ADOPTING THE CONSTRUCT OF FUNCTIONALITY WHEN IT FACILITATES SYSTEM CHANGE: A METHOD OF SELECTIVE INTEGRATION

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Abstract

The construct of the functionality of symptoms is discussed as a major differentiating point among strategic, systemic, and structural views of family therapy that bears importantly on the issue of integration. A method of selective integration of those views that use the construct of function with those that do not is presented using Buckley's (1967) classification scheme of levels of systems as a conceptual framework. Two case examples are presented that illustrate the use of the construct of function as a therapeutic tool and as a method of selective integration. A conclusion is reached that integration is possible and desirable, but that an overriding set of premises must guide such a process.

The notion of the functionality of symptoms has a long and rich history in the psychotherapy literature. The two major perspectives in the literature come from the psychoanalytic and behavioral views. The psychoanalytic view posits that symptoms function to defend the individual against repressed ideas which are threatening to intrude into consciousness. The behavioral view posits that symptoms can function to provide social reinforcement, such as attention and sympathy. Both perspectives discuss secondary gain as a function of a symptom, but of course assign different weights to its importance. Many views of strategic, systemic, and structural family therapy also conceptualize symptoms as functional to the individual or to the system and, as such, appear to have adopted elements of both of the above views on function. The family therapy view that symptoms serve a systemic function (e.g., diverting conflict, stabilizing a marriage, maintaining homeostasis) is somewhat reflective of the psychoanalytic view. The symptom is seen as evidence that dysfunction is occuring in another part of the system or in other words, the symptom is a surface manifestation of underlying conflicts within the system. Another view in family therapy, similar to the behavioral perspective above, sees symptoms as functioning to provide interpersonal gains such as for power and leverage in relationships.

Recently in the family therapy literature, the construct of function has been examined and its usefulness has been questioned. Dell (1982) asserts that function is an interpretation made by an observer punctuating an arbitrary sequence of events that constitutes a linear causal explanation of a recursive process. Duncan and Fraser (1983) argue that the construct of function arises

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from an organismic/biological level view of systems (Buckley, 1967) and may not be appropriate for a higher level sociocultural system such as the family. Following from these recent arguments and the continued reliance among certain views on the construct of function, the issue of function can be seen to be a major differentiating point that bears importantly on the question of integration. That is, how can a view that does not use function be integrated with a view that does? The adoption of the construct of function can be argued to preclude integration with a view that does not because the two perspectives are based on contradictory premises and two different levels of systemic models (Duncan & Fraser, 1983). However, it is the position of this paper that if one adopts the premises of the higher level model of systems that therapeutic flexibility is greatly increased and integration is possible in selected instances. It is possible in those instances where the adoption of the construct of function fits the scenario that the client offers and facilitates therapeutic change. In addition, it is possible in those instances when such an interpretation (of functionality) is new and thus introduces useful dissonance to the system. As with many other useful interventions in therapy, the therapist may send up a trial balloon or tentatively test the construct of functionality to assess its usefulness to facilitate change with a particular system. In the discussion that follows, a brief overview of Buckley's (1967) models of systems as pertaining to function will be presented. Two actual case examples will then be described where the construct of function was selectively used from a higher level process/adaptive model of systems to facilitate therapeutic change.

Buckley's Models and Functionality

Buckley (1967) presents a very useful hierarchical classification scheme of systems. While systems of all kinds have certain commonalities (e.g., wholeness, circular causality, and equifinality) Buckley's scheme allows for the description of constructs that apply specifically to different types of systems. Buckley classifies systems into three types or levels: 1) mechanical/equilibrium; 2) organismic-/homeostatic; and 3) process/adaptive. The latter two are germane to the current discussion. Briefly, the organismic/homeostatic level of systems is characterized by energy exchange, structure, function, and morphostasis. Biological systems, such as temperature regulation in animals, exemplify this level. The process/adaptive level of systems is characterized by information exchange, ongoing process, fluid structure, and morphogenesis (Buckley, 1967). Sociocultural systems, like the family, are examples of this level. The construct of function emerges from a biological level perspective of systems. Buckley (1967) argues that while such a construct is descriptive of lower level organismic systems, it is inadequate for a sociocultural system. In an organismic/homeostatic system, the function of a given physiological structure can be determined by its future consequences for the organism because the evolution and development of the structure itself is well understood (e.g., natural selection). Also function can be ascertained because the same structure can be seen to perform the same function in other systems. However, in a sociocultural system, there is no specific structure that performs a stability function within a well-defined limit that is normal for every system (Buckley, 1967). Buckley argues that there is not enough information and knowledge to determine the adequacy of a behavior to fulfill a systemic function because of the lack of understanding of

