

Four Useful Interventions in Brief Family Therapy*

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At the Brief Family Therapy Center we have developed some interventions that have repeatedly been found useful. Once a generalizable intervention is designed for a particular case and found effective, the team attempts to replicate by using it in other appropriate situations. When a pattern of usefulness emerges, it is time to think about and study what is going on that makes the intervention useful. The purpose of this paper is to describe four such interventions, the situations in which to use them or not use them, and our thinking about what is going on in each example.

At the Brief Family Therapy Center (BFTC), the use of teams, one-way mirrors, and the videotaping of sessions are routine procedures (de Shazer, 1982). Unlike some team approaches, at BFTC the team does not act merely as a consultant to the therapist but is, in fact, in charge of the treatment. Therefore,

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the interventions delivered after a consulting break are usually phrased in terms of “we ...” rather than “I.” The therapist in the room with the client can be viewed as an Ambassador who must receive instructions from the State Department about policy directions (this metaphor was suggested by Jorge Colapinto (1981) of Philadelphia Child Guidance Clinic), rather than a General in charge of the tactics and strategies of a battle. Unlike the Birmingham team, the Cardiff team and other teams that utilize the Milan model and set aside up to three hours for each session, at BFTC a session lasts one hour, including the team consultation break. This hour is divided as follows: (a) a 40-minute interview with the family; (b) a 10-minute consultation time with the team, or a 10-minute break to think when working solo; and (c) 10 minutes for delivering the intervention message and ending the session. Appointments are scheduled every hour on the hour. With roughly 10 minutes to design appropriate interventions, the therapists have developed (beginning in 1978) a repertoire of interventions useful in a variety of situations which team members use both when working as part of a team, and when working solo.

In this essay we will describe four interventions that have been found effective by the therapists at the BFTC. The clinical practice at BFTC is guided by an orientation toward helping clients solve problems. Our assumptions about the nature of change unquestionably form the “ground” of our ideas about intervention design, as well as other clinical practices (de Shazer, 1982). These basic assumptions include the following:

1. Change is not only possible, but it is inevitable.
2. Only minimal changes are needed to initiate solving the problems clients bring to therapy, and that once change is initiated (the therapist’s task), further changes will be generated by the client-system (the “ripple effect” (Spiegel & Linn, 1969)).
3. A change in one element of a system, or in one of the relationships between elements, will affect the other elements and relationships which are the system.

However, none of the interventions discussed here were self-consciously designed on the basis of a set of epistemological premises. Each of the interventions described below was developed in response to the specific problems posed by a particular case. When they produced useful results they were employed in other cases; when a pattern of effectiveness emerged, we attempted to explain what it was about these particular interventions that made them effective. Our efforts to understand how these interventions worked inevitably led us to theoretical considerations, and to the refinement and development of our theoretical premises. What follows is a statement of each of the interventions, a statement of the clinical problem each was designed to address, case examples, and a brief discussion of what we believe are the theoretical points suggested by the results.

Intervention One

“Between now and next time we meet, we (I) want you to observe, so that you can tell us (me) next time, what happens in your (life, marriage, family, or relationship) that you want to continue to have happen.”

Clinical problem: Clients tend to focus on the perceived stability of their problematic pattern.

The above intervention attempts to define the clients' situation as one in which the therapist(s) expects something worthwhile to happen, and to continue to happen. Frequently, this assumption is the opposite of what the clients expect to have happen. This intervention lets the clients know that the therapist expects change in a situation they have viewed as static, and that the therapist is confident that it will happen soon.

To further promote these expectations, and to help the client see changes, the therapist carefully opens the session following the session in which the above intervention was given with this question: “So, what happened that you want to continue to have happen?” The therapist needs to indicate that things worth

continuing to have happen are expected. The therapist then tends to respond to any of the information the client provides with comments of this nature: “Well, that seems different,” or, “That seems like a change from before.” The purpose of this approach is to continue to build the expectation of changing by indicating that the therapist would be surprised if the clients did not notice the changes and report them.

Case illustration. A young couple in their late twenties came to therapy because “something got lost somewhere.” Five days before the first session John had moved out after a big argument. Nancy (who cried throughout the session) had been feeling disappointed and cheated during the past year, while John had been feeling rejected and frustrated. Ten months ago they had had their first child, but that had ended all the good times. Prior to the baby, occasionally there had been some good times though these were getting further and further apart. As she put it, they went from “making love” to infrequently “having sex” to stopping sex. The situation hit bottom when, five months after the baby was born, Nancy went back to work. Both expressed a strong desire to get back together, but they also thought no solution was possible.

Throughout the session, the therapist repeatedly attempted to get the couple to establish a concrete and specific goal, or at least to define how they were going to know when things had started to change in a positive direction. Various phrasings or versions of the question were ineffective.

