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Keys to Solution
in Brief
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COMPLAINTS: DAMN BAD LUCK

WORKING WITH A TEAM: STIMULATING BUT NOT NECESSARY

The first phase of my work involved teaching myself how to do brief therapy with the aid of Erickson's work (Haley, 1967b) and Haley's (1963), and the second phase involved working in front of a one-way mirror with observers behind. Before and after the session we would talk about the therapy, but during the session they had their job while I had mine. In 1976, I discovered a group of like-minded therapists in Milwaukee who eventually founded the Brief Family Therapy Center with me in 1978. For the first time the people behind the mirror did not ask, "How come you did that?" Rather, they wondered about how we might teach people how to work effectively and research this way of working.

Although our philosophies and clinical methods were quite similar, those of us who founded BFTC did have some differences in our language. I was influenced more by the work of Milton Erickson than they were, while they were more influenced by family therapy. In order to pragmatically settle our language differences, we developed a team approach using a regularly scheduled intra-session break to consult with each other about the design of the intervention, which one of us would deliver upon returning to the therapy room. Prior to our agreement on this procedure, I sometimes took a break to hurriedly consult *Advanced Techniques* (Haley, 1967b) for a hint,

or to get help from behind the mirror when I felt too stuck. Quite unknown to us, the Milan group had developed a similar format (Selvini-Palazzoli, Boscolo, Cecchin, and Prata, 1978).

Behind the mirror, we developed maps about the complaints: behavior and meaning or context, the goals, and the potential areas for initiating change. The interventions that we used were structured in such a way that cooperation between client and therapist was promoted. *Patterns of Brief Family Therapy* (de Shazer, 1982a) describes this phase, during which the team members behind the mirror became more and more active participants in the doing of the therapy. Although working solo was briefly described, the focus was clearly on the team's approach to clinical research, practice, and model-building. This, perhaps, promoted the mistaken idea that a team is necessary for "working this way." The team's usefulness lies in research, experimentation, teaching, training, model-building, but, alas, it is not a practical approach for most therapists to use in doing therapy. A team is not *necessary* for working this way. Useful, certainly! Stimulating, certainly!

When several therapists observe the same case from behind a mirror, each one contributes his or her own knowledge about troublesome situations and the knowledge of solutions based on previous results. One might read the "data" as an example of Situation A, while another might see it as Situation B, and yet a third might map it as Situation R. If the experience is a busman's holiday, then A, B, and R can be taken as just a set of maps with interesting differences. Competition, should it arise, might well be friendly and humorous. However, when observing a case together becomes an ongoing situation that the group wants to continue, then a foundation of cooperation is necessary for the development of a team.

The Poly-ocular View

Bateson (1979) described ideas as developing from having two or more descriptions of the same process, pattern, system, or sequence that are coded or collected differently. A

bonus – the idea – develops out of the differences between or among descriptions. Metaphorically, this process is similar to that of depth perception. The right eye sees things in its way, while simultaneously the left eye sees things differently. The difference between the two eyes' views leads to the bonus of depth perception. Clearly, it is not that the right eye is correct while the left eye is wrong or vice versa.

When a group of therapists is behind the mirror, each codes or collects the information differently. It is not just a matter of selecting what to note from a heap of available information. Rather, the therapist's model, which includes a set of assumptions, determines how the therapist will construct or interpret what he or she has seen. Each therapist in the group sees something different and, at least metaphorically, a bonus develops which gives the group more depth or ideas. Importantly, there is no sense in which one therapist's construction is "right" while the others' ideas are "wrong." Their views are just different; these differences are useful and prompt creativity.

The Development of a Team

Axelrod's work (1984) confirms our experience that, when the future of the group is important to the group, then cooperation will evolve and thus the group will become a team. Of course, each member of the team must have a high level of trust and confidence in the other members' ability; otherwise the team will degenerate into factionalism and competition and be ineffective. Early on, the BFTC team had members from various "schools" and it was necessary to dampen the factionalism so that the work could be facilitated. We discovered that our productivity and creativity increased as we continued to work together and, as Ouchi (1981) suggests, a culture developed based on the philosophy of the team.

We took several steps to facilitate the development of the

team. First, we made a conscious decision to isolate ourselves from other groups of family therapists once we became a "free-standing" center. This allowed us to have the freedom to be creative in our therapy. Secondly, we each redesigned our interviewing techniques. Primarily, this meant a process of simplification, eliminating much of what was idiosyncratic to the various schools, i.e., one gave up doing "enactments" while another gave up doing "sculpting" and we all gave up "instant relabeling." Although individual variations continued, we developed a consistency of interviewing techniques which makes the tasks behind the mirror easier to perform.

