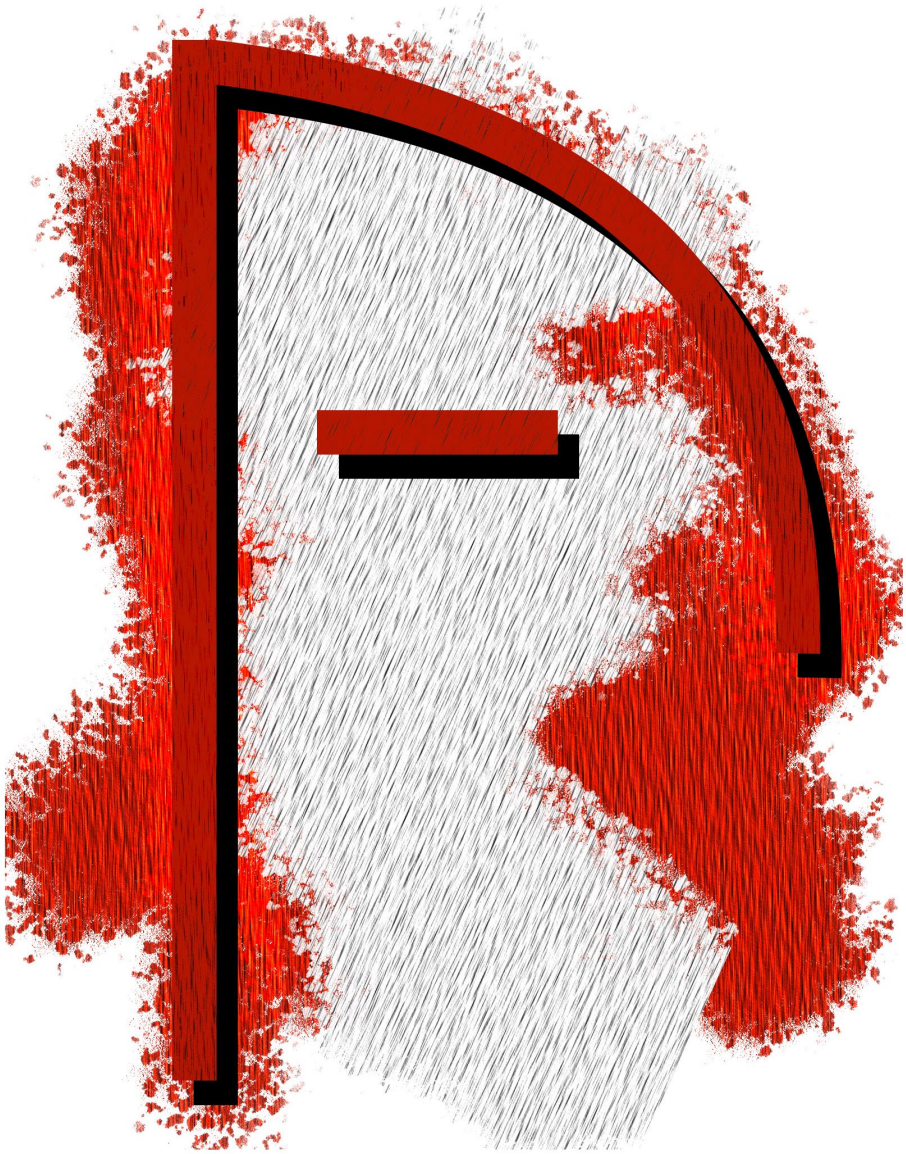

# **Doing something different for a long time . . .**

an extended journey within the brief therapy tradition

Andrew Turnell

**Doing something different for a long time . . .**
***an extended journey within the brief therapy tradition***

***By Andrew Turnell***

***Abstract***

*Brief therapists are probably the anarchists of the therapy field; they certainly like to subvert and question the dominant paradigms of the profession. But what exactly is useful about this tradition of doing therapy? This paper explores the tradition of brief therapy - meaning the connected models of focused-problem resolution and solution-focused brief therapy - through the professional experience of the author who has been applying and developing the tradition by using the models in various settings, particularly with families, survivors of torture and in child protection investigation and casework. The primary focus is an exploration of the thinking that informs the brief therapy tradition and case examples are used to highlight the ideas throughout.*

The fax kept coming and coming. The 36-page snake of it filled the photocopy room. It was a referral from the child welfare agency regarding a family they had been working with for many years. My colleague (John Holsgrove) and I were to see the family, but because of our schedule we were not able to read anything like all the referral information before the appointment. The reading time we did manage, told us of a family with many problems and asked us to deal with the severe acting out behaviour of the teenage son.

