Interventive Interviewing: Part 1. Strategizing as a Fourth Guideline for the Therapist

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A clinical interview affords far more opportunities to act therapeutically than most therapists realize. Because so many of these opportunities remain outside the therapist's conscious awareness, it is useful to elaborate guidelines that orient his or her general activity in directions that are liable to be therapeutic. The Milan associates defined three such basic guidelines: hypothesizing, circularity, and neutrality. Hypothesizing is clear and easy to accept. The notions of circularity and neutrality have aroused considerable interest but are not as readily understood. These guidelines may be clarified and operationalized when reformulated as conceptual postures. This process is enhanced by differentiating a fourth guideline, strategizing, which entails the therapist's decision making, including decisions about how to employ these postures. This paper, the first in a series of three, explores these four interviewing guidelines. The other papers will appear in a subsequent issue. Part II will focus on reflexive questioning, a mode of inquiry oriented toward mobilizing the family's own healing capacity. Part III will provide a scheme for analyzing and choosing among four major types of questions: linear questions, circular questions, reflexive questions, and strategic questions.

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INTRODUCTION

I HAVE become fascinated with the variety of effects a therapist can have on individual clients or families during the course of a clinical interview. In a conventional session, most of the therapist's questions ostensibly are designed to help him or her formulate an assessment. The questions themselves are not usually regarded as interventions to help clients. Yet, many questions do have therapeutic effects on family members, (directly) through the implications of the questions and/or (indirectly) through the verbal and nonverbal responses of family members to them. At the same time, however, some of the therapist's questions can be countertherapeutic.

The latter became painfully obvious to me a few years ago while reviewing a videotape of a marital session. One of my "innocent" questions appeared to have stimulated the re-emergence of serious marital conflict. It occurred during a follow-up session in which the couple were talking about the fact that they had not had any arguments for several weeks. In other words, there had been a major improvement in the marriage. After a lively and enjoyable discussion about these changes, I asked, "What problems would you like to talk about today?" Following this seemingly innocuous question, the couple gradually drifted into a bitter argument about which of the two of them most needed further therapy. I (privately) reconstrued the improvement as "transient and unstable" and resumed my treatment of their chronic marital difficulties. I remained completely blind to the fact that I had inadvertently triggered the deterioration until a colleague pointed it out to me on the videotape.l In retrospect, the assumption behind the question, that problems needed to be identified and/or clarified before I could act therapeutically, turned out to be limiting and pathogenic. It limited the discussion to areas of dissatisfaction and served to bring forth pathological interactions. Instead, I

could have capitalized on the new developments and asked questions that were designed to strengthen the recent changes. Unfortunately, I did not see that option clearly at the time.

This blunder and other more positive learning experiences (reported in Part II) led me to realize that a therapist is far more influential in what emerges during a session than I had previously imagined. I began examining the interviewing process in greater depth and eventually came to the conclusion that it would be more coherent and heuristic to regard the whole interview as a series of continuous interventions. Thus, I began to think in terms of "interventive interviewing," a perspective in which the range of therapeutic opportunities is extended by considering everything a therapist does during an interview to be an intervention.

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1 It would be easy to say that the couple had not yet "really" worked through their difficulties. To do so might absolve me of any responsibility for the deterioration, but it would not help me become a more effective clinician. I chose to construe my decision to ask that question as a mistake in order to restrain similar behaviors in my future work.

This perspective takes seriously the view that it is impossible for a therapist to interact with a client without intervening in the client's autonomous activity. (2) The therapist assumes that everything she or he says and does is potentially significant with respect to the eventual therapeutic outcome. For instance, every question and every comment may be evaluated with respect to whether it constitutes an affirmation or a challenge to one or more behavior patterns of the client or family. As illustrated in the scenario described above, to ask about a problem is to invite its emergence and to affirm its existence. In addition, to listen to and to accept the description of a problem is to concede power with respect to its definition (10). Within this perspective, no statement or nonverbal behavior is assumed, a priori, to be inconsequential. Nor is the absence of certain actions considered trivial. By not responding to particular events the therapist may knowingly or unknowingly disappoint or fulfill certain expectations of one or more family members. For instance, the failure to challenge explicitly a position statement or a particular construal of a situation is often experienced by family members as implicit agreement, support, and/or reinforcement. Thus, *interventive interviewing refers to an orientation in which everything an interviewer does and says, and does not do and does not say, is thought of as an intervention that could be therapeutic, nontherapeutic, or countertherapeutic.* While this perspective dilutes the conventional meaning of the term "intervention," it opens the possibility of entertaining an enormous range of therapeutic actions.