After the intervention break, the therapist returned to deliver this message:

First of all, having a baby no matter how much you both wanted the baby is always an upsetting time, particularly when it is the first baby. After the baby comes, mother needs to attend to the helpless infant and, usually, father feels left out or pushed away and rejected—particularly since his wife, as a new mother, probably won’t want sex for six months or so. You, Nancy, went back to work after five months on top of this typical upset, and you, John, went off on your business trip.

I have some ideas about the kinds of problems you two have fallen into, but my picture is not complete, so to help round out the picture, between now and next time we meet, I would like you two to observe, so that you can tell me next time, what happens in your relationship that you want to continue to have happen.

One week later, when asked, they reported the following as things they wanted to continue to have happen: (a) on Friday (two days after the first session) the two of them went to lunch together for the first time in over a year; (b) unlike most of their conversations in the past year, this one did not result in further conflict; and (c) on Saturday they “made love like we hadn’t in years.” As a result, both of them reported feeling that they found what they had lost, and that neither had been sure was there anymore. He was extremely pleased by this, while she felt shocked. Both felt the other was sincere, and both felt unusually close. Sunday and after, they had talked several more times and had come nearer to feeling that a solution was possible.

They also reported being in the midst of a big hassle over some practical arrangements necessary for care of the baby when Nancy changed shifts. Each clung to their solution despite the apparent logic of the other’s ideas. However, they were both in agreement that John should not move back home just to solve this problem but only when he was sure he wanted to be married to Nancy.

Their report is not uncommon. They discovered some concrete and specific behaviors, i.e., lunching out together and making love (sex in a particular context), which were signs to them, and to the therapist, that things could head in the right direction, and were beginning to do so. Furthermore, the other talks they had at various times during the week did not end in conflict. After the consulting break (used to think about the situation), the therapist returned with the following message:

I am impressed that you discovered on Saturday that the feelings had only been misplaced, not lost. And, I was

really struck by the other changes you've made toward solving the problem which you both now know that you can solve. It also seems important to me, though it might not seem so to you, that some of what you two are talking about are things which are not problems.

Now, I worry that you two, having rediscovered your feelings for each other and some confidence that you will work things out, might get your hopes up too high, or might become over-confident, or might get upset if, once again, your feelings for each other get hidden under some crap from the disagreements you feel you need to settle. I worry that you'll fall back into the old crap which hides the good feelings.

So, for right now, I have a suggestion: toss a coin to decide which plan to follow this week, and then do it. The following week, if you still do not agree, then follow the other plan for a week.

The coin toss allowed them to set their difficulties aside while following a definite plan. During the following session, three weeks later, they were back together, and the love-making had continued. They were also continuing to use the coin to decide issues on a temporary basis.

Comment. Over a period of a year, this intervention has been used as a homework assignment at the end of the first session. Data collected during two sample periods indicate that therapists at BFTC used this with 64% of their new clients (56 of 88). Of these, 50 (89%) clients reported something worth continuing had happened (the range was from 1 worthwhile event to 27, most frequently 5 to 7 events were reported), while 6 (11%) said nothing worth continuing had happened. Even more interesting, all 50 clients reported what happened in concrete terms, and 46 (82%) reported that at least one of the worthwhile things that happened was "new". 32 (57%) reported that things were "better", while 19 (34%) reported things were "the same". Only 5 reported things as being somehow "worse." 19 (76%) of the 25 reporting that things were the same or worse gave incongruous reports such as, "yes, something worthwhile had happened but things are either the same or worse."

These preliminary results are not to be taken as simple cause-effect phenomena, but rather as indications of what the clients saw and reported. This invariant prescription did not necessarily "cause" changing or worthwhile things to happen; it did change the clients' expectations during the week between sessions so that they focused on, and reported, worthwhile events and changes, some of which might have been occurring regularly but had not been noticed. Regardless, the expectation designed into this intervention, that worthwhile events and changes will occur, was quickly confirmed for both therapist and clients.

The biggest surprise among these findings is the concrete and specific nature of the clients' response reports. Brief therapists (de Shazer, 1975, 1982; Fisch, Weakland & Segal, 1982; Haley, 1976; Watzlawick, Weakland & Fisch, 1974; Weakland, Fisch, Watzlawick & Bodin, 1974) tend to want goals expressed in concrete, specific terms because measurement of failure and success is easier. This leads them to want concrete and specific complaints, and concrete and specific changes. However, not all clients (even with the aid of concrete-minded therapists) are able to define their problems and their goals in concrete and specific terms.

This project points out that clients tend to respond in concrete and specific terms to rather vague and non-specific tasks. That is, our clients reported concrete behavioral events and changes in response to the non-specific first session task, and the continuation of these changes could then be used by the therapist as a concrete goal. When these first changes are described as happening within the problematic pattern, then the goal of brief therapy can be seen as having been met; namely, change has been initiated. All the brief therapist then needs to do is work with the clients on keeping things the same. The task of therapy shifts from initiating change, to preventing a relapse and/or promoting the ripple effect.

