

Brief Therapy: Focused Solution Development

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This article describes the form of brief therapy developed at the Brief Family Therapy Center. We have chosen a title similar to Weakland, Fisch, Watzlawick, and Bodin's classic paper, "Brief Therapy: Focused Problem Resolution" (20) to emphasize our view that there is a conceptual relationship and a developmental connection between the points of view expressed in the two papers.

The theory and practice of brief therapy have developed significantly in the decade since the publication of Weakland, Fisch, Watzlawick, and Bodin's "Brief Therapy: Focused Problem Resolution" (20) and de Shazer's "Brief Therapy: Two's Company" (3). The work at the Brief Family Therapy Center (20) of the Mental Research Institute (MRI) was done within an expressed 10-session limit and Watzlawick *et al.* reported that 72 % of their cases either met their goal for treatment or made significant improvement within an average of seven sessions. Our follow-up studies at the Brief Family Therapy Center (BFTC) in Milwaukee, in which we used the same questions as those used at MRI, indicate a similar success rate. At BFTC we work without a

stated limit to the number of sessions but, when asked, we say “as few as possible.” Our average number of sessions per client has declined from 6 sessions for 1600 cases (1978 through 1983) to fewer than 5 sessions for 500 cases in 1984.

It is important to define brief therapy in terms other than time constraints because across-the-board clients tend to stay in therapy for only 6 to 10 sessions (10, 12, 16), regardless of the therapist’s plans or orientation. Therefore, we draw a distinction between (a) brief therapy defined by time constraints and (b) brief therapy defined as a way of solving human problems.

Evolution

The published history of brief therapy as defined here can be traced from Milton Erickson’s 1954 paper “Special Techniques of Brief Hypnotherapy” (7, 15). In this paper he detailed, through 7 case examples, an approach that focuses on

the therapeutic task [that] becomes a problem of intentionally utilizing neurotic symptomatology to meet the unique needs of the patient. Such utilization must satisfy the compelling desire for neurotic handicaps, the limitations imposed upon therapy by external forces, and above all, provide adequately for constructive adjustments aided rather than handicapped by the continuance of neuroticisms. Such utilization is illustrated ... by special hypnotherapeutic techniques of symptom substitution, transformation, amelioration and the induction of corrective emotional response. [15, p.390]

As we see it, this is the key to brief therapy: *utilizing what clients bring with them to help them meet their needs in such a way that they can make satisfactory lives for themselves.* Although Erickson talks about “neurotic symptoms,” he nonetheless says that – at least when doing brief therapy – no attempt is made to correct any “causative underlying maladjustments” (p.393). In our view, none is needed.

In the late 60s and early 70s, a number of developments in brief therapy occurred in connection with the growth of family therapy. In 1968, the Brief Therapy Center was established at the Mental Research Institute in Palo Alto, California; “Brief Therapy: Focused Problem Resolution” (20) was published in 1974; in the same year “The Treatment of Children Through Brief Therapy of Their Parents” (17), from the Center for the Study of the Family in Milan (begun in 1971), was published; and in 1969, de Shazer began to develop his own model of brief therapy (without knowledge of the Palo Alto group until 1972), and “Brief Therapy: Two’s Company” was published in 1975 (3).

These three papers, and two books published during this period – *Change* (19) and *Uncommon Therapy* (14) – have much in common: They all deal with *problems*, how they are maintained, and *how to solve them*. The focus was clearly on different and effective techniques, with a wide variety of cases as illustrations. Recently, however, we at BFTC have become more and more interested in solutions and how they *work*.

Main Principles Of Our Work

Most complaints develop and are maintained in the context of human interaction. Individuals bring with them unique attributes, resources, limits, beliefs, values, experiences, and sometimes difficulties, and they continually learn and develop different ways of interacting with each other. Solutions lie in changing interactions in the context of the unique constraints of the situation.

The task of Brief Therapy is to help clients do something different, by changing their interactive behavior and/or their interpretation of behavior and situations so that a solution (a resolution of their complaint) can be achieved. In order to construct solutions, it can be useful to find out as much as possible about the constraints of the complaint situation and the interaction involved, because the solution (that is, change in interaction) needs to “fit” within the constraints of that situation in such a way as to allow a solution to develop.

Von Glasersfeld's (18) distinction between match and fit is relevant in this content:

The metaphysical realist looks for knowledge that *matches* reality [with] ... some kind of "homomorphism," which is to say, an equivalence of relations, a sequence, or a characteristic structure} something, in other words, that he can consider *the same*, because only then could he say that his knowledge is of the world.