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2. Clients are, of course. continually intervening in the activities of the therapist as well. This important feature of the therapeutic system is alluded to but not elaborated in these papers. For some insightful reflections on this issue, see Deissler (3).

Interventive interviewing also takes seriously the view that the *actual* effect of any particular intervention with a client is always determined by the client, not by the therapist. The intentions and consequent actions of the therapist only trigger a response; they never determine it. Although many deliberate therapeutic interventions do have their desired effects, these effects can never be guaranteed. Listeners hear and experience

only that which they are capable of hearing and experiencing (by virtue of their history, emotional state, presuppositions, preferences, and so on). Thus, a carefully prepared question that a therapist intends as "a therapeutic intervention" may not turn out to have any therapeutic impact whatsoever. Conversely, something that the therapist does not intend as a therapeutic intervention could turn out to have a major therapeutic effect. For instance, an ordinary exploratory question could pique the client's curiosity in a crucial area and precipitate a major change in patterns of thought. Indeed, it is not uncommon for clients to report that they were significantly influenced by a particular question that seemed relatively unimportant to the therapist.

Adopting the perspective of interventive interviewing orients therapists to focus more closely on their own behavior within the vicissitudes of the therapeutic system, not just on the client system. When every action is regarded as an intervention, therapists are drawn toward attending to the ongoing effects of their behaviors in order to distinguish those actions that were, in fact, therapeutic from those that were not. In addition, when something undesirable occurs among family members during the interview, therapists are more liable to examine their own behavior as a possible trigger. With this increased scrutiny of the interaction between therapist and client, the discrepancy between therapeutic in tent and effect on the client becomes even more apparent. Consequently, therapists become more inclined to reflect carefully on all their actions before acting, not just on those that they previously might have chosen to define as "interventions." However, it is impossible to monitor every response and to reflect consciously on the details of every action before acting. The complexities of this perspective could quickly become totally unmanageable unless the therapist develops and implements some organizing priorities. One approach to this complexity is to establish guidelines which, when mastered, can be adopted as nonconscious therapeutic postures that facilitate desired actions and restrain undesired ones.

THE NEED FOR A FOURTH GUIDELINE

In their original paper (13) on how to conduct a systemic interview, the Milan team outlined three principles to guide the therapist. These principles or guidelines are now fairly well known, and "circular interviewing" is the term often used to refer to the style of inquiry associated with their application. Several authors have begun describing and elaborating various aspects of this method of enquiry (3, 4, 6, 8,11,12,14,15,17). At the end of the original paper, the Milan team raised an intriguing question: "Can family therapy produce change solely through the negentropic effect of our present method of conducting the interview without the necessity of making a final intervention?" (p. 12).[3] I would like to propose an affirmative answer: "Yes, circular interviewing alone can, and does, trigger therapeutic change." The basis for this affirmative response is clarified if one distinguishes a fourth interviewing guideline, namely, "strategizing," and recognizes circular questioning as a type of interventive interviewing.

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3 The term “negentropic” as used by the Milan team implies “ordering” or “organizing.” See the original paper (13) for an elucidation of this concept.

Anyone who has observed the members of the Milan team conduct therapy will know that they plan each and every move with great care. The process of generating plans of action, evaluating them, and deciding on which course to follow is not limited to the intersession discussion when they prepare the final intervention. It occurs throughout

the session. Indeed, the interviewers are continually making decisions on a moment-to-moment basis as the interview unfolds. In effect, they are posing questions to themselves and are answering them, either consciously or nonconsciously. Some of these questions might be: "Which hypothesis should I explore now?"; "Is the family ready to talk openly about that subject?"; "What would it mean not to explore that area just yet?"; "Which question should I ask?"; "What effect do I want?"; "How should the question be formulated?"; "To whom should I address it?"; "Should I pursue this issue further or explore another?"; "Should I pick up on the child's sadness now or ignore it?"; "Should I lean forward and offer Kleenex or should I ask a question that might trigger other family members to respond?", and so on. The answers to these questions arise from the therapist's history of socialization as a human being in general and of his or her specific development as a therapist. The team behind the mirror is also actively evaluating the therapist's activity, and if they have suggestions for a significant shift in the course of the interview they interrupt the session and call the therapist out to confer briefly. Most observers would readily agree that the whole therapeutic endeavor revolves around judgments about what a therapist should and should not do when interacting with the client or family.