The year was 1990; John and I were well versed in the focused problem resolution model of brief therapy of Weakland, Watzlawick, Fisch, Jackson and others from the Mental Research Institute (MRI) in Palo Alto, and this was our therapeutic modality of choice in our conjoint clinical work. The MRI model has its roots in the radical and pragmatic change oriented clinical practice of psychiatrist Milton Erickson and the rigorous systemic thinking of anthropologist, linguist and cyberneticist, Gregory Bateson. The solution-focused brief therapy approach of de Shazer, Berg, Lipchik and other Milwaukee colleagues arose directly out of the MRI model and in 1990 was beginning to become well known in Australia, (for a more thorough introduction to brief therapy, see Cade and O'Hanlon, 1993). John and I and our brief therapy team had read everything we could get our hands on regarding the solution-focused approach and dabbled a little with some of the ideas and techniques. To get a real feel for the model however, we knew we had to apply the model as rigorously as we could, to one case from commencement to closure. We decided this would be our first fully fledged solution-focused case, partly motivated by the thought that maybe this would help us avoid the seemingly endless catalogue of problems which the fax seemed portend. We also joked that this case would certainly test out whether the model of de Shazer's was up to much.

The teenage boy was already creating havoc when we laid eyes on him in the waiting room, and he bought that attitude straight into the session: he fought with his younger sister, swung round incessantly on the swivel arm chairs (never, have these sorts of chairs if you're seeing disruptive teenagers), forcefully interjected his disagreement with everything his mother said but displayed a complete disinterest in answering any direct questions. Fortunately, brief therapy doesn't have a rigid commitment (as do many traditional family therapy approaches) to working with all members of a family system all together, so we pretty soon asked the boy to cool his heels in the waiting room. The mother had already told us that the son was truanting regularly, was aggressive when at school, abusive to her and his younger siblings and becoming violent toward his sister. The mother also described that her partner was no help in dealing with her son, that in fact he was also violent and often abused alcohol and/or drugs. Trying to be true to our intended solution-focused commitment we asked the mother in various clumsy ways how she had already dealt successfully with any of these problems and what additional ideas she might have for dealing with the seeming chaos she had described. We weren't very successful in assisting the mother to speak about past successes however,

we were astounded to hear the mother give an extended account of what she felt she needed to do. In summary, this involved getting rid of her de-facto partner since she was fed up with the relationship and taking charge of the son's behaviour both at home and at school.

After taking a break, John and I returned with a message telling the mother that we thought she faced a very difficult situation, though one to which she had clearly given considerable thought. We expressed our caution however, suggesting it would be too much, too soon to attempt to do everything she was thinking of all at once. Instead, we invited her to use the time till the next session to think about what would be the best, first small course of action she could take (the caution we were expressing showed the influence the MRI model was exercising in our use of the solution-focused model in this instance).

It turned out that the mother was as interested in our caution as Steve de Shazer would likely have been (if perhaps he'd watching from behind the screen). The mother's solution was to put all of this in place in one fell swoop, and in the following session two weeks later she described how she had done everything she had talked about. The son's behaviour had improved, and she had decided that she now also intended to move to a new house to consolidate the sense of a fresh start. We saw the mother on two more occasions, she reported new steps she was taking and described continued improvements in her life and the son's behaviour. The referring officer from the child welfare agency was delighted. John and I were rather shell-shocked. However, we certainly knew enough of the brief tradition to apply its key maxim regarding change: 'if it works do more of it'.

On the strength of this case, I was moved to write to Steve de Shazer inviting him to come to Australia to run workshops and join us in our clinical practice. Surprise and shock was to be the order of that period of my career because I received a prompt affirmative reply that was to see de Shazer and his colleague and wife Insoo Kim Berg joining us in Perth less than twelve months later. The realization that in a short space of time the innovators of a model are going to be sitting behind the one-way mirror observing one's own application of their model is perhaps the best incentive and imperative I know to get up to speed in a therapeutic approach. From the impetus of that first case and that first contact with Steve and Insoo, I began something like a seven-year obsession with 'pure' solution-focused brief therapy, during which time I tried to do every case I worked with as closely as I could to the model, as I understood it.