Fit, however, is quite a different matter:

If . . . we say that something *fits*, we have in mind a different relation. A key fits if it opens the lock. The fit describes the capacity of the key, not of the lock. (pp. 20–21).

Like a skeleton key, an intervention only needs to open the way to a solution, which can be done without knowing all the details of the complaint.

We had long been puzzled by the notion of "resistance" in therapy (4). As we watched each other work,¹ we became more and more convinced that clients really do want to change. Certainly some of them found that our ideas about how to change did not fit very well. Rather than seeing this as "resistance," however, we viewed it more as the clients' way of letting us know how to help them. Again and again, we found the people sent to us by other therapists (complete with the label "resistant client") to be both desperate for change and highly cooperative. Actually, the key we invented for promoting cooperation is quite simple:

First we connect the present to the future (ignoring the past, except for past successes), then we point out to the clients what we think they are already doing that is useful and/or good for them, and then?once they know we are on their

¹ The authors wish to thank their other associates at the Brief Family Therapy Center: Patricia Bielke, Marilyn Bonjean, Calvin Chicks, Ron Kral and John Walter. (And Jim Derks and Marilyn La Court who were part of the group for a time.)

side?we can make a suggestion for something new that they might do which is, or at least might be, good for them. [5]

Clearly, people come to therapy wanting to change their situation, but whatever they have attempted to do to change has not worked. They have been getting in their own way, perhaps have accidentally made their own situation worse, and have developed unfortunate habit patterns. Given this, the idea that they are going to resist change is at least misguided (4). In fact, with this kind of idea in mind, the therapist can actually generate “resistance” (8) or noncooperation, if not conflict. That is, the therapist’s notions could generate a self-fulfilling prophecy of an unsuccessful outcome.

New and beneficial meaning(s) can be constructed for at least some aspect of the client’s complaint. It is not that a person either has or does not have a “symptom.” It is arbitrary that a certain behavior is labeled a symptom; in some other setting, or with a different meaning attached, the same behavior would be both appropriate and normal. That is, any behavior can be seen from a multitude of points of view, and the meaning the behavior (or sequence of behaviors) is given depends on the observer’s construction or interpretation.

Only a small change is necessary. Therefore, only a small and reasonable goal is necessary. One major difference between brief therapy and other models lies in the brief therapist’s idea that no matter how awful and how complex the situation, a small change in one person’s behavior can lead to profound and far-reaching differences in the behavior of all persons involved.² Both clinical experience and research seem to confirm the notion that a small change can lead to other changes and, therefore, further improvement. Inversely, it seems that the bigger the goal or the desired change, the harder it will be to establish a cooperative relationship, and the more likely that therapist and client will fail.

Change in one part of a system leads to changes in the

² John Weakland and I have frequently discussed this point of view, which brief therapists (at MRI and at BFTC) seem to hold quite strongly. I think that this statement expresses his viewpoint.

system-as-a-whole. Therefore, the number of people who are successfully constructing the problem and the solution does not necessarily matter. We have been puzzled for a long time by the idea some therapists have that “family therapy” means that the therapist must meet with the whole family, or that “couples therapy” demands that both spouses be present. Their idea seems to be that systems theory, which posits that the whole is greater than the sum of the parts, dictates the necessity of having the whole family unit in therapy. Of course, an individual’s change does need to fit within the constraints of the system so that it is compatible.

Effective therapy can be done even when the therapist cannot describe what the client is complaining about. Basically, all the therapist and client need to know is: “How will we know when the problem is solved?” At first this seemed counter-intuitive, but we have realized that any really different behavior in a problematic situation can be enough to prompt solution and to give the client the satisfaction he or she seeks from therapy. All that is necessary is that the person involved in a troublesome situation does something different, even if that behavior is seemingly irrational, certainly irrelevant, obviously bizarre, or even humorous. Details of the client’s complaints and an explanation of how the trouble is maintained can be useful to the therapist and client for building rapport and for constructing interventions. But, for an intervention message to successfully fit, it is not necessary to have detailed descriptions of the complaint. It is not even necessary to construct a rigorous explanation of how the trouble is maintained.

Complaints and Solutions

When describing a treatment approach, outlining basic premises may make its nature and implications more evident. For instance, definition of several idiosyncratic terms is necessary so that the distinctions between our model and other models can be understood:

Difficulties are the one damn thing after another of everyday life (20), which clients frequently call “problems.”

