully in the moment. His response had an odd quality of being sincere and absurd. It broke through the man's certainty about wanting to die. It contaminated his fantasy of controlling his own destiny. Being shot by the policeman, a stranger who had suddenly become invested in him, did not fit with his agenda. It ruined the dark purity of his plan. Once disrupted, he could not get it back. The decision to come down from the bridge and go on living now made sense. Whitaker believed that nothing worth learning could be taught. He emphasized that the experience, rather than understanding or insight, is the real impetus to meaningful change. If therapy is not symbolic, if it strives only to educate and problem solve, the outcome will be limited.

The middle stage of therapy is the most crucial. The dynamic interplay between the family and therapist is complex. Interaction is based on a myriad of factors, many of which are beyond the scope of the therapist and family's conscious awareness. The therapy experience consists of moments that are beyond technique (Whitaker & Malone, 1953).

Whitaker often created symbolic experiences by amplifying the role of mother, father, grandfather, boyfriend, or husband depending on what the family needed (Napier & Whitaker, 1978). Whitaker amplified roles to provide experiences for the family and then quickly moved out. For example, in one session, when the oldest daughter expressed her pain related to a recent breakup with her boyfriend, her father presented himself as insensitive and peripheral to the system. Whitaker amplified the role of the father by engaging the father in irrelevant conversation. By doing this, Whitaker was also presenting himself as insensitive and peripheral to the family system (Bumberry & Tenenbaum, 1986). The youngest daughter responded by screaming at Whitaker, "I don't want to talk about that. I want to hear what my sister has to say!" Whitaker became the symbolic father. The daughter could not take her own father on directly, but was very capable of expressing her feelings about Whitaker's insensitivity.

Likewise, the family had not been able to express anger toward the father directly. However, they did express anger toward Whitaker, whose actions symbolized those of the father. The father was then able to experience the family's anger indirectly. He was able to get a better sense of how his insensitivity affected the family. The father gradually became more involved with the family. He began to invest more of himself in the treatment process. As the family experiences father as more caring, the symbolic meaning of "father" may change.

Moving Out of the System

The family's level of investment in struggling together decreases as the beginning of the termination approaches (Napier & Whitaker, 1978). Their sense of urgency has faded. The anxiety that once fueled the sessions has diminished. In essence they are saying they have gone as far as they are ready to go, pushed as hard as they are willing to push. It is time to stop.

Whitaker interpreted such comments as "We really don't have anything to talk about" or "We're getting so busy" as the family's desire to tackle their world on their own. When anxious, therapists, much like concerned parents, have a hard time truly letting go. Whitaker stressed the need to inform the family that as a therapist you will not be a lonesome mother. He would introduce bits of his real world by talking about new projects he was working on, a trip he was planning with his own family, or an encounter with another family. He thanked the family for the opportunity to work with them. He commented on what he had learned from them and wished them well on their journey. One way to move out of the system is by distancing.

Husband: Hey, it's getting harder and harder to schedule these sessions. I'm losing work.
Whitaker: Well, maybe it's time to stop. Why are you still coming?
Husband: I thought of not coming today.
Whitaker: You want to leave now? You will only lose a few hours.
Husband: No, I think I'll stay to the end of the hour.
Whitaker: You know you don't have to.
Husband: Since I came, I might as well stay.
Whitaker: Mom is it all right with you if we stop?
Wife: We just got started.
Whitaker: Well, it's a shame for dad to lose all that work.

In summary, Whitaker facilitated change in families by accessing and intervening in symbolic processes. When first meeting the family, he focused on generating an interpersonal set. Once the family began to think systemically, Whitaker joined with individual members and the family to create a suprasystem. A sense of connectedness increased the level of intimacy among members. As Whitaker joined the system, he began to stimulate a symbolic context by attending to words and phrases embedded within the family's conversation that were affectively loaded. He placed minimal importance on content, shifting to the symbolic. This provided the context for symbolic change to occur. After entering "into" the symbolic world of the family, he activated stress within the system to facilitate movement. He then created symbolic experiences. When the family began to reorganize itself in a new way, he quickly disengaged himself from the process by moving out of the system. By identifying the core variables of symbolic–experiential therapy, we can begin to theorize about how symbolic change occurs.

DISCUSSION

This is the first study to identify core variables of symbolic–experiential therapy. The conceptual framework is grounded in theory (literature review and observation of videotapes) and validated by experts in the field (ethnographic interviews). It provides an organizing framework for studying and teaching symbolic–experiential therapy. The results of the study revealed that, although the content of family life varied for each family observed, the process of Whitaker's symbolic–experiential therapy remained consistent. Although the goal of the study was to bring the abstract process of Whitaker's work down to a more observable level, the intent was not to simplify the process of symbolic–experiential therapy. The whole of the conceptual framework is greater than the sum of its parts. Examples from the data have been presented to demonstrate only one way a variety of interventions can be relied on throughout the course of therapy. Rather than follow a planned agenda requiring the use of specific interventions during different phases of therapy, the therapist has access to a myriad of interventions. The intervention utilized by the therapist at any given time depends on the dynamics of the therapist, the dynamics of the family, and the here and now experience of the therapeutic system.

