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'The Ancient Cult of Madame': when therapists trade curiosity for certainty

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An experience in which the author followed his own objectives rather than the patient's, leading to a tragic end, is evoked as a frame for the presentation and discussion of a family treatment where the therapeutic process led by the therapist may have exceeded the needs and expectation of the family members. This is followed by a discussion about potential problems caused by a therapist's fascination for family stories, since its effects may be epistemologically discontinuous from, if not contradictory to, Cecchin's recommendation for 'curiosity' as a central dictum of the therapist's stance.

In tender memory of Gianfranco Cecchin

Introduction

In the early 1960s, a year after I graduated from medical school, very wet behind the ears, I was awarded a small grant to conduct an experimental trial of a new neuroleptic medication (Sluzki, 1961). It was the dawn of the phenothyazines, and this study involved a cohort of chronic psychiatric patients at the main psychiatric hospital for men in Buenos Aires, a rather dismal warehousing facility with thousands of inmates.

One of these patients, with whom I established a cordial and fond relation, was a lucid man, involuntarily committed seven years earlier by judicial mandate, having vehemently confronted a Supreme Court Justice. A former trumpet player, this patient was involved from dawn to dusk in an extremely rich delusional system about an organization of his creation aimed at bringing together 'talented people' who would devote themselves to 'saving the world from meanness'. He was, in fact, the only member of his organization and was

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endlessly writing plans of action, illustrated with multiple, allegorical pencil drawings. It was, in sum, an idée fixe *that filled his daily life with meaning and purpose; he was, as a result, routinely energetic and engaged, if not joyful. While he was adapted to the Spartan life at the asylum, he accepted voluntarily to participate in the trial of this new medication – that contained the promise of a release from his mandatory confinement – and complied faithfully with the treatment. The medication (and perhaps, in part, the friendly attention he was getting from me) accomplished the promise of its anti-delusional effect within a few weeks. However, as the whole belief system began to fade, that patient, joyous and energetic when involved in his project, became despondent, faced with a realistic assessment of his bleak, lone, empty future. For during his years of confinement, he not only lost whatever prior skills he had possessed as a musician, but he also lacked any family or extra-familial social support. Without an alternative theme/purpose to provide meaning to his life, he was bereft and alone. In turn, the institution lacked any discharge planning or social services which could have oriented him in terms of community resources. During my occasional visits to the asylum, I did my best to discuss with him possible activities he could explore once discharged but, not surprisingly, none of them could compete with the world he had lost. In despair, within a month, while scheduled for discharge, he slashed his wrists and died overnight.*

His ghost still visits me occasionally to remind me of the risks entailed in being symptom-focused, rather than context-focused; he also admonishes against wanting more change than what the patient or family may want or be able to tolerate. Needless to say, he also reminds me to ensure that appropriate discharge planning and community aftercare are incorporated into any treatment.

People come to a consultation with requests: 'help me change myself', 'change another person', 'modify my history, or my present, or my future circumstances'. The consultation, and the requests, comes after considerable unsuccessful efforts to change themselves and/or others. In most cases, people who consult know what they want to change. As therapists, we may sometimes disagree with their goal, or with the means they propose to achieve change, or with the tempo, or with the sequence proposed. From that disagreement may follow an overt negotiation, at times based on our hope that we will end up in a confluence of desires or goals. In turn, patients may expect – while frequently resisting it – that we will follow different premises and different guidelines than those they followed, or suggest different roads, or discover magic keys. Ultimately, patients expect that the therapist will have a good track record, solid reflections-in-action

(Schon, 1983) and a solid conceptual and ethical map that will tune into their own, and create pathways for the changes they were not able to make on their own.

In turn, the relationship therapists establish with the models that guide them affects their relationship with patients, not only in terms of the orientation of their activities as therapists, but in terms of competing hegemonies: the more the therapists pay attention to their own convictions the less flexibility they will have in terms of accompanying the patients in the display, or exploration of, their dilemmas. However, unless the therapists have guidelines for action, based on some convictions about the process of change, they will be engulfed hopelessly in the patients' story and both patient and therapist will wander in that labyrinth.