Our purpose in using the team was never to develop a team approach to therapy. Rather, we wanted to find out as much as we could about what we did that was effective. Fortunately, we all agreed that reported and/or observed changes in behavior within the complaint pattern and the end of the complaint (i.e., the "symptoms" stopped) were good enough indicators of success. This, of course, necessitated follow-up contacts, which have been routine from the start. In addition, we studied the short-range effects of our interventions. At the end of a session, we generally gave some sort of homework. Frequently this included a behavioral task which was checked on as the first order of business in the following session.

We quickly found that the rate of task performance was higher than it had seemed prior to the development of the team and the new procedures (de Shazer, 1982a). We also found that we could get as much information when the client did not perform the task as when the client did perform the task. Not only that, we also found that accepting nonperformance as a message about the clients' way of doing things (rather than as a sign of "resistance") allowed us to develop a cooperating relationship with clients which might not include task assignments. This was a shock to us because we had assumed that tasks were almost always necessary to achieve behavioral change. Thus, we became more successful with more clients in a fewer number of sessions.

COMPLAINTS AND HOW THEY GET THAT WAY

Therapists need to make some assumptions about the construction of complaints and the nature of solutions in order to do their job. Although the following set of assumptions is somewhat idiosyncratic, nonetheless there is a fairly high degree of similarity with Watzlawick et al. (1974) and with Haley (1963, 1973). Some aspects of the following assumptions about complaint construction lead inevitably to ways of constructing solutions. Problem-solving has been studied experimentally (see Mayer, 1983, for an overview), and this work can be suggestive about the nature of complaints and about the "unconstruction" of problems.

These assumptions can be seen to operate like the rules for mapping complaints and problems. If a therapist uses a certain set of assumptions, say "Y," then a certain type of map will develop. Let's say that the therapist assumes that symptoms have a systemic function, i.e., holding the family together. In this case he will attempt to draw a map which suggests to him how that function can be served in that system without the symptom. However, if the therapist uses set "X," a different type of map will develop. For instance, the therapist might assume that a symptom is just a matter of "bad luck" and does not serve a function; therefore, he will draw a different map that suggests eliminating the symptom by substituting what might have happened if there had been some "good luck."

Although the following assumptions seem central and basic, there are probably others (on some "deeper" levels) underlying the practice of brief family therapy. Although all the assumptions work together to influence practice, some individually have the "power" or "strength" to directly influence or even prescribe specific therapeutic interventions, while others have the "power" to directly inform the therapist about how to construct a problem in such a way that solutions develop. In certain situations, one particular assumption might seem more directly influential, while in other situations the interaction between two or more assumptions can be seen more clearly. A hypothetical model of complaints will be in-

terwoven with the descriptions of our assumptions so that reasoning behind the assumptions is clarified.

Assumption One

Complaints involve behavior brought about by the client's world view.

The first step in building a complaint seems relatively small, although the consequences can be rather disproportionate. It is as if people say, "I either behave in 'A' fashion or I believe 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. Hypothetically, a complaint can be constructed out of just about anything or even nothing (Watzlawick, 1983), somewhat in the following (undoubtedly oversimplified) manner.

A Model of Complaints, Part One

Bed-wetting is a behavior that is relatively common and rather normal for children, which, under various conditions, can easily become a complaint. When a child wets the bed, the parent makes a decision every time (1) about how to view this behavior: (a) normal behavior or (b) problematic behavior. If the decision is that it is normal, then things go on, "one damn thing after another." However, if decision (1b) is made, the following tree develops. Decision (1b) requires decision (2): that the bed-wetting is (a) a physical problem or (b) a psychological problem. If the decision is that the child has a physical problem (2a), the next step is relatively obvious, although physical intervention may not prove to be helpful. If (2b) is the choice, the child with a psychological problem can be seen as (3) either (a) bad or (b) mad.

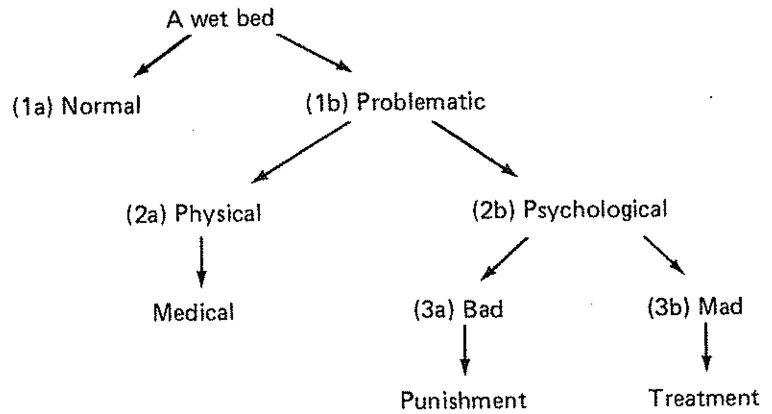

Figure 2.1 Complaint Tree

In the event that the parent decides that the child's problem is psychological (2b), the next step is not so clear. If the child is seen as "bad" (3a), then various punishments might be applied in the effort to stop the bad behavior. If the child is seen as "mad" (3b), then any treatment, professional or not, might be tried. Of course, the situation often is not this simple.