This decision-making process is implied but not adequately accounted for in the three interviewing guidelines that the Milan associates originally described. Hence the appropriateness of delineating a fourth to guide therapists in making these choices. *Strategizing may be defined as the therapist's (or team's) cognitive activity in evaluating the effects of past actions, constructing new plans of action, anticipating the possible consequences of various alternatives, and deciding how to proceed at any particular moment in order to maximize therapeutic utility*. As an interviewing guideline, it entails the therapists' intentional choices about what they should do or should not do in order to guide the evolving therapeutic system toward the goal of therapeutic change. In labeling this guideline, I chose the root term "strategy" to emphasize that therapists adopt a stance with a definitive commitment toward achieving some therapeutic goal. The gerund form, -ing, was chosen to emphasize its active nature; that is, it is an active process of maintaining a network of cognitive operations that result in decisions for action.[4]

It is possible to distinguish several levels of strategizing. In these papers, I will focus mainly on two: strategizing about general conceptual *postures* for a therapist to adopt, and strategizing about specific verbal *actions* for a therapist to enact. The four interviewing guidelines will be presented as conceptual postures (in Part I) while the questions asked in the session will exemplify actions (see Parts II and III). These levels are, of course, intertwined in that certain actions are easier to perform when a therapist has assumed one posture as opposed to another. For instance, it is easier to ask a genuinely exploratory question from a posture of neutrality, and it is easier to ask a confrontative question from a posture of strategizing. Having chosen to adopt a particular posture, the therapist can focus attention on other details and remain assured that the posture itself will guide his or her ongoing actions.

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4 The notion of "strategizing" has much in common with, but is not equivalent to, that of "strategic therapy." The latter refers to a commitment to a specific school of therapy, just as systemic therapy and structural therapy imply commitments to alternative schools. Strategizing implies a commitment to purposive therapeutic change in general, and as a guideline may be applied to all therapies. The intentionality inherent in strategizing will be discussed in Part III.

A MINOR REFORMULATION OF HYPOTHESIZING, CIRCULARITY, AND NEUTRALITY

In describing these three guidelines as conceptual postures, I am trying to bring them out of the abstract realm of transcendent principles into the concreteness of clinical activity, and to encourage therapists to accept more personal responsibility for adopting them. A conceptual posture may be defined as an enduring constellation of cognitive operations that maintain a stable point of reference which supports a particular pattern of thoughts and actions and implicitly inhibits or precludes others. Like a physical posture, it may be adopted without conscious awareness during the spontaneous flow of activity during an interview. Alternatively, it could be taken up deliberately as a way of preparing for certain actions or avoiding others. Conscious awareness in assuming a specific posture may be helpful when a therapist is learning to develop new patterns of behavior, but once mastered, the posture tends to become part of the therapist's nonconscious flow of activity (much like the physical posture of an actor, a musician, or an athlete).

To choose to adopt a posture of hypothesizing is to apply deliberately one's cognitive resources in order to create explanations. One activates those cognitive operations that seek connections among observations, reported data, personal experience, and prior knowledge, in order to formulate a generative mechanism that might explain the phenomenon one wishes to understand. The Milan team's statement about hypothesizing includes an excellent description of the issues involved. I encourage any reader not already familiar with their paper (13) to study it carefully. The only issue I wish to emphasize here is the difference between circular hypothesizing and lineal hypothesizing. If our conceptual posture is oriented to create circular and systemic explanations, we will tend to ask circular questions. If our posture is oriented to create lineal explanations, we will ask lineal questions. At the same time, however, circular and lineal questions as interventions are liable to have quite different effects in the interview. Circular questions usually have far more therapeutic potential than lineal ones (see Part III). Thus, to optimize our therapeutic impact during the process of interventive interviewing, it is useful to develop expertise in adopting a posture of circular hypothesizing.