These include, but are not limited to, such things as the car not starting, a pickle jar not opening, a husband and wife arguing now and then, and a child wetting the bed. *Complaints* consist of a difficulty and a recurring, ineffective attempt to overcome that difficulty, and/or a difficulty plus the perception on the part of the client that the situation is static and nothing is changing; that is, one damn thing after another becomes the same damn thing over and over. *Solutions* are the behavioral and/or perceptual changes that the therapist and client construct to alter the difficulty, the ineffective way of overcoming the difficulty, and/or are the construction of an acceptable, alternative perspective that enables the client to experience the complaint situation differently. Some solutions develop through the resolution of a constructed *problem* (that is, the client's complaint plus the therapist's view of the complaint, which includes potential solutions); other solutions develop through the construction of alternate futures that do not include the complaint.

The Construction of Solutions

Therapists need to make some assumptions about the construction of complaints and the nature of solutions in order to do their job. (Although our assumptions are somewhat idiosyncratic, they are related to Watzlawick's [19] and Haley's [13, 14].) Let's say that the therapist assumes that "symptoms" have a systemic function – they hold the family together. In this case he or she will draw a map that suggests how that function can be served in that system without the symptom. However, if the therapist assumes that a symptom is just a matter of "bad luck" and does not serve a function, then he or she will draw a different map that suggests eliminating the symptom by substituting what might have happened if there had been some "good luck."

Complaints involve behavior brought about by the clients' world view. In order to develop solutions, it can be helpful to think of complaints as if developed in the following, over-

simplified fashion. Our imaginary first step in building a hypothetical complaint seems relatively small, although the consequences can be rather disproportionate. Let us imagine that people say to themselves, "I either behave in 'A' fashion, or I behave in 'non-A' fashion. For whatever reason (or set of reasons), 'A' seems to be the right (logical, best, or only) choice." As a result, everything else (all "non-A") is lumped together and excluded. That is, the "either behavior" ('A') seems as though it is in a class by itself, and the "or behaviors" ("non-A") seem to be all the remaining classes (all classes minus class "A") of behavior that might have been chosen.

It is as if complaints are maintained by the clients' idea that what they decided to do about the original difficulty was the only right and logical thing to do. Therefore, clients behave as if trapped into doing more of the same (19) because selecting an alternative behavior from the rejected and forbidden "or" half of the premise is excluded.

We have found it useful to focus on helping clients describe their "favorite" factor(s), the ones they choose to emphasize in their description, and which reflects the hypothetical choice. Importantly, in each case, those aspects of the situation that are excluded from the client's description of the complaint are potentially useful for designing interventions and prompting solutions. For example, clients frequently complain of feeling (usually phrased as "being") depressed:

- 1 Some will immediately be able to describe the behavioral aspects of it, while others find that difficult or impossible;
- 2 some will focus on the involuntary aspects;
- 3 some will easily describe significant others who are trying to cheer them up (accidentally making it worse);
- 4 while others find that difficult to describe and instead bemoan the fact that historically they have good reasons to be depressed; and
- 5 still others are depressed about something they are sure is going to happen (or not happen) in the future.

To illustrate, a client stated that he had “always been depressed.” The therapist asked him, “What gave you the idea you were depressed?” The client responded, “I know I’m depressed because now and then I have ‘up days’.” The therapist then asked the client to describe what is different on “up days” and, particularly, what he does differently.

The client’s mention of exceptions to the “always depressed” rule led to further descriptions of behavior and perceptions and ideas that, according to the client, would not have happened on “down days.” The client then was asked to predict, before going to bed, which kind of day was going to follow and, if he predicted a “down day,” then, as early as possible the next day, he was to do something that he normally would have done on “up days.” By the third session the client was reporting fewer predictions of “down days” and far fewer “down days,” all of which he could turn into more or less normal days.

Although there is no one-to-one relationship between the components excluded from the construction of complaints and the construction of solutions, nonetheless, what clients emphasize strongly suggests possibilities. For instance, if it is clear that the complaint only happens in one particular place, then task assignments – particularly anything directly to do with the complaint behaviors themselves – could be scheduled to happen in some other location, which assures some minimal difference. For example, if a couple reports that their fights happen only in the kitchen, the therapist can suggest to them that the next fight be in the living room. There is a good chance that the different “stage” will prompt different behavior. Thus, each client constructs the complaint reality out of some combination of factors, and the therapist constructs solutions out of the known factors as well as out of what may be excluded.

Given the complexity of complaint construction, it would seem reasonable that solutions would need to match that complexity. However, it is our view that interventions and solutions only need to fit within the constraints of the complaint in much the same way that a skeleton key fits within the constraints of many different locks (5, 6).