At any decision point (1, 2, or 3), a child with two parents might have one parent picking "a" and the other picking "b," and some parents might not be able to choose between "a" and "b." In this way the child's bed-wetting can be seen as if "coming between the parents," which is a map used by many therapists and thus an even bigger problem (4) can evolve: either (a) mother is right or (b) father is right. In some families, if one parent "wins," the whole tree (1, 2, and 3) might be gone through; then, if the "winner" is proved wrong, the other parent might take a turn at trying to solve the complaint. Even in-laws might get involved in defining the situation, potentially adding chaos to confusion.

Another possible branching (5) occurs when the question arises, "Who is to blame for the problem?" It might be (a) the child's fault or (b) the parents' fault. If there are two parents,

it can be either (a) mother's fault or (b) father's fault. Complaints can be constructed in various ways depending upon who is at fault, or how the complaint is framed.

Assumption Two

> *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 (Watzlawick et al., 1974) because of the rejected and forbidden half of the either/or premise.*

When driving we reach many decision points, "Should I turn right or should I turn left?" If one turns right, everything on the route to the left remains unsampled and unexperienced. In an interactive system such as a family, essentially similar decision points can occur over and over ("The

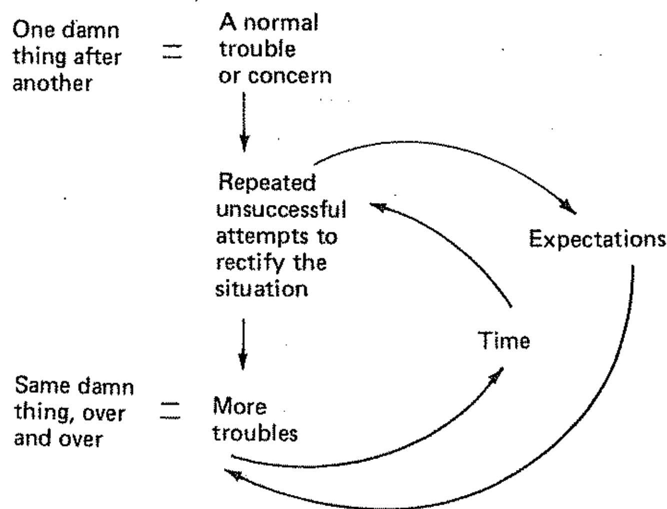

Figure 2.2 The Process of Complaint Development

bed is wet again."). However, once the "right" decision has been reached, the response to the wet bed becomes as habitual as the wet bed. People do not stop to remake the decision and see each wet bed as distinct. Rather, they see it as, "Here we go again." Brief therapists call this, "The same damn thing over and over."

A Model of Complaints, Part Two

Once the "right" decision is made (e.g., bed-wetting is a problem), then people set about trying to solve it. For instance, if the child is framed as willfully wetting (bad), then the child needs to be punished. Punishment can take many forms, and it seems to escalate when it does not work. First one punishment is tried, then either more of the same punishment or an (apparently) different punishment (which is logically more of the same) is tried. Wet beds continue to follow punishments, while punishments continue to follow wet beds in a "never ending" round of frustration and perhaps anger. Since the initial decision was the only "right" one, "the same damn thing over and over" is perfectly logical: There must be an "effective" punishment. People seem to think that as long as they persist, it will be found!

The cycle of punishment/wet bed/punishment continues with each step escalating in turn, but the decision "this is a behavior that needs punishment" is frequently not called into question. On the "either/or" tree, the relabeling of the child as "mad" or "normal" has been excluded by the decision and, therefore, so have all the many possible different things parents might do which are not (logically identical with the) punishments.

Once this "either/or" construction is recognized, it follows that *any* "non-A" behavior might make enough of a difference (by lifting people out of their rigidity) to provide a solution. In this sense, "either/or" thinking can be seen as the root of many clients' complaints. This line of thinking involves standard binary logic, and systemic situations do not seem to operate according to the rules of binary logic (Wilden, 1980).

Therefore, "systemic or cybernetic logic" is called fo what Bateson (1979) calls the "twin stochastic proce: more simply, randomness.