The above statements are, of course, booby-trapped by recursivity: reality is always constructed through the lens of our assumptions and models, and there are no 'patients' that hang out there, free of our constructs organizing and privileging what we perceive, nor 'stories' that do not reside simultaneously in the storytellers and in all those who listen to them, therapists included. Patients, their stories, and their therapists mutually construct and reinforce their world.

In the course of therapeutic interview we therapists may inhabit comfortably an amalgam of 'being there' and models, of interest, empathy and conceptual guidelines based on our prior experience. Models appear to be melted to our professional self, granting us coherence in our practice, with all the pros and cons those 'choices' entail. And there are times when models or theories are not background but operate as a third party, since we evoke them actively as lenses with the hope that they will add clarity or offer a guideline and a pathway out of the labyrinth, when our own internal compass fails to orient us. In those circumstances, we adopt this or that lens hoping that one or another will allow us to organize, with patients, a new reality.

As mentioned above, and as discussed in recent stimulating professional dialogues in our field (Blow *et al*., 2007; Eisler, 2007; Sexton, 2007; Simon, 2006, 2007; Sprenkle and Blow, 2004, 2007), there are pros and cons for each of these lenses, ranging from the degree of pleasure of the fit between conceptual models and personal style/worldviews, the ambivalence of following a given therapeutic tack dictated by a model (at the expense of personal comfort), or the traps arising from the arrogant certainty of cosmogonies. In fact, it could be argued that unless we therapists acquire a recursive awareness of the models we rely on, that is, a certain minimally detached, instrumental

view of our theories, holding them as 'theories', we may risk becoming slaves of our models, rather than their owners (Sluzki, 1992). In sum, models orient as well as, paradoxically, imprison us. While loyal fanaticism to our chosen model has some soothing power, since it reduces uncertainties and minimizes the agony of falsification as a proof of its conceptual solidity, it also increases our insensitivity to alternative, equally plausible or even more powerful views. At the same time, we cannot *not* be at the mercy of our own personal style, aesthetic preferences and the impact of prior experiences, that is, of our self, both conscious and unconscious.[1] At the least, we should be aware of the possible ways in which those extra-methodological variables express themselves, facilitating or hampering our professional work.

This article focuses on a nine-sessions family therapy which I facilitated a number of years ago, a treatment that taught me (again) an important lesson on the subject of the boundaries between the patient/family's and the therapist's (construction of) reality, and, more specifically, on who establishes the focus and the endpoint of therapy, whether the family or the therapist, and what may happen when they fall out of sync. In this particular case, my own goals and expectations, conceptually reasonable, once again exceeded those explicitly stated by the family.

'The Ancient Cult of Madame': a failed attempt at exorcism

I received a telephone call from a woman requesting a family consultation, arguing that she felt trapped in a triangulation between her father and her brother. Her brother, she described, had been suffering from schizophrenia for many years. Her father, retired and living abroad, had returned to the area to take care of some family business. She reported that when he met with his son, he found him in such a bad shape, poorly dressed and poorly nourished, that he, the father, decided to invite the son to live with him for a short while in an attempt to help his son to improve his condition. However, the two ended up being at each other's throats and driving each other, as well as her, insane. Apparently, they would phone her at any hour of the day or the night, dragging her from where she lived, some seventy miles away, to their house, sometimes in the middle of a snow storm, claiming that they were ready to kill each other. She wanted help in reducing the relational chaos so that she could return to her own life's routines. Intrigued, I agreed to interview the family a few days later,

[1] I follow here Flaskas' wise 2005 recommendation to retain key notions from psychoanalysis as legitimate part of our systemic language.

obtaining the family's consent for the interviews to be videotaped as well as observed from behind a one-way mirror by a small group of colleagues.