CASE EXAMPLE

A mother and father brought their three children with them for family therapy because of their concerns about the younger boy's "hostility and violence." All three of the children were successful in school and with their peers. The complaints centered entirely on how family members dealt with each other. Every attempt to help them focus on the interactional patterns of their situation, that is, who does what and when in the "hostility and violence" pattern, led to some member of the family complaining about the other four. Further attempts to focus on any of the specific complaints led only to more complaints. In general, the family gave the impression that life was an unsatisfactory mess.

Using the exceptions to the family's complaints, the team developed this message:

We are impressed that, in spite of the many difficulties you've told us about, there is success going on. The children are doing well in school and are not in trouble of any kind; the marriage has survived 15 difficult years; both father and mother's careers are going well. This means to us that you all are doing something awfully right, and we'd like to know more about this. Therefore, between now and next session, we'd like each of you, separately, to observe what happens in the family that you'd like to see continue to have happen.

Two weeks later, the family gave a report on their observations that took thirty minutes. Each one had observed all of the other four doing things they wanted to see continue. Some of the things they described were new and others were just infrequent events and behaviors that had been missing during the past year. Although things were certainly not "perfect," complaints were minimal, and the team assured them that things would never be perfect. We told them about one of our rules: If it works, do more of it. If it doesn't work, don't do it again; do something else.

Our aim is to start the solution process rather than to stop the complaint pattern (19, 20) and, thus, the complaints will stop being something worthy of complaint. The intervention in the first session was designed to fit the general nature of the family's complaints and to open up the possibility that they could develop a more workable view of their situation, that is, one that leads to a solution to their complaints. Attempts to design an intervention built on stopping the "hostility and violence" complaint would have been impossible because the pattern remained unknown. Attempts to build an intervention on the pattern of complaints the family showed during the session, that is, attempts to match the "unsatisfactory mess," while possibly effective, might not as readily have led toward the eventual solution, which the family itself invented between the first and second sessions. The remaining two sessions were devoted to helping them find ways to encourage themselves to do more of what they wanted to see more of and to helping them invent ways to respond that encouraged things they wanted to see continue.

Creating Expectations of Change

Each complaint can be constructed into many different, possible solutions, and any intervention that successfully prompts any different behavior and/or a different way of looking at things might lead to any one of the hypothesized solutions. That is, what you expect to happen influences what you do. If you expect the same damn thing to happen again, then doing the same things and thinking the same way make sense. However, if you expect something different to happen, then doing something different (perhaps to make it happen) makes sense. Of course, what you specifically want to have happen might not, but because you did something different, at least something different will happen. As a result, you might feel more satisfied. We have found it useful to help clients describe what things they want to be different when their complaint is resolved. It seems commonsense that if you know where you want to go, then getting there is

easier. What does not seem so commonsensical is the idea that just expecting to get somewhere different, somewhere more satisfactory, makes it easier to get there. In fact, just being somewhere different may be satisfactory in itself. Descriptions of potential solutions are used to define where things are going and how they are going to be more satisfactory.

CASE EXAMPLE

A woman came to therapy complaining that she was depressed and did not know why. She thought that perhaps she was depressed about her marriage, but that seemed unreasonable to her; or she thought she might be depressed about her career, but again that seemed unreasonable. Whatever the "cause," she had been depressed for about two years. On a scale from 0 to 10, with 10 being the worst her depression had been, she rated herself at 7. Early in the first session she was asked, "If there were a miracle one night while you were sleeping and the depression was gone when you woke up, how would you know? How would your husband know? How would your employer know?" She described a whole range of activities that might or might not include her husband and her current position.

The team complimented her on her ability to describe things in fine detail (listing several examples) and on her wisdom in refusing to act rashly, which a lot of people might have done in hopes that a radical change might solve the problem. Because she had told us about her successful children, we also complimented her on her abilities as a mother. Because she was convinced that her husband did not know the extent of her depression nor did her boss, we asked her to observe what she did when she overcame the urge to show her depression at home or on the job.

One week later, she reported being at a 3 on the 10-point scale. She had started to do some of the things that she had described as "post-miracle" and her husband responded with flowers. He evidently knew more about her depressed state than she knew he knew. At that point she could think of nothing that would prevent her continuing her new behaviors and activities even though still feeling depressed.