RECONSTRUCTING COMPLAINTS INTO PROBLEMS

As we have continued to work together, our interviewing style has continued to simplify as we developed a poly-ocular view of the situation: Each therapist maps the same situation differently (but not competitively). In our opinion, the multiple maps enhance and enrich the possibility of change. Clients' complaints are usually rather complex constructions involving many elements, any one of which they may emphasize more than the others. We have learned that complaints generally include:

1. a bit or sequence of behavior;
2. the meanings ascribed to the situation;
3. the frequency with which the complaint happens;
4. the physical location in which the complaint happens;
5. the degree to which the complaint is involuntary;
6. significant others involved in the complaint directly or indirectly;
7. the question of who or what is to blame;
8. environmental factors such as jobs, economic status, living space, etc.;
9. the physiological or feeling state involved;
10. the past;
11. dire predictions of the future; and
12. utopian expectations.

If there are two or more people talking to the therapist, they may agree or disagree about the definition, importance, and significance of any of the elements. Fortunately, couples and families are micro-cultures; therefore, the elements deemed important often overlap and each element is somehow connected to one or more of the other elements.

Each of these elements seems to be connected to all of the other elements in the complaint construction in such a way that they define each other. Consequently, a change in one can "lead to" changes in the others. The same event will be defined in various ways due to the various other factors involved in the situation. For instance, we all know that if the car does not start, our reaction will differ according to how we feel. If we are already "down," the stalled car will be just one more thing going wrong. But if we are "on top of the world," then the stalled car will be nothing more than a minor inconvenience. From situation to situation, some elements may be more connected or more pertinent than others. For example, frequently clients complain of feeling (usually phrased as "being") depressed. Some will immediately be able to describe the behavioral aspects of it, while others find that difficult or impossible; therefore, they will focus on the involuntary aspects. Some will easily describe significant others who are trying to cheer them up (accidentally making it worse), while others find that difficult and instead bemoan the fact that historically they have good reasons to be depressed. Still others are depressed about something they are sure is going to happen (or not happen) in the future.

During the interview, the therapist asks questions about each of the areas listed above and illustrated in Figure 2.3, attempting to define the problem in such a way that a solution can develop. Each client seems to have "favorite" factor(s) that he or she chooses to emphasize in the description of the problem. Likewise, the therapists behind the mirror map the information in ways which they deem important (using similar categories). Our collective experience since 1977 indicates that any of the 12 factors can be subject to change, and the change of one factor can be followed by changes in the others.

Although there is no one-to-one relationship between the building blocks used to construct complaints and those used to construct interventions, nonetheless what clients emphasize strongly suggests possibilities. For instance, if the complaint is described as happening only in one particular place,

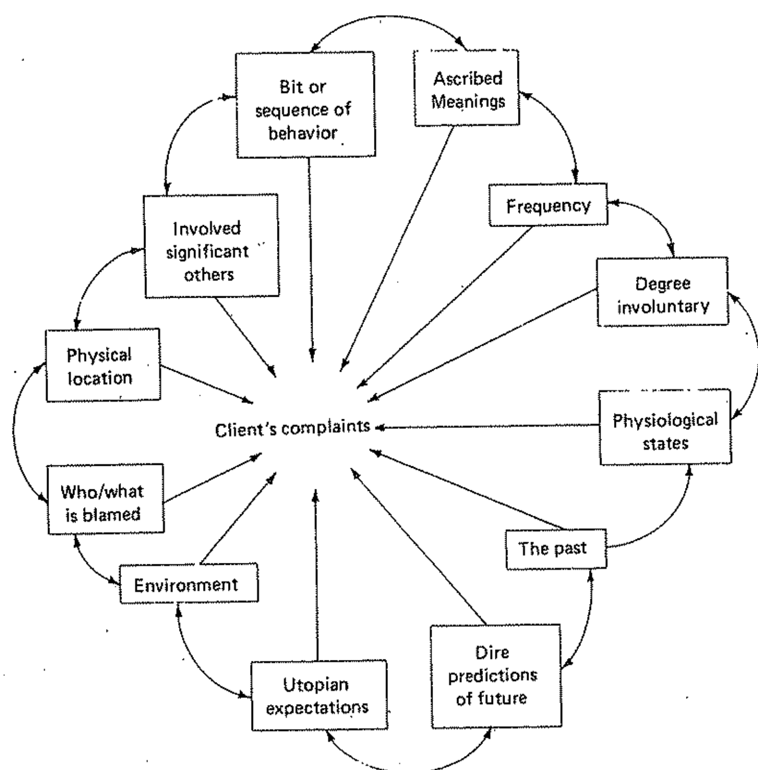

Figure 2.3 The Building Blocks of Complaints

then task assignments – particularly anything directly to do with the complaint behaviors themselves – need to be scheduled to happen in some other location in order to assure some minimal difference. For example, couples sometimes report that their fights happen only in the kitchen. Many behaviors seem to be situationally specific and the therapist can simply prescribe that the next fight occur in the bedroom. There is a good chance that the different "stage" will prompt different behavior. They might make up with a good sexual experience. Or, if the complaint involves a relationship to some person not