They arrived punctually. The consultee, a woman in her mid-thirties, was pleasant, energetic, displaying long, frizzy hair, comfortably and slightly unconventionally dressed; overall, she had a strong, friendly presence. Her brother, two years younger, broadcasted all the stigmata of the 'chronic schizophrenic patient in the community': he was dishevelled, dressed in dirty and worn-out clothes, and exhibited rather disorganized behaviour and many mannerisms. Their father, in turn, was an elegantly dressed man with a strong British accent, very contained and formal in his behaviour while displaying many social graces. This was an unlikely group: a Jane Goodall look-alike, a Dustin Hoffman in Rain Man and an Anthony Hopkins in one of his 'English butler' roles (I will identify them by those names throughout this article).[2]

Mr Hopkins told me that he lived a good part of the year on a Caribbean island, subsisting on his retirement and the rental from their local house; he also gave money monthly to his son. Dustin, in turn, lived in a local half-way house near a community mental health centre, where he participated in outpatient programmes. Jane lived by herself – sometimes with her boyfriend – in a community an hour away by car. Mr Hopkins was in the vicinity of his son's community, selecting new tenants for his rental property. However, he explained that when he met Dustin he found him in such poor shape that he invited his son to live with him for one or two months while refurbishing the rental property for the next tenant. His intention was 'to buy him new clothes, and teach him how to wash himself, how to cook, and all that'. However, they quickly found themselves locked into an untenable, damn-if-you-do-and-damn-if-you-don't interaction, fighting constantly. While his son refused to collaborate, Mr Hopkins felt that he could not just abandon him in such poor shape.

I explored their expectations for the family consultation, and each of them stated their goals very clearly: Jane wanted 'out of all this as I need to go on with my own life. I don't want to keep being caught in the middle'. Mr Hopkins, in turn, stated, 'I want to go back to my modest refuge in the Caribbean and to my daily routines – I want to be able to disengage from my son'. And Dustin proposed a similar goal: 'I want to be left alone and continue with my life.' In sum, each wanted to disengage from their current relational trap(s). We agreed to work together on a weekly basis for the following two months.

The fourth character in this family consultation was also introduced in the first session, and enriched in subsequent sessions into a thick but concordant portrait: Mrs Hopkins, even though she had been dead for five years, remained

[2] Some additional identifying information has been distorted for the purposes of preserving the family's anonymity.

a strong, intense, charismatic central character in everybody's life. Mr Hopkins described her as an enfant prodigy, a remarkable multifaceted painter and sculptress who in her mid-twenties had studied with first-line artists such as Calder and Miro. However, after having been spurned from an important exhibition, she had decided to stop exhibiting her work and, instead, married impulsively one of her wooers, Mr Hopkins, a parks and landscape designer. She then proceeded to live the rest of her life almost secluded in their house. She was described by the three of them as an extremely temperamental and possessive woman who would spend months on end inside the house, painting, defacing and repainting canvass after canvass, playing the piano with virtuosity, involved in self-guided activities such as studying Chinese on her own (even though she never travelled). She never trimmed her hair, so that it flowed out extravagantly behind her. She would often engage in tantrums and displays of despair. As an example, she would run up to the attic in their house, her hair flowing behind her, lock herself in and proceed to wail while banging the walls with her fists. The agreement she had with her husband was clear: 'The house is my territory', she was quoted as saying. 'You take care of the garden.' And he, obligingly, landscaped the garden into an almost medieval refuge, growing huge hedges around the house that, over the years, totally hid it from the street. They had two offspring: Jane, a strong, rebellious, creative tomboy attached to her father was involved in outdoor adventures that evolved over the years from horseback riding, to a commitment to wildlife preservation, to human rights advocacy abroad. Dustin, born two years later, openly his mother's favourite, was a mild, introspective child ('an expert in inner wilderness', commented his sister with some tenderness) and an outstanding student with few friends. He used to stay at home with his mother and write poetry, until he went to college, where he promptly had a severe psychotic break with a diagnosis of schizophrenia. From then on he alternated between living at home, under his mother's care, and occasional hospitalizations. Seven years ago, Mrs Hopkins was diagnosed with cancer. She refused treatment, and was eventually hospitalized for pain management and terminal care. Jane described dramatic scenes during this time in which her mother lay profoundly emaciated and surrounded by intravenous lines and catheters, her long hair hopelessly entangled with the lines; concerned, Jane asked her mother for permission to cut her hair. Her mother nodded in agreement but she then observed with an expression of utter horror as her daughter carried out the task, both necessary and, in its own way, symbolically terminal.