Clearly, then, there is no need for this intervention when the client presents a specific problem and concrete goals are established. In fact, its use in that situation would only promote confusion and the derogatory effect of redirecting therapy away from the presenting complaint.

Intervention Two

“Do something different.”

Clinical problem: Clients tend to believe that they have used up their repertoire of available responses to the problem.

According to Bateson (1979), a source of randomness is necessary for change within a system. However, most people’s range of response to certain situations is limited by what they think is correct, moral, or logical. The necessary randomness must be isomorphic with the system. Therefore, it is frequently better for the therapist to give vague instructions rather than specific ones.

The “do something different” task is frequently given when clients complain about some sequence of events that repeats, e.g., a child has temper tantrums to which the parents react in the same ineffective fashion. This direct, non-specific intervention gives clients a wide range of possible new behaviors to choose from and insures that, when they do something different, it will be something that fits for them and not something specific suggested by the therapist that might seem outside the bounds of possibility for their system.

Case illustration. An 8-year-old boy was throwing temper tantrums both at home and at school. Typically, he was given “time-outs” and lectures and, sometimes, spanked. But this approach did not stop the tantrums. Then both parents and school tried to reward him during the intervals between tantrums, but that did not work. The parents frequently found themselves yelling at the boy while he threw his tantrums. (None of these parental responses were effective because they were all “more of the same”; punishment to stop the tantrum.) At the end of a session with just the parents present, the therapist told them to “Do something different next time Jimmie throws a tantrum, no matter how strange, or weird, or off the wall what you do might seem. The only important thing is that whatever you decide to do, you need to do something different”.

During the next tantrum, father gave Jimmie a cookie without saying a word. The tantrum stopped. When mother

next witnessed a tantrum, she danced circles around the boy while he kicked and screamed. The tantrum stopped. Subsequently, neither the parents nor the school reported any tantrums. The cookies and the dance seem to have been effective because neither was “more of the same”. Both were behaviors from some different logical class which served as a context marker for “this tantrum and response sequence is different”.

Case illustration. Another family, faced with a similar tantrum problem and given the same task, reported that they had been unable to think of anything different to do, but the need had never come up since their son had thrown no tantrums during the two-week interval. Unlike the first case, the boy had been present when the “do something different” task was assigned. The therapist then asked the boy about this lack of tantrums, and the boy replied, “I used to know exactly what they would do, but now I don’t”. So, he decided that rather than find out what different things his parents might do, he just stopped having tantrums. Here, the parents did not have to think of something different to do because the boy found something different to do, and the tantrums ceased completely.

This task seems to promote some random, or apparently random, behaviors in clients which allows them to alter the sequences of behaviors that are part of the complaints they brought to therapy. It seems to work because it reaffirms to the clients the therapist’s expectation that changing can, and will happen, and that they, the clients, can change and solve the problem.

The “do something different” task has also been found useful once a change in pattern has occurred. It can be used as part of the relapse warning, as a suggestion of what to do should the old pattern appear to be starting again.

Case illustration. A wife recently reported that her husband had stopped coming in the front door with a bitter frown on his face, which for years had been a source of annoyance for her and conflict for the couple. He had changed this by taking a short walk after parking the car and before coming into the

house. For both of them, the new pattern had the effect of making their entire evening more relaxed. The therapist, worried about maintaining the new pattern, expressed some doubt about the husband's ability to continue to shift his mood with this short walk. Therefore, he suggested to the wife (in the husband's presence) that if her husband should come in with a frown again, it was important for her to *do something different* to prevent the old pattern from returning and ruining their evening. Two weeks later the opportunity arose, and she found something different to do. She spontaneously threw one of the grandchildren's rattles at him, and he laughed. The evening continued in a pleasurable fashion.

Intervention Three

“Pay attention to what you do when you overcome the temptation or urge to . . . (perform the symptom or some behavior associated with the complaint).”

Clinical problem: Clients tend to view their problem behavior as compulsive and beyond their control.

Case illustration. In a previous session a young male client was told to “Pay attention to what you do when you overcome the temptation to drink too much beer”. He reported going to a bar and drinking orange juice, starting to jog, starting to fix and paint his living room, and starting to read again. He explained not having given in to any temptations to drink, noting that possibly he had had only weak urges, and wondered if he could handle really strong ones. The therapist gave him the following message:

Now that you know how to deal with temptations, at least some, and we're impressed with the stuff you are doing to overcome the temptations, we suspect that some situations might develop in your life when you need to do something different, no matter how strange, just so it's different, to continue to overcome the temptations. So, continue to pay attention to what different things you do, and which of the

same things you do, to overcome the temptations between now and next session.