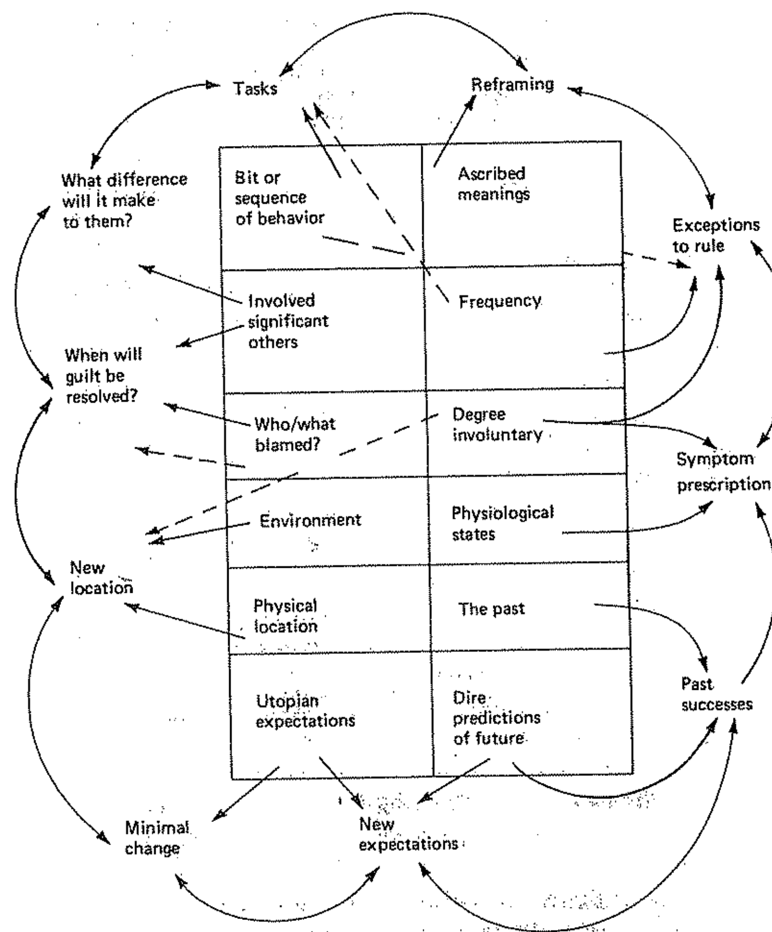

Figure 2.4 Transforming Complaints Toward Solution

in the therapy room, then a major question revolves around how the other person(s) will know that a change has occurred.

A Metaphor

These 12 factors are like 12 different doors leading to solutions. Each complaint is different, and the various potential

solutions are the doors that have the better oiled locks and hinges. Various doors may lead to the same solutions or different solutions, while the same door may lead to different solutions. Any door may lead to a blind alley. Together, therapist and client have to figure out which door is the most likely to be the easiest to open. Since they are all locked with different locks, needing different keys (otherwise the client would have found his way out), a skeleton key would be useful.

Behind the mirror, each team member maps the client's presentation in a different way. If the team is large enough or experienced enough, any door and each of the doors might play an important role in the maps drawn by an individual therapist. For instance, a behaviorist probably would want to use the behavioral door to the solution but, for any given client, this door might be really stuck and, therefore, therapy might fail. However, when there is a team behind the mirror, the behaviorist might learn that other doors might be easier to open. If there is a team of three and one client, then there are at least four different realities made out of this material and we have a poly-ocular view.

Importantly, it is not that the team members just see things from different angles or perspectives. Rather, they each construct a different therapeutic reality based on the information provided by the client during the interview. One member of the team may map the situation by focusing on the client's complaint as related to another person, while another may map the information in such a way that the client's reaction to feeling states is emphasized, and another may emphasize the client's perception of the involuntary nature of the complaint. Each of these separately points to particular potential solutions. As the team discusses the problem construction, a different approach is often noticed. For instance, with this combination of individual views, the team might develop the idea that the most potential for change lies in the differences of location – where the complaint happens and where it does not.

Each client constructs the complaint reality out of these 12 factors, and each therapist constructs the therapeutic

reality (complaint plus potential solutions) out of the same materials, but with a focus on solution. Because of the different emphases in the therapists' constructions, the therapeutic problem will be "different" from the complaint construction. It is this difference which leads to solution.