She was asked to predict, before going to bed, where on the scale she was going to be the next morning and to keep track of where she actually felt she was in the morning. She was also asked to keep track of what she did differently on the days the rating was lower (feeling "less depressed") rather than higher. Over the next month, her rating varied from 6 to 1 and her activity rate continued to increase. When therapy stopped, she was convinced that her depression was over.

Once the expectation of change has been created, the therapist elicits descriptions of any changes in any area of the client's life. Anything that prompts the client to say that "things are better" needs to be identified as verification of change, and anything new or different or more effective that the client reports needs to be encouraged or amplified. That is, any news of different behavior and perception or news of increased satisfaction is accepted by the therapist as movement toward solution.

Operation of The Brief Family Therapy Center

BFTC was established in 1978 as a research and training-oriented therapy center. The range of complaints clients have presented covers the continuum from "normal difficulties of living" to "repeated failures at psychotherapy," and includes the whole range of "psychiatric problems."

Currently, at our main location, we have four therapy suites each of which include two rooms with a one-way screen and an intercom system. Two of the suites have video-taping equipment. (One of our branch offices is equipped with a mirror-video setup and the other is not.) Teams are made up of one therapist in the room with the client and one or more therapists behind the mirror. Although the same therapist tends to continue in the room with a particular client, membership on a particular therapy team behind the mirror is irregular and dependent on availability, unless it is a training team in which trainees and trainer stay together for the duration of the cases involved.

The first session (which, like all our sessions, is less than one hour) follows the following format:

- 1 Introduction to our set-up and procedures.
- 2 Statement of the complaint.
- 3 Exploration of exceptions to the rules of the complaint.
- 4 Establishment of goals for the therapy.
- 5 Definition of potential solutions.
- 6 Intermission – Consultation break.
- 7 Delivery of the message from the team.

Each of these will be considered in turn.

Introduction

When the client arrives, he or she is given descriptive information about BFTC, the team, and our use of the mirror. The client is also asked to read and sign the necessary forms giving us permission to videotape, and so on.

Prior to the start of the first session, to minimize pre-set ideas, the therapist has a limited amount of information about the client, except in situations where it might be better to view the referral source as the client (2). The therapist begins by explaining the physical and organizational arrangements, including the fact that a team of therapists will be involved, and requests the client's permission to videotape. Infrequently a client will ask to meet the team behind the mirror, in which case one or more representatives will be introduced, preferably at the end of the session – although the session can be interrupted for this purpose at the beginning if the client wishes.

Statement of the Complaint

As the first order of business, after a short discussion of who works where and who goes to what school, and so on, the therapist begins by asking about the complaint. “What can we help you with?” or, “What brings you in?” A response like “Sometimes we have fights which become physically violent” or

“Johnny wets the bed” or “Susie throws temper tantrums” is an adequate statement. The therapist then attempts to direct the conversation toward as much concrete detail as possible:

- Step-by-step, what exactly happens?
- Who is involved in the complaint?
- How does the complaint differ depending on who is and who is not involved at a particular point?
- With what frequency does the complaint happen?

The more details about the complaint pattern the client describes, the more potential interventions and goals, that is, potential ways for the client to know that the problem is solved. Even complaint statements as vague as “I don’t know who I really am” or “We just can’t communicate” can be adequate. In this case, the setting of goals becomes the focus: “How will you know when you know who you really are?” “What will you be doing, when you know who you really are, that you are not doing now?” “How will your best friend know that you really know who you really are?”

This stage frequently overlaps with and is interspersed within the next stage.

Exceptions

This phase of the interview is designed to find out what happens when the complaint does not happen and how the family gets this exception to happen. What happens when the couple’s fights do not become violent? What happens when Johnnie’s bed is dry? What happens when Susie does what she’s told? What happens when mother is there and not father? What happens when they do communicate?

Our view is that both therapist and clients need to know what the clients do that works or is effective. Not only can this discussion lead to some models for intervention design and solution, but it implicitly lets the client know that the therapist believes that they not only can do – already are doing – things that are good for them. In Batesonian terms,

the exceptions at least implicitly provide the client with “news of difference” (1) between what works and what does not work.

Our view is that although change is continuous, only some differences are seen to make a difference (1). Weiner-Davis (21) began to study more systematically exceptions to the complaint rule by beginning the session with a variation of our “formula first session task,” asking clients to observe what happens in their lives between the first and second session that they want to see continue to happen (see below):

Many times people notice in between the time that they make an appointment for therapy and the first session that things already seem different. What have you noticed about your situation? Do these changes relate to the reason you came here? Are these the kinds of changes you would like to continue to have happen?

Interestingly, two-thirds of the clients noticed changes and answered “yes” to the second and third questions.