During that same period of the nineties, solution-focused brief therapy became hot property in the helping professions; it was cast as the latest and most effective form of therapy. The popularity of the approach was enhanced by the fact that it is readily teachable through the various well-known techniques, including miracle, scaling and exception questions, compliments, and end of session messages. This momentum was further enhanced in the US by the model's ready adoption in the managed care environment. The title of the approach solution/focused/brief/therapy whatever else it might mean is, in its own right, a wonderful marketing strategy.

The momentum the model and its proponents had generated was always going to draw attention and criticism; and so, for example the approach was described as "relentlessly positive" (Efran and Schenken, 1993), contributing to a "manualization" (Griffith and Griffith, 1992) of therapy and of being capable of generating therapists that are "solution-forced" (Nyland and Corsiglia, 1994).

The clear clinical methodology and techniques of both brief therapy models (see Weakland, et. al., 1974, Fisch, Weakland and Segal, 1983, de Shazer et. al., 1986, and Turnell and Hopwood 1994, a, b and c.) is one of the great strengths of this tradition. Other approaches to therapy place more emphasis on theory about human problems and their causation or may require extensive periods of self-exploration and reflection, preparatory to developing clinical skills. The problem though, faced by every helping professional as soon as they are in their first job, is finding oneself wondering, what exactly do I do and say to the client? Brief therapy is very attractive since it offers specific skills

readily applicable to clinical work and case practice. This very significant strength of brief therapy can also be a weakness or vulnerability. The brief therapy tradition can find itself being reduced to or seen primarily as a formulaic bag of tricks, questions, techniques, strategies and interventions. As well as critique from outside the brief therapy tradition the risk of an excessive and exclusive focus on technique has been offered by insiders. Scott Miller (1994), for example, wrote a short article in 1994 called, 'No more bells and whistles'. Eve Lipchik, who is an often over-looked third co-creator of the approach expressed her own concerns in her book 'Beyond technique in solution-focused therapy', (Lipchik, 2002). In a similar vein, Eve and I wrote a paper together called 'The role of empathy in brief therapy' (Turnell and Lipchik, 1990).

The reality is the strategies and questions do not always work; sometimes the questions simply do not get the expected solution-building answers, carefully created strategic interventions are ignored and compliments fall flat. For example, a mother to whom I asked a miracle question broke down and through tears said, 'how can I hope for anything when my oldest daughter (17) is in public housing with a child of her own and my youngest (14) is on the streets doing drugs?' In another situation, a mother came to see me because her daughter (14) had run off with a 19-year-old young man for a weekend of sex, alcohol, and drug use. The mother had in the intervening period dealt with the event in numerous ways including, confronting the 19-year-old and his parents, letting them know if he came near her daughter again, she would go to the police, grounding her daughter (and enforcing this) and also spending considerable time with her daughter to understand what had triggered this behaviour. These actions resulted in mother and daughter doing several new things together and in the young woman commencing contraceptives. In solution-focused terms here was not just one exception but a whole slew of them. However, as I tried to expand these and give compliments to the mother for her actions, the mother became more skeptical responding with continual 'yes buts'.

At times like this, a therapist is faced with the pragmatic question 'the techniques aren't quite playing out the way I understood they should, what do I do now?'. More importantly, I found myself wondering, what is the substance behind the techniques? At this time, I had the opportunity to work and write with Eve Lipchik and she was asking and thinking about similar questions. Eve's own ideas came to maturity in her 'Beyond technique' book she was later to publish.

My own professional journey took me into seeking to apply the brief therapy models in a cross-cultural setting working with refugees who have survived torture and co-creating an approach built upon the brief therapy tradition for use in child protection investigation and casework (Turnell and Edwards, 1997, 1999; Turnell and Murphy, 2017). In this work I was wrestling with the question, beyond the techniques what are the unique and valuable elements of the brief therapy tradition I want to draw upon in working with people who have survived torture and that I want to offer to statutory child protection practitioners? At no stage in this journey, which continues to this day have I wanted to abandon the brief therapies, rather my experiences have continually prompted a more careful revisiting and reconsideration of the thinking and assumptions that underpin the tradition.

**The brief therapy tradition**

The foundational ideas of brief therapy are significantly different to other forms of therapy. The brief tradition since its inception has always adopted a non-normative and non-pathological perspective in how the therapist approaches the client. By non-normative brief therapists mean they 'use no criteria to judge the health or normality of an individual or family . . . we do not regard any particular way of functioning, relating or living as a problem if the client is not expressing discontent with it'. In adopting a non-pathological perspective brief therapists mean that they do not 'imply that individuals or families have anything inherently wrong with them', (Fisch, 1988, p78 and 79). In short, brief therapists, have never been that disposed towards something like the DSM V.