Between sessions (a two-week interval) he discovered a young lady who did not drink at all, which he considered a strange and different way to overcome the temptation to drink too much. However, he found this new way both pleasurable and effective.

This task is related to both Intervention One and Intervention Two in that it presupposes that clients will overcome the urges or temptations at least some of the time and that they will, perhaps, do something different in order to overcome them. The task is also designed to help clients pay attention to what they do, i.e., the behavior rather than some interior state. In the session following the assignment of this task, the therapist frequently opens the session with a comment such as: "Well, what did you do when you overcame the temptations during the past week?" Again, this statement presupposes that the clients will have done something to overcome at least some of the temptations. Regardless of the response the clients give, they are encouraged to see and use the tools necessary to overcome the temptation to "go back to the old way".

Intervention Four

"A lot of people in your situation would have . . ."

Clinical problem: Clients tend to assume that what they are doing in response to their problem is the only logical thing to do.

Frequently, when clients present their situation as one in which they are stuck, as one in which stability is the only course of action, the therapist can redefine that stability as the most difficult course of action, one that really demands the most changes. This redefinition of stability as change, then, permits the therapist to suggest change as being the way to promote the desired stability.

Case illustration. A woman married ten years came to

therapy because of her husband's continued infidelity. Throughout the previous two years she knew he was having an affair, but for the sake of their three children she had pretended that she did not know. She desired to keep things stable for the children, the in-laws, and her own parents. Moreover, marriage for her was defined by religious training as forever and ever. But sleepless nights, lack of stamina, and increasing irritability had caused her to seek help for herself in dealing with this problem.

The intervention in the first session was intended to describe this stability as change, a most costly way of changing, and to point out to her some other possible ways to maintain the stability by changing.

A lot of people in your situation would have thought about suicide, which you wisely rejected as worse than useless, or they would have had an affair to get even, or they would have left him, or they would have yelled and screamed. But you chose the more difficult route, essentially pretending to remain unchanging as far as he's concerned. This course of action means that you've really had to change a lot in order to keep things appearing to be stable. A lot of people in your situation would have been unwilling to make this extreme sacrifice, and they would have thought that any change which impacted on him, any change which made him uncomfortable, might work to either end the affair or save the marriage or both. Perhaps you need to stop changing so much, to be more rigid. Rather than continuing to change, maybe you need to pick something and stick to it. Then again, maybe you need to continue to sacrifice, continue to change.

The woman thought about these ideas, and decided that changing by telling her husband that she knew about the affair and that she wanted to keep the marriage going would really be ways of achieving the stability she wanted. She stopped changing "inside," and began to change on the "outside" by increasing her demands on her husband. His response was to join her in working on the marriage which he, too, valued.

This intervention is not useful when the client has tried a lot of different approaches to solving the problem (outside changes). The “do something different” task is more appropriate in those cases.

Discussion

Our efforts to understand how the interventions described above worked revealed that they have one quality in common: each attempts, in some way, to help the clients experience changing. This was accomplished by setting the stage for the clients to change what they observed about themselves (“Observe what you want to continue to have happen,” and, “Pay attention to what you do when you overcome the temptation or urge to . . .”) or, by setting the stage for the clients to change their judgement about what they do (“A lot of people in your situation . . .”) or by setting the stage for the clients to change a behavior (“Do something different”). The results of these interventions also suggest that, in terms of problem resolution, there is no clinical distinction between clients’ perceived change and observed change. If clients perceive a change then, in terms of their problems (for clinical and perhaps epistemological purposes), there is a change, whether or not there is an observable behavioral change. (Of course, perceptible, behavioral change is good evidence.)

Our observations about these four interventions also helped us to formulate general questions useful in developing other interventions: (a) What in this system can be labeled as changing?, (b) What can be acceptably labeled as changing even if we are not sure that it is?, and (c) How can therapists promote ways to help themselves see change? As we formulated these questions, it became clear that they not only have clinical utility, but that they helped us clarify and make explicit two epistemological premises and assumptions important to our practice: (a) Changing is independent of human observation and is continuous (Stcherbatsky, 1962; Zukav, 1979), and (b) human observation alters the nature of the changing observed (Capra, 1977; Heisenberg, 1962).

Our experience with the interventions described in this article, the questions we have formulated to help us design future interventions, and the epistemological premises we have made explicit, have all been helpful in advancing our clinical and theoretical understanding. It now appears to us that the therapists' ability to see change and to help the clients to do so as well, constitutes a most potent clinical skill in Brief Family Therapy. It is the seeing of changing that seems to be the trigger that shifts problematic patterns. Having seen this trigger work, an important research task now facing us is to more fully describe the trigger, and how to get it to work reliably.

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Note

- ¹ In addition to the authors, the staff of BFTC includes Insoo Berg, Marilyn La Court, Eve Lipchik and Elam Nunnally.