This phase naturally leads to goal setting because the client may just want more of what happens when the complaint does not happen. The simple fact that sometimes the complaint happens and sometimes it does not, helps to create the expectation that a future is possible which does not include the complaint.

Goals

Establishing a concrete goal provides a way to measure the usefulness of the therapy for the client and, importantly, the goal helps to build the expectation that change is going to happen. It is important for everyone involved to know how they will know when the problem is solved and therapy can stop. Without a goal, any therapy could become a life-long endeavor. Concrete goals are an important part of our evaluation program and are a necessary part of our follow-up or outcome studies.

Solutions

Clients often talk in vague or global terms when asked directly about concrete goals. We have found that it is frequently more useful to have a conversation about how the clients will know that the problem is solved and what will be different once the problem is part of the past. Of course, when the therapist is talking with more than one person, the ideas about what life will be like after the goal is met, or what life will be like when the complaint is part of the past, might be many and varied. The more alternate futures or alternate solutions are talked about, the stronger the client's expectations of change will be.

Our aim is to have the main body of the conversation throughout the session focus on the absence of the complaint. Simply, complaints seem to maintain themselves because people expect the same damn thing to continue to happen over and over. Talking about possible alternate futures when the complaint is no longer a complaint helps to create the expectation that change is not only possible but inevitable.

Intermission – Consultation Break

After 30 to 40 minutes the therapist excuses himself to consult with the team or, when working alone, to think about things. The purpose of this 10-minute break is to decide what to do and how to do it. Because we are interested in solutions, there is little or no talk about the complaints, how the complaints are maintained, and what the clients have tried that failed, or about hypothetical etiologies. Instead, the talk tends to focus on

- things the clients are doing that is good for them
- any exception to the complaint pattern
- what the team imagines the clients will be like once the complaint is part of the past.

Intervention Design Worksheet

The behind-the-mirror process is approximated and summarized on an “intervention design worksheet” that we use for training purposes.

1. Note what sort of things the client(s) do that is good, useful, and effective.
2. Note differences between what happens when the complaint happens and what happens when the complaint does not happen. Promote the latter.
3. When possible, extract the step-by-step facts of the problematic pattern or the complaint sequence.
4. Note difference between pattern and any exceptions to that pattern.
5. Imagine a solved version of the pattern by:
 - (a) making the exception into the rule
 - (b) changing the location of the pattern
 - (c) changing who is involved in the pattern
 - (d) changing the order of the steps involved
 - (e) adding a new element or step to the pattern
 - (f) increasing the duration of the sequence
 - (g) introducing random starting and stopping
 - (i) increasing the frequency of the pattern
6. Decide what will fit for the particular client(s), i.e. which task, based on which variable (a through i), will the client(s) most likely accept and perform. What will make sense to the particular client(s)?

Ordinarily, the message developed during the intermission has two parts: (a) Compliments and (b) Clues.

Compliments are not necessarily linked to the complaints, but are based on what the client is already doing that is useful or good or right in some way, regardless of the specific content and context. Compliments are designed to help the client “see through” their frame of the situation in such a way that a more flexible view of the situation is possible; thus, the development of a solution is begun. The goal is to

help clients see themselves as a normal persons with normal difficulties.

The purpose of the compliments is to support the orientation toward solution while continuing the development of what Erickson (5) called a "yes set," which was begun during the interview but now will be pursued in a more intense and focused manner. Simply, the start of the therapeutic message is designed to let clients know that the therapist sees things their way and agrees with them. This, of course, allows the clients to agree easily with the therapist. Once this agreement is established, then the clients are in a proper frame of mind to accept clues about solutions, namely, something new and different.

Clues are focused therapeutic suggestions, tasks, or directives about other sorts of things that the clients might do that will likely be good for them and will lead in the direction of solution.

When the conversation has focused on one clearly described behavioral complaint pattern, the clues will tend to reflect that clarity. Various kinds of behavioral homework tasks might be suggested that are designed to shift from the complaint pattern toward solution. For instance, if the parents are complaining about their bright child's failure to do his homework in spite of their joint nagging and joint lecturing, then the parents' homework task might be for them to toss a coin so that, randomly, one or the other gets a day off; or, if they want the child to be solely responsible for his own work, they might be asked to toss a coin to decide randomly which days neither of them would even mention homework to their child. In both examples, they would be asked to observe the differences between the two conditions. If the parents wished to continue to supervise the homework performance, then a system might be developed so that they and the school would have immediate checks. If they had described a noticeable exception, then they would be encouraged to make the exception into the rule. Any of these tasks has the potential for prompting some difference in the pattern that makes enough difference: better homework production.