I underline this episode not only because of its poignancy but because, in the course of the nine sessions of this family treatment, Jane cut her own hair twice: during the first three sessions her hair was shoulder-

length and rather wild; then, around the fourth session, she trimmed her hair substantially, and, in the last session she came with her hair cut quite short, fitting her plans to return to her activities at a refugee camp in Africa. Of course, during the sessions I created, for myself and for her, a link between her own haircuts and her cutting the hair of her own mother; I was assuming that these haircuts were an indication of liberation from the relational entanglements, concurrent with her progressive differentiation from her mother – or at least mother's role.

As the family narrative unfolded, I learned that after Mrs Hopkins' death the remaining members of the family disbanded: Jane, who was living on her own or with a boyfriend since her late teens, pursued her involvement as an activist, mostly abroad; Dustin moved to a half-way house for chronic psychiatric patients with follow-up care provided by the local community mental health centre, and their father retired to a small town on a Caribbean island where he had previously, upon occasion, taken refuge from the chaos at home.

Despite the fact that Mrs Hopkins was no longer at the centre of the family storm, her presence continued in her absence. The family referred to her as 'Mother' by both offspring and as 'Madame' by her widower; collectively, they frequently described her with vividness and enthusiasm, exchanging many picturesque anecdotes and memories about her. When, early in the treatment, I praised them for having kept wife/mother so faithfully alive in the midst of them, Mr Hopkins answered rather pensively: 'Ah, yes, yes, the Ancient Cult of Madame!'

'Cult of Madame' indeed! They described, almost sacramentally, that the house had been carefully kept as it has been when Madame was alive, a temple at the service of that cult; rooms were filled not only with the memory of her but also with her memorabilia. Since her death five years ago, a rather large collection of her paintings, both finished and unfinished, and of other objets d'art, *as well as her piano and a substantial amount of sheet music, remained untouched. At one point I asked, half innocently, 'Have you ever considered donating the sheet music to the Music Department of the local college or her paintings to a local museum or something like that?' to which Mr Hopkins answered very seriously 'Oh, no, no! Madame wouldn't like that!' with both siblings nodding in agreement.*

Many themes were visited and many issues discussed during that therapy. However, as the sessions progressed, I became more and more fascinated with the presence of that ghost in their life and in the sessions, as Madame was virtually materialized over and over again throughout the interactions. For instance, while the daughter usually sat in a corner of the room, father and son would tend to sit in a row but leave a space or an empty chair between them,

and they would frequently lean forward to converse, as if Madame would be sitting between them, materializing the stable triangulation that seemed to have operated in the family throughout their life. On one of those occasions in which the seating arrangement would include an empty space between them, I moved an empty chair towards that space, defining it as Madame's chair, and everybody interacted around this enactment with excitement, ease and laughter. Dustin even sat for a moment in that chair and, moving into a role play, imitated her, with hilarity all around. After a few interactions as 'Madame', he moved back into his own seat, commenting, with laughter, about the play.