As the therapeutic reality is constructed, the question about which door is most likely to be useful looms large. This can sometimes prove troublesome when the client's least favorite door (i.e., behavior change) is the one the therapists think will most easily lead to solutions. So, the therapist needs to find out which are the favored doors, the best indicator for that being *how* the client describes the complaint. For example, if the client is complaining about feeling depressed because of his past (and, therefore, he cannot help himself), then behavioral tasks might be the least likely entry, even though they might be the easiest for the therapist to devise and might lead to the quickest solutions. In this case, the client's description and his language (Watzlawick et al., 1974) suggest that the depression is involuntary and that he blames it on his past actions or on others. Two types of keys (therapeutic interventions) might prove useful in this case. One is called a "symptom prescription" in which the therapist suggests that the client force himself to be more depressed (the "involuntary" door) in order to become less depressed. The other key, "reframing," would involve ascribing different frames or meanings to the depression in such a way that the client will find it beginning to make more sense to not be depressed (the "ascribed meanings" door). (The distinction between these two keys is not always clear-cut, pointing to the skeleton key aspect of at least some interventions.) Although these keys might work well, the locks and hinges might be rusty and, therefore, solutions might be slow in developing. Which door to use? Which key will be useful?

In many cases, this locked room mystery is approached by the therapist's gathering as much information as possible about the 12 elements or about what it is that keeps the client stuck in the complaint. Reasonably, therapists (and other troubleshooters) often think that more information will be

useful, which it is in some situations. However, somewhere along the line more information can cross a barrier and usefulness can turn to confusion. In order to find a solution, the question is not, "How much information is needed?" but rather, "What kind of information is needed?"

THE CONSTRUCTION OF SOLUTIONS

Assumption Three

> *Minimal changes are needed to initiate solving complaints and, once the change is initiated (the therapists' task), further changes will be generated by the client (the "ripple effect" [Spiegel and Linn, 1969]).*

The way change develops is similar to the way a small error can end up making a big difference. If a pilot upon leaving New York for San Francisco makes a one degree error in direction, when he should be in San Francisco he will instead be considerably off course.

A simple rule might be proposed here: Clients frequently present their complaint in either/or terms and, in these situations, it can be useful for the therapist to construct the problem in both/and terms. The switch from either/or to both/and is useful on the law-schema and map-making levels and, as a heuristic, on the action-schema level. The clinical techniques follow not only from successful practice but also from the more philosophical and conceptual work on "systems" (Wilden, 1980).

A Model of Complaints, Part Three

If the parent(s) of the bed wetter are to solve this, they need to break the repeating cycle. However, anything other than punishments has been excluded by the earlier decisions. It is exactly these excluded and forbidden responses which stand a chance of solving the problem (stopping both the parental approach and the wet beds). For instance, rewarding dry beds, or ignoring wet beds, or teaching the child to wash

his wet bedding, or hanging up a sign in the child's room which says, "Wet The Bed Tonight" – all have worked in some situations. The point is that *any* new behavior stands a chance of being different enough, and *all* these have been forbidden by the "same damn thing" rule after the "right" decision was made.

In choosing a new response, we find it useful to look for exceptions to the rule. It seems overly simple-minded to say that nothing is ever exactly like anything else. If the child's bed was wet last night, the night before, and the night before, etc. – which causes people to say "the child always wets the bed" – the bed might be more wet on one night than on the next, or more dry. And the child might have wet the bed at a different time on different days and probably the sheets are different. Although the child is seen as always wetting the bed, there are probably some dry nights now and then – *exceptions to the rule* (an important concept developed jointly by the author, Wallace Gingerich and Michele Weiner-Davis to describe what the therapist is after during the first session). However, these exceptions frequently slip by unnoticed because these differences are not seen as differences that make any difference. The difference is too small or too slow.

These exceptions to the rules of the pattern are exactly the kind of information the therapist needs to know. It is important for the therapist, the child, and the parent(s) to know that the child in some (perhaps unconscious?) way knows how to have a dry bed! And, therefore, there are times when a dry bed pattern operates in this family. The therapist needs to find out: What are the differences between the dry bed pattern and the wet bed pattern? Then he can figure out how the dry bed pattern can be used to form the basis of an intervention that solves the problem. What differences does the child's having a dry bed make to the rest of the family? What change is there in the parents' attitude toward the child?

Of course, any intervention into a wet bed pattern based on the family's dry bed exceptions to that pattern will have the benefit of *fitting*, since it is part of the family's reality (it is, after all, their solution). This can only promote cooperation and increase the chances of problem solution.

*Case Example: Toward Being a Perfect Mother**

Mrs. Baker came to therapy complaining about her approach to her children. She thought she should *completely* stop yelling at them because the yelling did not achieve its aim and just left her frustrated. Trying to establish a minimal goal, the therapist asked her, "What sort of thing do you think will happen when you start to, Joan take a more calm and reasonable approach to your children?"** The phrasing recasts the goal as the start of something (a more calm and reasonable approach), rather than Mrs. Baker's impossible goal of stopping yelling completely. This start then can be measured and known by Mrs. Baker. It could be something very small indeed that occurs in between yellings that would allow the yellings to happen now and then without their necessarily being seen as a setback. In fact, the therapist directed Mrs. Baker to randomly decide, by a toss of the coin, between (1) yelling and (2) a calm approach, and to figure out, based on the results, when to do which. She reported discovering that sometimes yelling was the best thing to do, and sometimes a calm and reasonable approach was more effective.