To describe circularity as a conceptual posture requires some preliminary comments. This principle, as originally described by the Milan team, has led to considerable confusion, with varying interpretations about what is entailed. The confusion appears to have resulted from a failure to draw a clear distinction between the circular aspects of the observed system (the family) and the circularity of the observing system (the therapist-family unity). This distinction separates first order cybernetics (the cybernetics of observed systems) from second-order cybernetics (5) (the cybernetics of observing systems) and delineates very different domains (even though the first is incorporated as a component in the second). In this discussion, I will limit the notion of circularity as an interviewing guideline to the second domain and apply it to the recursive feedback in the therapeutic (observing) system. Other aspects of the original definition are allocated to other guidelines. For instance, first-order cybernetic descriptions regarding reciprocity in "differences" and circular patterns among family members are regarded as part of circular hypothesizing. Decisions about what kinds of questions to ask, such as triadic questions to reveal a family's circular patterns, are accounted for in the new guideline of strategizing.

6 Heinz von Foerster (5) has been a central figure in the elaboration of this distinction. For an excellent historical account see Keeney (7).

Given this reformulation, circularity refers to the dynamic structural coupling between the therapist and the family that makes it possible for the therapist to draw distinctions about the family. As a conceptual posture, it entails an acute sensitivity on the part of therapists to nuances in their own sensory responses during their recursive interaction with clients. It includes an acknowledgement of the discontinuity between intent and effect (as described in the introduction), and orients therapists to attend to what they perceive as the ongoing behavior of clients in the evolving therapeutic system. The more astute the observing, the more the therapeutic responses can be refined to fit the family's responses, and the more closely therapist and family become coupled. Therapists are by no means passive in this observing process. Just as the eye, in order to see, needs to move back and forth with a continual micro-nystagmus in order to distinguish "differences" in the patterns of light falling upon the retina, so therapists must continually probe family members by asking questions, paraphrasing their answers, and noting their verbal and nonverbal responses in order to draw distinctions about their experiences. Indeed, this activity on the part of the therapists is the major reason this guideline is labelled "circularity" rather than simply "observing." Continual movement on the part of the therapist in relation to the movements of the client or family is essential if therapists are to become more refined in structural coupling with them in the therapeutic system. It is the nature of this coupling that provides the foundation for all of the other cognitive operations in the course of therapy. 6

As with hypothesizing, there are variations in the posture of circularity. Two contrasting modes may be referred to as "caring circularity" and "obligatory circularity." The first is based on natural human love, the second on coercion. They lead to different ways of being structurally coupled in the therapeutic system. To adopt a loving posture is to attend selectively to those differences in the responses of the client(s) that offer space for the therapist to be genuinely supportive of the autonomous growth and development of the client(s). On the other hand, to adopt a posture of circularity by "necessity," perhaps because the therapist realizes that she or he must do so in order to be a "good" clinician, is to attend selectively to those responses of the client(s) that provide openings for the therapist to be therapeutically efficacious. While these variations in circularity may not always be mutually exclusive, whichever posture the therapist adopts as the priority will significantly influence the direction and tone of the interview. On the one hand, the client(s) may experience warm and sensitive understanding and, on the other hand, insensitive and penetrating scrutiny.

Neutrality as an interviewing principle is a difficult notion to understand because, strictly speaking, it is physically and logically impossible to remain absolutely neutral. At the moment one acts, one is not being neutral with respect to that specific action; the behavior affirms itself. Thus, the clearest behavioral manifestation of neutrality might be "not to act." However, in situations where action is expected, not to act may be construed as a definitive action; furthermore, it is antithetical to the need for action in circularity.

6 For a theoretical grounding regarding the nature of cognition upon which this view of circularity has been elaborated, see Maturana and Varela (9).