More frequently, however, clients' complaints are not well defined, or described well enough in the first session for the above approaches to be useful. It is in these latter situations that conversation about what things will be like when the complaint is part of the past will prove quite useful.

Erickson had an idea that we have found useful in these situations. According to Erickson (11), clients come to therapists

because they don't know exactly why they come. They have problems, and if they knew what they were they wouldn't have come. And since they don't know what their problems really are they can't tell you And you listen with your background and you don't know what they are saying, but you better know that you don't know. And then you need to try to do something that induces a change in the patient ... any little change, because that patient wants a change, however small, and he will accept that as a change ... and then the change will develop in accord with his own needs.
[p. 16]

It was in following this line of thought, and because of the practical necessity of trying to help trainees learn what to do with undefined, vague complaints, that we were pushed to develop the formula task we use in first sessions (4, 5, 6):

Between now and next time we meet, we would like you to observe, so that you can describe it to us next time, what happens in your life that you want to continue to have happen.

With surprising frequency (50 of 56 in a follow-up survey), most clients notice things they want to have continue and many (46 of the 50) describe at least one of these as "new or different." Thus, things are on the way to solution; concrete, observable changes have happened.

Message Delivery

After an intermission of 10 minutes or less, the therapist returns and gives the formal intervention. Frequently this message is written down for the therapist to read in an “ad lib” fashion. Perhaps because the clients have been kept waiting, their receptiveness seems increased. These messages themselves are rather short, frequently taking less than 5 minutes to deliver. (Business matters, such as setting the next appointment, are handled in a different place.) And so the therapist quickly, but not rudely, ends the therapy session.

Second and Subsequent Sessions

The major difference between the first session and subsequent ones is that the complaint has already been talked about in the first session and, therefore, there is little or no need to talk about the complaint in the second session. The therapist’s first order of business is to have the conversation focus on “What happened that you want to continue to have happen?” This question can be phrased in many other ways: “So, which days were better?” (in coin-tossing situations) or “What are you doing that’s good for you?” (in less defined situations). That is, the therapist needs to detect anything the client can list as worth continuing, to identify and comment on them. As each item or sequence is mentioned, the therapist wonders if it is “new” or “different.” If something is not new, but is just an infrequent exception, is it something the client would like to have happen more often? Once the list is finished, or interspersed with the listing, the therapist shifts from the notion that these things have just “happened” to “How did you get them to happen?” and “What did you decide to do when that (worthwhile thing) happened?”

If the client is reporting that things are better (the previous intervention “fit” and led toward solution), the therapist then shifts the conversation to questions about “What do you need to do to get those things to continue to happen?” It is our view that when something works one should do more of

it or more things like it. That is, the goal of therapy then becomes helping the client continue the changes that happened between the first and second sessions. If the parents discovered that the child did the homework on days when neither parent mentioned it, then the parents need to continue their silence on the homework topic. It is only if that approach fails that they need to do something different. Because it is perfectly natural to forget something now and then, the parents might want to forget to do something for the child when the child forgets to do his or her homework.

If the client is reporting that things are not better (the previous intervention did not “fit” and did not lead toward solution), or that they have remained unchanged, the therapist will, nonetheless, begin to ask questions about what it is that the client is doing that is working. The question might be phrased in this way: “It is our experience that if people don’t do something right, things will get worse over time rather than remain the same. What are you doing?” And the search for exceptions and minor differences to amplify continues. If the client is reporting that things are worse, the therapist tends to focus on: “Have things hit bottom and you can reasonably expect things to change soon? Or, have things yet to hit bottom and so things won’t get better as quickly?” Homework tasks in this situation would be focused on signs of things getting better now or still getting worse before they start getting better.

The therapist again takes an intermission after 40 minutes or so and designs a message that includes compliments based on any changes, on anything the client did that worked, and clues aimed at helping the client continue or even amplify the rate and degree of change.

Provided things are reported as “better” in the client’s life, the interval between sessions is lengthened; the second session is usually one week after the first, the third is two weeks after the second, the fourth is three weeks to a month after the third. We decided to use these intervals to send the implicit message: “Since things are going better, you do not need to come to therapy so often.” At the point when the therapist and

team thinks things might be “better enough,” the client is asked for advice about the need for another session, and about the possible interval. This advice is usually followed although the therapist might ask for a follow-up session in six weeks. Until things are reported as “better,” the interval between sessions usually remains at a week.