A powerful, if perhaps omnipotent, fantasy started to become dominant for me over several sessions. If I could exorcize this ghost, if I could help them dissolve the 'Ancient Cult of Madame' as a dominant theme and rite, this family would be able to get unstuck and evolve, and, equally important, perhaps even Dustin would be able to free himself from the trap of schizophrenia. In other words, I began to believe in a theory that the illness of the son was anchored in the practices and rituals that kept Madame, or Mother, alive.

Consequently, during the sixth session, I pushed the issue further in the midst of still another conversation about Madame: 'Perhaps,' I proposed, 'as we are nearing Memorial Day, a day devoted to honour those who have died but that are present in our mind, perhaps it would be a respectful time to let go of Madame's ghost. Where is she buried?' Jane informed me, in a rather long and humorous fashion, that her mother doesn't have any burial site but is 'all around us', as she had been cremated and her ashes scattered into the wind from a small airplane flying over the area of their house (and my office!). Further, the family, with collective amusement, told the story of how difficult it had been to dispose of Madame's ashes from a plane, as the ashes kept circulating back into the plane's cockpit again and again, 'refusing to be spread'. The symbolic component of those difficulties was clear to all, and explicitly discussed, in one of the many escapes into laughter that characterized this family's way of defocusing. I continued to pursue the theme: 'Well, allow me to insist, where could be a place that would represent her burial site, one around which you would be able to organize for her the rituals one organizes for the dead?'

Until that moment, Dustin had always either participated in a very flaky or timid fashion, or left the room whenever he experienced some tension; however, after I asked that question, he leaned forward, looked at me intently while pointing at me with his index finger, and admonished me sternly and with a firm voice: 'Doctor! Not one word more! This is going too far! This family cannot tolerate it! Return to a discussion of trivialities! Now!' I was startled by his intensity and clarity, and, in fact, became slightly physically afraid; I remember wondering whether there were colleagues behind the one-way mirror who could come to my aid if Dustin were to attack me.

But I also remember evoking, for myself, the ghost of the patient described at the beginning of this article. Mutatis mutandis, *I became suddenly aware that the elimination of the 'Ancient Cult of Madame' would entail a loss of meaning and of purpose, of a reason for being in the world for Dustin, if not for the other priest and priestess of that intimate cult. I reminded myself of the very specific goals posed by each of them during the first session; namely Mr Hopkins' wish to be able to return to his Caribbean routine, Jane's plea for disengagement, and Dustin's request to be able to live without interference, irrespective of the opinions or judgements of his sister or father.*

This cascade of emotions and thoughts took place in the course of seconds, as a wake-up call, reorienting me. I immediately agreed with Dustin's explicit request. Jane in turn responded to her brother as if asking permission, 'But, couldn't I go on with my need to bury mother?' I answered in his stead: 'You could, and perhaps you should. However, I will respect Dustin's request not to continue with this theme at this time.' Father, always placating and a little startled himself, supported immediately the idea of dropping the theme. This was a critical turning point in the session and in the therapy as, in fact, I proceeded, during the rest of that session and in the following three, to focus on 'trivial subjects', namely the specific ways in which their goals could be met, including pragmatic arrangements, money disbursements, timing of their moves, living arrangements for Dustin that would be satisfactory to all, and issues of autonomy and connectedness between the three. The banned theme, namely the closing of The Ancient Cult of Madame, was not touched on except for an interaction initiated by Jane, at the ending of the eighth session, when she commented to all that the theme of needing a symbolic burial place for her mother had been extremely moving and useful for her, and quite liberating.

As the ninth and last session was ending, Jane expressed enormous relief for having ceased to become an arbiter for conflicts between father and brother for the past two months, and commented that father and son seemed to be getting along reasonably well. In turn, Mr Hopkins informed me that he had found a tenant for his house and was ready to return to his Caribbean refuge. Dustin stated that he was also ready to return to living alone, with improved living quarters and a more satisfactory mechanism for receiving his monthly modest allowance, as a result of agreements between his father, himself and his case worker.