In actual practice, the therapist does act (as guided by the other guidelines) but strives to balance the movements so that the net result is to maintain an overall posture of neutrality. Thus, time is an important component of this posture. The therapist participates in an ongoing "dance" with the client or family and maintains a careful balance in relation to the various desires of family members (much like the continual movements of a tightrope walker to maintain balance in relation to gravity). The logical difficulty applies at the level of meanings and values where a therapist either takes a certain position on an issue or does not. To not take a position is to take the position of not taking one, that is, to be noncommittal, to decide not to decide, or to be deliberately evasive. Nor does the synthesis of "both/and" escape the dilemma. The synthesis is the beginning of a new dichotomy; both/and versus either/or. The problem in drawing distinctions is inherent in the language, which we cannot escape. With respect to meanings and values, neutrality is closest to taking the position of remaining noncommittal.

Despite these difficulties, neutrality is an extremely important guideline in systemic therapy. To be neutral in an interview is to adopt a posture in which the therapist accepts everything as it is taking place in the present, and avoids any attraction to, or repulsion from, anything that the client(s) says or does. The therapist remains open to whatever happens, and flows with the stream of spontaneous activity, not against it. At the same time, however, the therapist avoids being drawn into taking a position for or against any person or issue. In addition, the therapist remains open to reconsider whatever she or he has construed to be happening. By releasing any attachments to his or her own perceptions and intentions, the therapist's neutrality insures more flexibility in overall interventive behavior. There is more space for the intuitive, nonconscious aspects of cognition to emerge and become active in the therapeutic process. In neutrality, the therapist does not claim to know what is accurate or true, what is useful or not useful, but instead places "objectivity in parenthesis." [7] For instance, when a husband complains that his wife is being unreasonable with a child, the therapist listens and accepts the husband's complaint as his action in the present, then listens to and accepts what the wife has to say. The therapist does not agree or disagree with the husband's or the wife's views, that is, avoids aligning with either of them. Nor does the therapist insist that the husband's statement was, indeed, "a complaint." By releasing any attachment to such a perception, the possibility that other intuitive perceptions might emerge are enhanced. For example, the husband's statement could constitute "a plea" to the wife that she be more accepting of him. But, if the therapist was committed to the complaint construal, the possibility that it was a plea would not be entertained. During the course of the interview the therapist may or may not choose to indicate a lack of agreement or disagreement (for example, with the content or intent of the husband's statement) in the form of a question or comment, but this choice has to do with strategizing. Neutrality itself is limited to a conceptual posture in which the therapist is immersed in experiencing the present as fully as possible and accepting everything that occurs as necessary and inevitable, including the family's and his or her own construals.

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7 In his theoretical work on cognition, Maturana draws the important distinction between objectivity and objectivity in parenthesis. The latter entails the recognition that an object, event, idea, belief, and so on, is a distinction made by an observer. There can be as many different, yet valid, distinctions as there are observers to make them; and any individual observer can distinguish as many objects or phenomena as the coherences in his or her cognitive operations allow.

It is possible to distinguish several variations in this posture. Indifferent neutrality, the purest form, implies a posture in which a therapist attends to and accepts everything with equal interest. In so doing, however, this may convey a relative lack of concern for clients as unique human beings. Affirming neutrality is more differentiated. It orients a therapist to attend to individuals as persons and to accept them as being human, in whatever way they happen to be. It tends to support therapist behavior that confirms the other and, hence, is very engaging. In this respect, caring circularity and affirming neutrality constitute mutually supportive and synergistic postures. Aloof neutrality emerges when a therapist has difficulty accepting others without agreeing with them. Consequently, the therapist takes a metaposition and remains somewhat distant. Strategic neutrality implies a slippage toward strategizing, to using neutrality as a strategic change technique rather than as a posture of acceptance. For instance, to remain deliberately neutral with respect to persons by equalizing talk-time, when the therapist perceives the family to be organized as having a single spokesperson, reflects a choice that arises out of strategizing.

In essence, however, neutrality contrasts sharply with strategizing. While neutrality is founded on an acceptance of "what is," strategizing is based on a commitment to "what ought to be." Leaning too far in either direction can impede a therapist's potential. If a therapist adopts too much neutrality, and only accepts things as they are, eventually he or she stops doing therapy. Thus, this danger is self-limiting. On the other hand, if a therapist adopts too much strategizing, becomes too purposive, she or he may become blind and violent. In his writings on the mind, Bateson (1, 2) warns us about the inherent blindness and lack of wisdom in too much purpose. Unless therapists are able to adopt some degree of neutrality they will not be able to see and experience "the other side" of an issue. Furthermore, therapists who are too strongly committed to their own ideas and values about "correct" solutions can easily become "violent" in imposing them on a "resistant" client or family. When this happens, the strategic means defeat the therapeutic end, and more neutrality is clearly in order. Fortunately, a strategic commitment to neutrality as a posture in its own right, that is, not to be so purposive, can help reduce the blindness and potential violence of excessive purposiveness.