how an element and the transactions around the element has developed; i.e., there is no process like natural selection that is understood for complex social systems.

The assertion of this paper is not that the notion of function is inappropriate for use in therapy. Rather, it is being asserted that function can be utilized in specific instances for therapeutic gain and not with every client or system that enters therapy. The assumption of function can lead to the skewing of therapeutic action to find the function of the symptom and then to direct an intervention at the subsystem that utilizes it (e.g., the couple that detours conflict through a symptomatic child). This initial assumption, based upon an organismic/-homeostatic level of systems, may limit therapeutic freedom. An alternative perspective, from a process/adaptive level of systems, allows for increased flexibility by enabling a therapist to utilize a lower level systemic construct if it fits the presentation of the client/system. Beginning with the premises of ongoing process, morphogenesis, and nonfunctionality frees the therapist to construct his/her intervention to match the clients' world view and historical presentation. Rather than the therapist fitting his or her theoretical template (e.g., function) on the family, the therapist takes the transactional and historical template from the family to design his/her stance and intervention strategy. If the client presents with a world view that supports the construct of function, then it is helpful to utilize that construct. In other words, it is the therapist who must be flexible to fit the client's presentation and not the client who must fit the therapist's orientation.

The construct of functionality may also be useful as a tool to introduce variability or dissonance into the system. If such new information is accepted by the system and promotes change, the therapist may choose to continue to reframe behavior in functional terms. However, as with any other intervention, the usefulness of functionality must be continually assessed in the context of the therapeutic system. It is the major thrust of this paper that accepting the higher level process/adaptive model of system behavior as an overriding set of premises maximizes therapeutic flexibility by enabling a therapist to choose among lower level constructs as is appropriate to the template that the system presents. Specifically, if the notion of function emerges from the world view of the client, the therapist may adopt that construct to design an intervention to facilitate change.

Case Examples

Two examples, from the author's caseload, illustrating the selective integration of the organismic/homeostatic construct of function is presented below. The first case exemplifies the notion of systemic function and the second the notion of interpersonal gain.

Systemic Function

The client is a 58-year-old white female. Cindy's diagnosis was major depression with psychotic features. She had been hospitalized four times in two years and had recently attempted suicide by overdose. Cindy lived with a sister and lived next door to another sister. She described her life as one full of sacrifices for her family and of abusive treatment and ridicule from her sisters. Cindy expressed much hostility towards her sisters for their continual use of her "to take the fall for them". Each of her hospitalizations was described as an instance where she was victimized to cover up her sisters' problems.

The intervention with this woman consisted of different interwoven variations with the following theme. Cindy was told that she was fulfilling a

most valuable function in her family with her hospitalizations, depression, and suicide attempts. She stabilized her family with her illness and protected her sisters from conflict through her continual sacrificial behavior of taking the fall for them. Furthermore, without her, her sisters would have to deal with their conflict and argue it out. This would probably be very difficult and upsetting to her sisters, given that she has acted as a buffer between them for many years. Finally, the therapist expressed his admiration for her loyalty to her sisters.