With a question structured in this way, the therapist not

*For security and confidentiality reasons we give titles to cases, particularly to those we videotape. These titles sometimes are relevant, sometimes not.

**This kind of unusual sentence structure will be found throughout in the verbatim excerpts from intervention messages and therapist's questions during the session: "What sort of thing do you think *will* happen *when* you start to, Joan take a more calm and reasonable approach to your children?" Several messages are implicit here: (1) the idea or suggestion that Joan should take a more calm and reasonable approach (the second part after the comma), (2) the expectation that Joan will take this approach (the "when" before the comma, not an "if"), and (3) the expectation that a more calm and reasonable approach will make a difference that Joan can notice (things will happen).

This structure is derived from the hypnotic techniques developed by Milton Erickson (Haley, 1967b; Erickson, Rossi, and Rossi, 1976; Erickson and Rossi, 1979). It is our view that brief therapy sessions employ hypnotic techniques whether or not a formal trance is used (see Chapter 5). Therefore, we tend to follow Erickson's lead in the construction and use of therapeutic suggestions.

only recasts the goal as the start of something, but also makes the goal achievement into a therapeutic suggestion. This allows the client to view the change as self-generated, minimizing the therapeutic interference.

When Mrs. Baker came for therapy she framed the complaint as *either* she yelled all the time *or* she stopped yelling entirely. She had tried to stop yelling, but these efforts were not successful and only led to more frustration. However, the expectation she had that she should and could completely stop yelling is unrealistic. There are times when any mother of small children is going to yell at her children, and there may be times when yelling is the best thing to do. The therapeutic suggestion that she randomly start taking a more calm and reasonable approach recast her problematic either/or frame into a both/and frame. Mrs. Baker can *both* take a calm and reasonable approach *and* she can yell. The decision is hers to make, and hopefully she will develop some decision-making procedures other than the coin toss.

There is a bonus to this approach. Mrs. Baker reported a ripple effect resulting from her different behavior. Once Mrs. Baker randomized her approach, the children no longer found her so predictable and, therefore, the "causes" of mother's yelling diminished both in frequency and intensity. In a matter of three weeks, the yelling took on a new meaning: Mother means business since she is not being calm and reasonable. This approach to solving Mrs. Baker's problem allowed her a high degree of freedom in her response to the interventions. Both yelling and not yelling are acceptable responses. Of course, not yelling includes a lot of behaviors which can be framed as "starting to take a more calm and reasonable approach." Even deciding *once* to not yell when she thought she normally would have yelled would be a minimal change that could lead to solution of the problem.

This approach fully accepts Mrs. Baker as she presents herself (a yeller), does not scold her for it, does not tell her to change by eliminating the yelling, and would not consider any continued yelling as a sign of resistance; it is a *cooperating* mode of therapy.

Case Example: The Key

A mother brought her two children (a daughter, age 15, and a son, nine) to therapy because the girl, who had been an honor roll student in the past, was on her way to setting a record for number of days absent from school. Each morning, mother would tell the girl to go to school and the daughter would say that she was going and she would leave home at the proper time. Then, as soon as mother went to work, the girl would come back home and watch TV all day. Since mother spent a lot of time talking about the girl's past achievements, the therapist became interested in mother's past successes. At one point the mother had taken the girl's keys away and the girl went to school. However, mother was concerned about the safety of both children after school until she returned from work. Therefore, she gave the keys back.

Since taking the keys had worked before, the team thought that this was the simplest intervention possible. Mother had explained her reasoning and the team was afraid she would not follow through if they told her to take the keys away. Therefore, the team constructed the following message:

> "We don't know when, Marsha is going to go back to school and stay there, and we don't know if you, mother, know when, Marsha is going back to school, and we don't know if you, Sam, know when, Marsha is going back to school, and we don't know if you, Marsha, know when you are going back to school. We don't know *who holds* the *key* to this problem."*

On the way home from the session, mother took Marsha's keys and the next day arranged for a neighbor to supervise Sam after school. Marsha returned to school and, as reported two weeks later, continued to attend. By not directly telling mother to take the girl's keys, the team was able to allow mother to save face and to have the idea herself. The indirect

*Intervention messages quoted in this book are as close to verbatim as possible.

method allowed, therefore, for the minimal intervention possible. The follow-up reports again indicate that the ripple effect occurred: Marsha went to school, stayed in school once there, and resumed getting good grades.