A brief clinical vignette may help illustrate the therapeutic consequences of neutrality. While interviewing a man who had been incestuously involved with his stepdaughter, I found myself becoming increasingly frustrated by his unwillingness to acknowledge responsibility for what he had done. I was intent on getting him to accept personal responsibility as a first step toward a commitment to change his patterns of behavior. I realized that I was not being sufficiently neutral but, being repulsed by his behavior, found myself unable to change my posture. When my frustration almost reached the point of anger, I excused myself and left the therapy room. Once I was in the hallway, I could concentrate on trying to regain a neutral stance. By developing some circular hypotheses about how certain activities of his wife and stepdaughter (as well as some memories from his childhood) participated in a systemic pattern that included his incestuous behavior, I was able to regain a conceptual and emotional posture of neutrality. When I returned and resumed the interview, he began responding to my change (in manner and tone) by becoming progressively more open. Only then could I begin to see that he was far more frustrated with himself than I was. Indeed, he was furious with himself to the point of being suicidal for what he had done. I then proceeded to work with these feelings and to help him modify some of his inappropriate ideas and behavior. Thus, giving the posture of neutrality priority proved to be very therapeutic in this case.

Is it reasonable to wonder whether it is possible to adopt postures of strategizing and neutrality at the same time? After all, they are contradictory positions in many respects. Fortunately, the human nervous system is sufficiently complex so that we can operate at multiple conceptual levels and within different domains simultaneously. Thus, we can be strategizing about the need to maintain neutrality at one level, adopt the latter relational stance at another, and at the same time be asking questions out of circular hypothesizing and adjusting ourselves to the client's sensitivities in circularity in other domains. Indeed, we are probably employing some aspects of each conceptual posture nonconsciously most of the time while conducting therapy.

STRATEGIZING ABOUT CONCEPTUAL POSTURES

As noted earlier, the guideline of strategizing may be applied at several levels. Indeed, it could orchestrate the entire spectrum of the therapist's perceptual, conceptual, and executive activities. In this way, the inherent commitment to therapeutic change could permeate the whole interviewing process, even down to the level of nonverbal and paraverbal behaviors like hand and leg movements, body orientation, direction of gaze, tone of voice, cadence of speech, and so on. What would be extremely important to include, however, is strategizing about our own strategizing. This has already been alluded to above and requires hypothesizing about ongoing developments in the therapeutic system. We need to keep noticing whether or not our decisions to act therapeutically are, indeed, being therapeutic at any particular moment. For example, I needed to recognize that my earlier choice to encourage, cajole, push, and even "force" the incest-prone father to explicitly acknowledge his responsibility was constraining my therapeutic potential, otherwise I may not have abandoned that course of action and could have lost the case altogether. On other occasions I have found it useful to try helping by not helping (16). Therapists are more liable to develop this capacity to strategize about strategizing if they choose to opt for a posture of *personal* strategizing, by which I mean that they decide to take full personal responsibility for their choices and actions. This stance may be contrasted with *projective* strategizing in which decisions are made because the therapist "was forced to" or "had no choice" as a result of external factors (for example, the "real" situation or the "correct" rules of treatment). Personalizing one's choices is a way to maintain more flexibility and freedom of movement in strategizing. That is, it is always easier to change one's own construals and choices than to change an "externally determined" situation.

Another major dimension of strategizing is the size of the unit of activity that the therapist is strategizing about. Obviously, this is related to the level of strategic focus (choice of specific nonverbal movement, type of question to ask, general therapeutic technique to employ, conceptual posture to adopt, and so on), but it is not exclusively determined by level. For instance, if the therapist is strategizing at the level of specific therapeutic techniques or strategies, he or she could be formulating a specific question to get past an apparent impasse, or could be strategizing about a whole sequence of questions that might occupy a major portion of the interview. It is beyond the scope of this paper to discuss the way in which the posture of strategizing supports the implementation of particular treatment techniques. My primary purpose here is to introduce the notion of strategizing as a foundation for interventive interviewing.