In this way, symbolic–experiential therapy differs from other experiential approaches. For example, in emotionally focused therapy (EFT), the therapist accesses and intervenes in couples emotional processes utilizing specific methods during each phase. Greenberg and Johnson (1986) delineate seven steps to facilitate expression of emotion and reconstruction of affect. Therapists using EFT work outside of the system to reorganize affective change. In contrast, the symbolic–experiential therapist utilizes self and interactional processes to create symbolic experiences from within the system in hopes of replacing rigid family symbols with healthier ones.

At a time when managed care demands that therapists empirically validate their methods and MFT programs require faculty to teach evidence-based models, we hope that students continue to be exposed to existential approaches such as symbolic-experiential therapy. Although the task of operationalizing an aesthetic approach is complex (Gurman & Kniskern, 1981; Keeney & Sprenkle, 1982; Sprenkle, 2002), we agree that therapists working from these approaches need to be held accountable for their methods.

Limitations of the study include use of the framework to code only Whitaker's work, expert interviews conducted with only male therapists, and the exploratory nature of the research. Although this study identifies core variables of symbolic–experiential therapy, the number of studies demonstrating the effectiveness of these methods continues to be zero. Future studies on the process of change and outcome of methods with specific problems and various populations are needed. We hope that the article has generated an interest in studying the approach and provides an impetus for therapists utilizing symbolic–experiential methods to engage in future research endeavors.

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APPENDIX

Final Revision of the Conceptual Framework for Symbolic Interventions in Symbolic–Experiential Therapy

ASSESSMENT PHASE

Generating An Interpersonal Set

Expanding the symptom

Take the focus off the IP [identified patient] by accessing anxiety in all members of the family.

Create a shift in the family's view of what is wrong.

Getting at crossgenerational/intergenerational influences

Increase the family's awareness of symptoms and interactional patterns that have occurred within the family for generations.

Expand the symptom from the nuclear family to 3–4 generations.

Move from a present problem to a historical phenomenon, suggesting that members are victims of their set.

Identifying and amplifying affectively loaded issues

Highlight emotional themes and sensitive issues of family life.

Redefining pathology

Relabel pathology.

Normalize subjective, idiosyncratic experiences.

Redefine craziness as a social function, rather than a biological abnormality.

Emphasize that any symptom makes sense within a context.

INITIAL PHASE

Creating A Suprasystem

Adopting their language

Use similar words and phrases.

Engage in similar gestures exhibited by family members.

Parallel play

Share personal experiences similar to those described by the family.

Going one down

Empower the family by refusing to take on the role of expert.

Emphasize the family's responsibility and capability for making decisions about how to live their lives.

Being caring

Facilitate an understructure of caring by sharing positive feelings and concerns for members.

Provide the anesthesia needed to tolerate confrontation.

Stimulating A Symbolic Context

Picking up on symbolic bits and fragments

Attend to words that infer visual images and/or have symbolic meaning.

Identify symbolic meaning underlying phrases, such as "I feel like a slave."

Inquire about dreams and fantasies.

Expanding the fantasy

Ask questions to push the image.

Add to the fantasy symbolically by communicating with the client about his/her inner world.

Identifying universal issues.

Identify universal issues, such as loneliness, sexuality, rage, and death.

Normalize and bring to the surface universal life experiences.

Using humor, confusion, and absurd comments

Share humorous and absurd thoughts to stimulate primary process thinking and lower defenses.

Induce confusion to disrupt the process.

MIDDLE PHASE

Activating Stress Within The System

Challenging roles

Identify various roles played by family members such as victim, bully, and so on.

Challenge members to change these roles.

Challenge rigid cultural roles of men and women.

Using own affect

Therapist's use expression of his/her anger or any other emotion related to the therapy process to facilitate movement.

Using silence

Use silence to increase anxiety within the system.

Use silence to encourage the family to take the lead.

Amplification deviation

Amplify the family's absurdity by becoming even more absurd.

Encourage reenactment of a process until it can be given up.

Push the system without taking a position or telling the family what they ought to do.

Confronting

Clarify a discrepancy between the therapist's experience of the family and the family's perception. For example, "You say you care but it doesn't seem to me like you give a damn."

Challenge beliefs and directly confront the family regarding areas they have failed to change.

Use confrontation to challenge the personal growth of individual members and the family as a whole.

Creating Symbolic Experience

Sharing free association, fantasies and visual imagery/metaphors

Therapist shares his/her own beliefs and free associations to facilitate primary process relating.

Provide metaphors or "picture images" that may become powerful symbols for the family.

Telling stories

Tell stories that serve as a metaphor for the family.

Present the story in a way the family cannot refute because "it's just a story."

Creating experiences

Determine what experience the family needs to move on, such as the opportunity to express anger or any other positive or negative emotion and provide that experience.

This includes amplifying the role of mother, father, and so on.

The therapist invests self in the process as a way to push for change.

TERMINATION PHASE

Moving Out Of The System

Distancing

Move out of the system.

Model the process of individuating for the family.

Avoid being absorbed by the family process by redirecting, looking out the window, changing the topic, and so on.