Brief therapists also have little interest in developing etiologies about the causation of problems. de Shazer (1991a) suggests that in a systemic world causation is so complex that it is in fact, unknowable. When asked about using hypotheses in the therapeutic endeavour, Steve de Shazer was known to suggest 'if you feel a hypothesis coming on take two aspirins and lie down' (1991b). Likewise, insight is not regarded as necessary condition of change. Being unsure what causes a problem, brief therapists could hardly privilege this position.

Eschewing the development of expertise regarding causation and diagnosis, brief therapy has evolved a seemingly simple framework of three rules that underpin our ideas about problems and their resolution, that focus attention on the pragmatic endeavour of creating change:

Rule one, *if it ain't broke don't fix it*

Rule two, *once you know what works do more of it*

Rule three, *if it doesn't work don't do it again: do something different.*

At first glance, these rules are like motherhood statements and many, if not all professionals would probably say they agree with them. The real challenge of these simple propositions is confronted time and again when seeking to apply them in practice. The case of a chronically truanting teenage boy, bought to therapy by his parents is a good example. The parents had responded to the boy's truanting by continually lecturing the boy regarding the error of his ways. Sometimes they themselves did the lecturing and hectoring or when someone else got involved in the problem for example the truancy officer, the Principle and the police, they would take on the same role. This approach wasn't working but the parents and others kept at it again and again which is in fact brief therapy's principal speculation about how problems are maintained.

In this case, my team and I had gathered the detail regarding the problem in a very MRI-type manner, but then in a solution-focused manner that was the norm in the early 90's I had inquired about exceptions, asking about times when the boy did go to school. The parents eventually recalled a day several weeks previously when the father had to urgently go to his work and the mother unexpectedly had to take her daughter to the hospital, all before 7.30am. The mother had woken the boy as she rushed out the door, telling him he would have to organise himself. The boy had breakfasted, gathered a lunch of sorts and taken himself to school. *Here* was something different that did seem to work, so implementing rule two with the guidance of the team I asked the parents to ignore the boy each morning for a week as an experiment. The boy attended three of the following five school days and in subsequent weeks returned to school full time.

It's often hard to believe the change can be as simple as this and I most certainly found it so. A continual challenge of brief therapy is to try to keep clinical practice as simple as this. Seeing this family, many therapists would have broken rule one (or at least been tempted to), and instead of focusing on the boy's truancy (the problem the parents brought), turn their attention to the conflict that could be seen in the parent's relationship. It would have been easy to cast this as the 'real' problem', and the truancy as symptomatic of a 'breakdown' in the marital relationship.

Rule one, when broken, makes it impossible to follow two and three and is probably the most challenging to adhere to. I have worked with a man who, when tortured, was forced to rape a fellow detainee; he had never told his wife of the torture or what he was forced to do. When therapy began, he and his wife had not been sleeping together for more than five years. By focusing on his picture of the future he wanted through detailed questioning using a form of the 'miracle question' and then inviting the man to begin to enact this vision the man made a successful recovery from the PTSD symptoms and recommenced his sexual relationship with his wife. This occurred without ever disclosing to his wife anything about the rape or unpacking very much about his feelings of shame

and self-loathing he initially told me he had experienced over many years. These would have been things many therapists would have seen as essential to change.

This sort of thinking perhaps reflects the anarchistic temperament of brief therapists; we like to see *ourselves* (as well as our clients) as doing something different. Expressing different foundational ideas to the mainstream, brief therapists in my view have sometimes fallen into the trap of being holier than thou about our assumptions. It is good that brief therapists keep posing non-normative challenges to the broader field, however, when we start to be dismissive of others and think we have all the answers, this is not in my view ultimately productive for either ourselves, our clients or the field.