One task in embracing this perspective on interviewing would be to strategize about developing competence in maintaining a constellation of carefully refined conceptual postures so that one's spontaneous responses at any particular moment would likely be

therapeutic. To do this with conscious deliberation, a therapist would have to critically examine what his or her current inclinations are (preferably with the help of a supervisor or colleague) and decide on modifying and/or strengthening specific areas. For instance, if one decided to strengthen skills in circular hypothesizing, one might join a clinical team that is committed to systemic brainstorming. However, if one wanted to develop substantive expertise in this area (especially after a history of prolonged immersion in a culture disposed toward lineal thinking), one might have to undergo considerable theoretical study, self exploration, and perhaps some "corrective" personal experiences. As one's expertise and security in holding a certain stance develop, there is a natural shift in focus from decisions about the posture to its behavioral products, that is, to the specific questions, sequences, and nonverbal activity that flow from it.

A second task would be to organize a heuristic direction for the flow of the therapist's consciousness. For instance, a logical sequence for focused attention is to examine the products of circularity, then those of hypothesizing, then of strategizing, then of neutrality, and back to circularity. In other words, therapists can begin by drawing distinctions about the family in the recursive interaction of circularity and take these observations into hypothesizing. Having developed a hypothesis of some sort (possibly including the hypothesis that what one still lacks is a clear hypothesis about the family), they make some strategic choices about what to pursue (for example, first elicit more information) and how to do so (perhaps explore how they decided to come for therapy). These decisions become the basis for purposive actions (like asking about the initiative for a referral). Having intervened, one jumps back (conceptually and behaviorally) to a position of neutrality to accept whatever happens. One observes the family for differences in their responses (the father may interrupt the mother to point out that the pediatrician sent them) and a new circuit begins. The new observations are taken into the ongoing process of hypothesizing, and on the basis of a modified hypothesis (for example, the husband is minimizing family initiative for help), the therapist once again begins strategizing about what to do (Should I ask the wife who first thought about and is most interested in therapy, or should I respect the husband's sensitivity and ask about the pediatrician's views?). Thus, while the interview is taking place the therapist may attend to the products of circularity, hypothesizing, strategizing, neutrality, and circularity in a recursive circuit that is parallel to the scientific method. Disciplined application of this recursive pattern of thought and action would probably significantly enhance the therapeutic effectiveness of interventive interviewing.

Another task may be to develop a special sensitivity to cues in the therapeutic system that suggest that a major shift in posture is indicated. For instance, when the atmosphere in the interview has become constrained or is oppositional, it is likely that the therapist is leaning too heavily in the direction of strategizing. The client(s) may be experiencing the therapist as highly judgmental or as demanding too much change. This should be a cue for the therapist to shift posture and to become more neutral. On the other hand, if the session seems rather dull or boring, there is probably a need for more vigorous strategizing. When an interview seems to lack direction, more hypothesizing (including hypotheses about the therapeutic system) is clearly indicated. If the therapist does seem to have clear hypotheses, yet the session does not seem to be very fruitful, one can give more refined attention to what the clients are actually doing and experiencing by focusing on the feedback in circularity. New "differences" or distinctions need to be drawn from the experiences of family members that may intervene in the the therapist's existing hypotheses. In addition to learning to pick up and respond to such cues, a therapist should remain open to s intermittent re-evaluation and refinement of

established postures. Some degree of inadvertent drifting as a result of the continuous interventions from family members usually does occur. For instance, if a therapist does not have a sensitivity to 10. deceptiveness, caring circularity could drift into naivety when clients have well established skills in exploiting the good will and trust of others. Here, perceptiveness to changes in self (as well as in the family and therapeutic system) is required. Ultimately, the strategies for mobilizing, maintaining, and altering these postures will "sink" into nonconscious process, along with the conceptual postures themselves, so that the therapist's consciousness can "float" freely to where it is most needed to maximize the clinical effectiveness of the interview.

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