In addition, Mr Hopkins initiated his own effort to solidify a new identity for his son. It happened that, throughout his life, Dustin wrote and kept in several folders a number of poems – most of them Koan-like pieces. A few weeks before the final session Mr Hopkins had asked his son to lend him those folders, and proceeded to order from a private printing firm 500 copies of The Collected Poems of Dustin Hopkins, *which he gave to his son in an almost*

baptismal ceremony enacted in our presence before his departure, thus legitimizing his identity as a poet.

It is tempting to speculate alternatives: perhaps this was an identity fostered by Madame but previously disqualified by Mr Hopkins, rescued through his noble gesture; perhaps it was Madame who had discarded that identity, and this edition materialized the previously secret support of her husband; or perhaps it was simply a gesture that opened for Dustin the possibility of an identity as a bohemian poet rather than only as a chronic psychiatric patient. One way or another, all of us were moved by that gesture.

The therapy ended and the family seemed content with the outcomes. In a three-year follow-up, Jane informed me that she had married her long-time lover and continued living abroad, fulfilling her vocation as a human rights worker; she also noted that Dustin maintained his marginal lifestyle, but in a less disorganized fashion; and Mr Hopkins was basking happily in the sun at his Caribbean retreat. In terms of outcomes, the therapy had generated what the family had requested.

Discussion

For me, this treatment was a major learning experience. It became not only a lesson in humility but a reminder that even while exploring themes with the family that consults, it is necessary to keep in mind family members' stated goals, watchful as to whether emerging therapeutic agendas follow our, but not their, expectations. This clash may be at the core of the notion of 'resistance', a label we tend to use when we complain about those patients who are not changing according to the mandates of whatever model we are using (Sluzki, 1983). It may also be discussed in terms of whatever 'resonance' (as Elkaim (1989) would call it), or whatever 'counter-transference' (in the traditional psychoanalytic sense of the term) the dominant theme may evoke in us. In any case, it was clear to me that the family were not going to adopt collectively the narrative that I offered them, demonstrating the resilience of a family's narrative or worldview in the face of an unacceptably destabilizing new story.

There are many caveats to certainty, in terms of any explanation of the critical turning point in this session. Perhaps Dustin's reaction, blocking my proposal to bury Madame, indicated simply that I made an error in tempo, as I should have followed, rather than led, when

that theme appeared in the course of the treatment. In other words, perhaps my impatience led me to jump transformative steps in the evolution of the story. Perhaps I had been sensitive to Jane's readiness to move forward on this theme, but insensitive to how that would destabilize the position of her brother as main priest of the cult. Or perhaps there was something soothing for all of them in keeping Madame in the limbo state of 'ambiguous loss' (Boss, 2005); that is, in preserving the 'Ancient Cult of Madame': considering the liveliness, joviality and teasing evoked by their management of the ghostly presence of Madame, the burial would have robbed them of the remnants of the family glue that Madame may have provided.

One way or another, everything indicates that I became fascinated by the virtual presence of Madame in this family, allured by the story and the rituals that held it in place. It could therefore be proposed that I joined, in that fashion, this family's 'psychotic game', in the systemic self-organizing sense alluded to by Selvini Palazzoli and collaborators (Selvini Palazzoli *et al*., 1989). In fact, any family story originally offered and sustained by a family who consults becomes, as therapy evolves, a narrative product that 'inhabits' the system therapist-family, sustained by all. However, the more we therapists become trapped by our fascination and attachment to the *content* of the story, the more difficult it becomes to work to keep it open or even destabilize it. Interestingly, Cecchin's wise plea towards *curiosity* (Cecchin, 1987; Cecchin *et al*., 1994) embeds both the recommendation to remain empathic and connected with people's story production while avoiding becoming too fascinated by any given story's content. This double injunction aims at facilitating the therapeutic destabilization of the original narrative, exploring new views and different explanatory models, while not moving ahead of the family's readiness for alternative scenarios. To destabilize symptom/conflict-sustaining dominant narratives may be one of the key goals of therapy, while another is accompanying the family in the process of generating alternative, equally viable, ethically and aesthetically sound stories that do not require or evoke the presence of the pain, symptoms or conflicts that brought them to the consultation. The process entails a permanent exploration of boundaries, of tolerance, of refined attention to the family goals and worldviews while participating in its transformation. Here still another friendly ghost appears, in a silent duet with the ethereal presence of the asylum patient, mentioned in the first vignette, who tells me, 'Don't want more than what a patient wants'. It is Gianfranco Cecchin, who also visits me with certain