<The fact that both Paul Watzlawick and also Steve de Shazer have long been leaders in the engagement of the helping professions with constructivist thinking, should have made brief therapists leery of reifying our ideas and practice.>

In my view this sort of arrogance can be largely dissolved if we as brief therapists were to see our foundational ideas not as "assumptions" that we have fully made manifest (as some brief therapy texts seem to communicate), but rather as "aspirations". Brief therapy ideas are ways of thinking which are not only a challenge for the broader field but also - perhaps even more so - an ongoing challenge for those of us who have generated, revivify, and propagate them. Under certain circumstances everybody gets normative, I have for example, seen Insoo Kim Berg give advice to the husband of a philandering wife that he should not be content to accept his wife's promiscuous behaviour (at which point Steve de Shazer exasperatedly walked out from behind the screen). A controlling and dominating male or female will push the normative buttons of many of us (this is certainly true for me). More than that violence and abuse is not acceptable, while it is absolutely the case that what constitutes abuse is socially constructed, I have for 30 years dedicated the majority of my professional energies to creating a model for child protection services that most definitely requires the clear articulation of norms about what constitutes abuse and neglect.

I suspect that Dick Fisch, the founder of the focused problem-resolution model of brief therapy quoted earlier, would be non-normatively accepting of a parent who is abusing a child or a husband battering his wife (brief therapy has been critiqued for being inattentive to such things, see Shoham, Rohrbaugh & Patterson, 1995). My colleague, Steve Edwards and I have faced this latter issue during the five years we have developed a model of practice for child protection investigation and casework. This model integrates the need for child protection workers to apply norms regarding the abuse/ neglect and what needs to happen so everyone knows the child is safe *alongside* the challenge of being responsive to family members' perspectives, achievements and goals (Turnell and Edwards, 1997).

My point then is to say that I doubt that any brief therapist fully manifests any, let alone all, of our assumptions all of the time; therefore it is much more meaningful and realistic in my view to see them as "aspirations".

As I have grappled with my own integration of these ideas, I have come to the conclusion that brief therapists should approach their clients and what they think they know about them from a position of humility (Turnell, in press). Humility about what we know (I continue to be uncomfortable with the constructivist idea of 'not knowing' since I am of the view that we do know things) makes most sense for me since brief therapists also consider that we never actually understand our clients, rather we arrive at our own misunderstanding of them (de Shazer 1991a) and because client are the experts on their own lives and what is best for them.

**Conclusion**

A final case example about my own application of this thinking is perhaps an appropriate conclusion.

I met regularly over a period of seven months (not so brief) with a refugee we will call Asif who had been imprisoned and tortured and then further traumatized by the experience of five years in a brutal refugee camp. At the first contact, the refugee seemed largely confused about why he was seeing a therapist, let alone what it might achieve for him. The referring professional who came to that first session was clearer; she was very worried about the man who she described as having considerable difficulties in sleeping, was very fearful and refused contact with his fellow country men and women, in significant debt, disgruntled with his new wife, refused to undertake his required English classes, he moved home continually, and though he had secured several jobs had lost each of them within a week. It also seemed he was depressed.

The man spoke little in the first session in which the referring professional was present, but the in the next session, the man said *he* was only concerned about drinking a bottle or more of spirits each day which ate up all or most of his social security income and showed him that as a man he was weak. He scaled his life at somewhere between a three-and-a-half and four out of 10. When asked he readily proffered that his solution to this behaviour was to recommence painting, informing me he was a fine arts graduate of his country's leading university. He needed, he said, assistance to get materials to start painting again and wanted to gain a sense of the fine arts scene in Australia of which he knew nothing. At this stage, part of me wondered whether this man was spinning me a story, since what I had seen of him seemed to provide little support for the proposal that he was a competent artist, and the interpreter was clearly sceptical. I decided though to stay true to the brief tradition and take him seriously. I took him to a room in our agency where we had art supplies and said he could take whatever he wanted and a little later assisted him to buy some basic arts materials. I also organised for him to meet with several well-established painters who I knew since he said he wanted to meet other artists but not artists from the recently arrived migrant community. Within a matter of weeks, the man had stopped drinking entirely, replacing this with extended daily periods of painting. Five months later he had held an exhibition displaying 25 of his works and sold paintings worth several thousands of dollars. Interestingly, I felt this sort of progress must be worth at least 2 to 3 points improvement on the progress scale, my client though felt his life remained at about 3 and half to 4. He said he still felt like a stranger in a strange land. The man was happy with what he had achieved, and he also knew he had more to do to settle in this country though he did feel comfortable proceeding without my assistance.

For me there is something ironic that I concluded my involvement with this man without my beloved scaling questions revealing any progress. This caused me to wonder; what was it that was achieved? I was once again reminded to retain a sense of humility about what I think I do. My colleague Larry Hopwood who had worked at the Brief Therapy Centre in Milwaukee from 1987 to 1992 helped me too observing that in working with homeless man he had found it not uncommon that their scaling of their lives would not change but they would report being happier . . . Larry framed this as a ‘bigger two’. I was also reminded of a maxim John Weakland was fond of: "life is one damn thing after the other, you only need a therapist when it becomes the same damn thing over and over". Asif's life had certainly moved out of the cycle of ‘the same damn thing’ over and over and by Weakland's criteria and the client's, he was ready to move on.