Discussion

From an organismic/homeostatic model of systems and a functional view of symptoms, the above intervention resembles a positive connotation of a system that diverts conflict and maintains stabilization through the activation of a symptom in one of its elements. The system itself and the other sister's relationship remains stable through negative feedback processes involving illness behavior in the identified client. However, while the intervention is built upon these constructs, it was not designed to eliminate the need for the symptom by the subsystem that utilized it. Rather, from a process/adaptive system model of higher level sociolcultural systems, it was designed to interdict the vicious cycle problem maintaining process that surrounded the symptom. The intervention was chosen because it matched the client's presentation of the problem in hopes that it would facilitate behavioral change that would interrupt the problem cycle. Using the client's perception of her sacrificial role in life and her hostility toward her sisters, the therapist reframed her behavior in functional terms - not because of the belief in function, but because the client presented a scenario that fit such a conceptualization. In this actual case example, the client angrily refused to continue helping her sisters avoid conflict and began to engage in outside social activities to allow them the opportunity to argue. The solution attempts of the sisters (as well as other helpers), which seemed similar to Coyne's (1984) description of a depression cycle, were interrupted and more adaptive behavior began.

Interpersonal Gain

The client was a 28-year-old white female who lived in a residential treatment unit. Polly was diagnosed as manic depressive and was generally considered by the staff to be grossly organically impaired, because of her echolalic speech and bizarre behaviors. Her symptoms or problems consisted of repeating everything that was said, getting loud and angry, using abusive language, and walking away when being confronted about any of these problems. The staff was quite annoyed and frustrated with her and considered much of her behavior as maneuvers for interpersonal gain in the form of special considerations and noncompliance with the unit's rules and regulations. The staff's behaviorally oriented solution attempts had failed. As these symptoms were not really considered as problems by the client, the customers for change were the staff of the unit. Therefore it was their world view that was utilized to set up the intervention. The staff was told that the client's behaviors were truly manipulative and only for the benefit of maintaining control and getting what she wanted from the staff. Her behaviors functioned to give her leverage in interpersonal situations as well as maintaining her in a patient role so her needs could be met. The staff was asked to change their stance and encourage the problem behaviors because they now recognized the benefits from them. An example staff statement would be, "Polly, I want you to continue repeating everything I

say because I know that you need to be different so that people will still take care of you." The staff was told that they could gain control and turn the tables on the client by such an intervention because it exposed the game that was being played.

Discussion

From an organismic model/functional view, the unwanted behaviors of the client functioned to her interpersonal gain by giving her power and leverage with the staff. The intervention, from this perspective, resembles a positive connotation and symptom prescription to expose the power in the client's behaviors and ultimately diffuse that power by making the rules of the game overt. However, the intervention was not designed to call attention to the tactical benefit of the behaviors even though the language of the intervention was formed from such a notion. The intervention was based upon the premises of a process/adaptive system model and was designed to interdict the problem solving attempts of the staff. It was couched in functional terms because it fit the staff's conceptualization of the problem. The staff was seen to attempt control with the client through behavioral contingencies and parental exhortation, which increased the unwanted behaviours, which increaed the staff's efforts, etc. The purpose of the intervention was simply to interdict the cycle by getting the staff to try something different, which was accomplished by the use of the construct of function. In this case example, the unwanted behaviors were reduced to the point where the staff could interact positively with the client, and as such ultimately questioned their previous suspicions of organicity.

Conclusion

This paper had presented a model of selective integration of those strategic, systemic, and structural views which utilize the construct of function with those strategic views that do not. Buckley's classification scheme of levels of systems models was used as a conceptual framework to understand such an integration attempt. It was argued that such a process must be guided by an overriding set of premises. The premises of the process/adaptive system model were asserted to enable maximum therapeutic flexibility and are therefore probably the most useful set of constructs from which to operate. From this higher level perspective, i.e., of sociocultural systemic process rather than biological systemic process, a therapist is free to utilize any lower level construct or any therapeutic language (e.g., dynamic, behavioral, etc.) from other views that match what the client presents.

In the therapeutic system, there is a reality that emerges from the transactional and historical presentation of the client that the therapist must absorb and incorporate in his/her attempts to get the client to do something different. The major point being made here is that one specific perspective of reality, such as the strategic, systemic, and structural views that utilize the construct of function, will restrict therapeutic freedom by fitting every client into that reality whether it fits or not. A more useful and pragmatic position may be to discriminitively select the reality or set of theoretical constructs such that the reality matches the transactional and historical template of the client while basing one's overall treament goal upon the overriding process/adaptive system model.

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