frequency and reminds me, with a warm smile, of his admonition, 'Don't fall in love with a story',[3] – a tall order indeed.

References

Blow, A. J., Sprenkle, D. H. and Davis, S. D. (2007) Is who delivers the treatment more important than the treatment itself? The role of the therapist in common factors. *Journal of Marital and Family Therapy*, **33**: 298–317.

Boss, P. (2005) *Loss, Trauma, and Resilience: Therapeutic Work with Ambiguous Loss*. New York: W. W. Norton.

Cecchin, G. (1987) Hypothesizing, circularity, and neutrality revisited: an invitation to curiosity. *Family Process*, **26**: 405–413.

Cecchin, G., Lane, G. and Ray, W. A. (1994) *The Cybernetics of Prejudice in the Practice of Psychotherapy*. London: Karnac.

Eisler, I. (2007) Editorial: The heart of the matter – a conversation across continents. *Journal of Family Therapy*, **28**: 329–333.

Elkaim, M. (1989) *Si tu m'aimes, ne m'aimes pas*. Paris: Seuil (edition in English entitled *If You Love Me, Don't Love Me*. Northval, NJ: Jason Aronson, 1997).

Flaskas, C. (2005) Psychoanalytic ideas and systemic family therapy: revisiting the question 'Why bother?'. *Australian and New Zealand Journal of Family Therapy*, **26**: 125–134.

Schon, D. (1983) *The Reflexive Practitioner: How Professionals Think in Action*. New York: Basic Books.

Selvini Palazzoli, M., Cirillo, S., Selvini, M. and Sorrentino, A. (1989) *Family Games: General Model of Psychotic Processes in the Family*. New York: W. W. Norton.

Sexton, T. L. (2007) The therapist as a moderator and mediator in successful therapeutic change. *Journal of Family Therapy*, **29**: 104–108.

Simon, G. M. (2006) The heart of the matter: a proposal for placing the self in the therapist at the center of family therapy research and training. *Family Process*, **45**: 331–344.

Simon, G. M. (2007) The heart of the matter: continuing the conversation. *Journal of Family Therapy*, **29**: 100–103.

Sluzki, C. E. (1961) Trifluorperazine in the treatment of chronic delusions. *Acta Neuropsiquiatrica Argentina*, **7**: 136–140.

Sluzki, C. E. (1983) Bumping against walls: resistance as a misnomer. Audiocassette In H. Aponte, C. E. Sluzki, C. Anderson, P. Papp, P. Wachtel and E. Wachtel (eds) *From Resistance to Alliance in Family Therapy: New Perspectives and Techniques*. New York: BMA Audio Cassette Publications.

Sluzki, C. E. (1992) Transformations: a blueprint for narrative changes in therapy. *Family Process*, **31**: 217–230.

Sprenkle, D. H. and Blow, A. J. (2004) Common factors and our sacred model. *Journal of Marital and Family Therapy*, **30**: 113–129.

Sprenkle, D. H. and Blow, A. J. (2007) The role of the therapist as the bridge between common factors and therapeutic change: more complex than congruency with a worldview. *Journal of Family Therapy*, **29**: 109–113.

[3] I heard Cecchin making this remark on several occasions, and feel confident that I am quoting him accurately, in spite of not being able to provide a specific bibliographic reference for that statement.