I have tried here to do some justice to and exemplify the rich tradition of thinking that underlies the brief therapy models. It is brief therapy thinking that in my view is the tradition’s most substantive contribution to the field of psychotherapy. I think it is important that for the broader field to engage with the brief therapy tradition that we brief therapists don't become arrogant about our foundational ideas. As an alternative I suggest we acknowledge that even experienced brief therapists will continually face the challenge of utilising and integrating our own philosophy.

As my own expertise as a brief therapist has increased the foundational ideas continue to engage and challenge me and cause me to increasingly adopt a position of humility about what I think I know.

Over more than thirty years I have been energised by this process and I can only see my extended journey in the brief tradition, continuing.

**References**


Cade, B. and O' Hanlon, W., (1993). *A brief guide to brief therapy.* New York, WW Norton.

De Shazer., Berg I.K., Lipchik E., Nunnally E., Molnar A., Gingerich W.C., and Weiner-Davis M. (1986) 'Brief therapy: focused solution development' *Family Process,* 25, 207-221.

De Shazer S., (1991a) *Putting Difference to Work.* New York, WW Norton.

De Shazer S., (1991b) One-day clinical demonstration workshop at the William Street Family Therapy Centre, Perth, Western Australia, April 29th, 1991.

Efran, J. and Schenken, M. (1993). A potpourri of solutions, *Family Therapy Networker*, May/June 71 - 74.

Fisch R., Weakland J.H. & Segal L., (1983). *The tactics of change: doing therapy briefly.* San Francisco: Jossey-Bass.

Fisch R. (1988)., Training in the brief therapy model. In H. Liddle, D. Breunlin, & R. Schwartz (Eds.), *Handbook of family therapy training and supervision* (pp. 78-92), New York, Guildford.

Griffith, J. and Griffith, M., (1992). "Owning one's own epistimemological stance in therapy", *Dulwich Centre Newsletter*, 1992, No 1 5 -11.

Lipchik, E., (2002). Beyond technique in solution-focused therapy, New York: Guilford.

Miller S.D., (1994). No more bells and whistles. *The Family Therapy Networker*. March/April. pp 53-63.

Nylund D. and Corsiglia V., (1994), Becoming solution-~~focused~~ forced in brief therapy: remembering something important we already knew, *Journal of Systemic Therapies*, Vol 13, No 1, 1994.

Shoham, V., Rohrbaugh, M. & Patterson, J., (1995). Problem and solution-focused couple therapies: The MRI and Milwaukee models. in N.S. Jacobson & A.S. Gurman (eds.), *Clinical handbook of marital therapy (2nd edition)*. New York, Guildford.

Smart, R., (1994), "Expertosis: is it catching?", *The Australian and New Zealand Journal of Family Therapy* 15, 1 - 9.

Turnell, A. & Hopwood, L., (1994a), "Solution-focused brief therapy A first session outline" *Case Studies in Brief and Family Therapy,* Vol 8(2);

Turnell, A. & Hopwood, L., (1994b) "Solution-focused brief therapy An outline for second and subsequent sessions" *Case Studies in Brief and Family Therapy,* Vol 8(2);

Turnell A. & Hopwood L., (1994c) "Solution-focused brief therapy Beyond the first few sessions - Ideas for 'stuck' cases and case closure" *Case Studies in Brief and Family Therapy,* Vol 8(2);

Turnell, A. and Edwards, E., (1997). Aspiring to Partnership. The Signs of Safety approach to child protection. *Child Abuse Review, 6;* 191- 202.

Turnell, A. and Edwards, E. (1999) *Signs of Safety*, New York: Norton.

Turnell, A. and Lipchik, E., (1999) The role of empathy in brief therapy: the overlooked but vital context, *Australia and New Zealand Journal of Family Therapy*, *20*(4); 177-182.

Turnell, A. and Murphy, T., (2017). *Signs of Safety briefing paper v4.0.* Perth: Resolutions. Available at:

Weakland J.H., Watzlawick P., Fisch R., & Bodin A., (1974). Brief therapy: focused problem resolution, *Family Process*, 13, 141-168.