Evaluation and Results

Although researchers would prefer comprehensive ways of evaluating therapeutic results, therapists frequently can only offer their clinical impressions. Because therapy needs to be evaluated, we are taking a position somewhere between “research findings” and “clinical impressions.” We suggest that an evaluation can be based on a comparison between what a therapy proposes to do and its observable results.

From the start, we decided to follow Weakland *et al.* (20) in this matter because that would at least give BFTC a standard of comparison. Because our follow-up is based on client self-reports, the questions regarding the validity of client self-reports apply. We recognize that difficulty, and only wish to point out that therapy begins with a client self-reporting a “complaint” that is troublesome enough to bring them to therapy. Accordingly, a self-report 6 months to one year after therapy that they had no complaints worthy of therapy surely can be taken as one indicator of success.

1. The kind of brief therapy done at BFTC appears to be effective within a short period of time and within a limited number of sessions. Between 1978 and 1983, we saw 1600 cases for an average of 6 sessions per case. Our follow-up phone calls to a representative sample of 25% (done by someone who had no connection with the case) indicated that 72% either met their goals for therapy or felt that significant improvement had been made so that further therapy was not necessary. Weakland *et al.* (20) reported a similar success rate within an average of 7 sessions per case.

2. The kind of therapy done at BFTC appears to be effective even when the complaints and/or goals are vague and ill-defined. We conducted a study concerned specifically with our formula first-session task. We were able to contact only 28 of the 56 clients in the original project after a follow-up period of 6 months to one year after termination. When asked: "When you came to therapy, your main complaint was x. Is that better? The same? Worse?", 23 of the 28 reported that what they had complained about was "better." The average number of sessions per case (for the 56 cases) was 5, which represents a decrease in our overall average number of sessions per case in the past 2 years. The results of our follow-up contacts supported our clinical impression, namely, that we and our trainees have been more successful with vaguely defined complaints since we began using the formula task in mid-1982.
3. Rapid changes can be enduring. In this same project the clients were asked about the changes reported in the second session. When asked: "During therapy, you noticed a change in (something our records indicated they reported during the second session), is this continuing?", 23 of the 28 responded in the affirmative. Although the number of respondents is very small, we are encouraged by the direction of the responses.
4. One small change can lead to others. In the same project, the 28 clients were asked about further improvements. Three questions were used:

(A) "You were also concerned about ... Is this better? Same? Worse?" (Twenty-one had mentioned a secondary complaint, not necessarily dealt with explicitly in therapy, and 11 reported that was better too.)

(B) "Have any old problems that were not directly dealt with in therapy improved since you finished at BFTC?" (Fifteen reported improvements in areas not dealt with at all in therapy.)

(C) "Have any new problems developed since you finished therapy at BFTC?" (Sixteen reported that no new problems

had developed; 8 reported that a new problem had developed but that it was not bad enough for them to seek therapy; 5 reported that someone in the immediate family was in therapy for something other than their presenting complaint.)

None of this was surprising to us because the distributions were about the same as in our previous follow-up studies. As Fisher's findings also indicate (9), things tend to continue to get better – rather than deteriorate – after brief therapy.

Conclusion

In this essay we have proposed a particular conception about the nature of solutions to the kinds of complaints clients bring to therapists. We have described our brief therapy approach to developing solutions and have presented some of our results. Clearly, this is not the final report. More clinical research and formal research needs to be done as important concerns remain:

- 1 Is there as little correspondence as our results suggest between the particular complaint and the specific new behavior and frames that lead to solution? As counter-intuitive as this idea seems, our work strongly points in this direction.
- 2 Is the distinction between (a) concretely described complaints and equally specific goals and (b) vaguely described complaints and equally vague goals, one that will continue to be useful?
- 3 What are the most useful ways to describe and study what it is that the therapist does during the interview? How does what the therapist does during the interview relate to satisfactory change? What kinds of things do therapists do during the session that they ought to discontinue?
- 4 What construction of the brief therapy situation will evolve that is more useful than the one we propose here?

Each step of the way, we have continued to construct alternate models and, one by one, complexity has been replaced by what we think at the time is a simpler model. Attempts to help others learn our models have always led to further simplification.

In short, our view holds that clients already know what to do to solve the complaints they bring to therapy; they just do not know that they know. Our job, as brief therapists, is to help them construct for themselves a new use for knowledge they already have.

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² John Weakland and I have frequently discussed this point of view, which brief therapists (at MRI and at BFTC) seem to hold quite strongly. I think this statement expresses his viewpoint.