Assumption Four

> *Ideas about what to change are based on ideas about what the clients' view of reality might be like without the particular complaint.*

During the interview, both in front of the mirror and behind, we try to build scenarios about how the client's situation will be different *after* the therapeutic goal has been achieved. If, for instance, a dry bed would not seem to make any real difference in how the boy and his parents relate to each other, then perhaps how the parents view the child and how the child views the parents should be the focus of the therapeutic efforts. If this hypothetical solution seems to include dry beds, then the "ascribed meaning" door, or the "blame" door, or the "environment" door might be more useful than some other doors.

A Model of Complaints, Part Four

Most simply, if the parents think of the wet bed as only one of the many signs that mean "this is a bad kid," then just initiating dry beds is not likely to shift their framing of the situation in such a way that it can be the solution. The therapist needs to at least create some doubt about the meaning of the wet bed and/or create some doubt about the frame "this is a bad child." Frequently, some doubt can be created by the therapist's describing wet beds as a normal problem given other circumstances of the child's life, i.e., whenever an overly sensitive and creative child is mistaken for a bad child, bedwetting will continue until the child is convinced that he will continue to receive just as much attention when he has a dry bed and/or until the parents are able to convince him that he

will receive just as much attention when he has a dry bed. (A child who is always doing things that cause trouble can frequently be effectively labeled as "creative" and the bed-wetting proves his sensitivity.) Of course, a dry bed following this sort of framing needs to be viewed with the utmost caution: The family needs to be warned that the child might create some more trouble until he is really convinced!

Regardless of the specific situation, the therapist needs to know what meaning(s) the client ascribes to the complaint. Frequently meaning(s) can be found by asking about what the client thinks things will be like when the problem is solved. What a "wet bed" means or what a "dry bed" means helps to determine the frame the therapist can use to effectively solve the problem. For the "bad kid," a dry bed is not enough. The child will probably be seen as doing something else equally "bad." Once the therapist knows these negative meanings (frames), he can reframe by substituting positive meanings for the same behaviors (de Shazer, 1982a).

Assumption Five

> *A new frame or new frames need only be suggested, and new behavior based on any new frame can promote clients' resolution of the problem.*

An Experimental Approach to the Construction of Frames

Duncker (1945) designed the following experiment which illustrates how frames (definitions and meanings) influence what happens. Group One was given three boxes, one with matches, one with candles, and one with tacks. Group Two received the same materials, but the matches, candles and tacks were not *in* the boxes. The object was to mount the candle vertically on a screen to serve as a lamp. Group Two found the problem much easier to solve. In a replication, Adamson (1952) found that only 41% of Group One solved this problem within 20 minutes, while 86% of Group Two were successful

within the time limit. It seems that, for Group One, the boxes were framed (or defined) as "containers," while for Group Two the boxes, since they did not contain anything, could more easily be seen as potential platforms (a reframing for empty boxes) upon which to stick the candle. That is, some frames (i.e., container) are less useful in solving this platform problem than other frames (i.e., empty boxes). This leads directly to Assumption One (see p. 23) and Assumption Five.

As suggested by Duncker's experiment, frames (ways of seeing or defining situations) and the labels attached to them dictate (to a greater or lesser extent) what we can see and *do*: Our point of view determines what happens next. This seems clear not only in art and science but also in everyday life: Frames and their labels affect paradigm- or frame-induced expectations and enable us to articulate and measure the world. Any concrete "fact" can have several different labels implying different frames (Watzlawick et al., 1974).

A Model of Complaints, Part Five

It is fully possible that the frame, "This child knows how to have a dry bed," may be sufficient to initiate some change in the problematic patterns. There are a variety of ways a therapist might promote the acceptance and utilization of this frame. The family might be asked to notice what is different on the nights before dry beds or what is different on the mornings after dry beds, or they might be asked to each secretly predict to themselves when the child goes to bed whether it will be a dry night or a wet one.

The responses to these tasks, should there be any noticed and noticeable differences, can form the basis for the next intervention, which could be assigning the differences. Or the family might be asked to watch for signs that the dry beds are going to continue and (since relapses do happen) any signs that a wet bed might happen.

This gets at a rather central premise: *A minimal (although not easy or simple) task for the therapist in the first session at least, and perhaps in other sessions as well, is to induce*

some doubt in the clients' minds about the frames and the behaviors which follow from those frames. If the family can come to have some doubts about their perception that this child *always* wets the bed, then alternative behaviors become a real possibility. Similarly, if the family members can behave differently and *see* a difference (a dry bed), then they can also come to doubt their original framing of the situation. Frames and behaviors interact and mutually define each other: This is not an "either/or" situation.

Case Example: The Aluminum Crutch

The strength of labels was clearly described by a client who initially described her situation with these words: "I am letting my handicap cripple me." A polio victim at a young age, she wore leg braces and used a crutch to aid her walking. She believed she had adjusted to her handicap since she knew nothing else. However, she was repulsed by the type of men who were attracted to her and thought her handicap prevented her from ever having a chance for a relationship with a man she would find attractive. At the start of therapy, she described herself as being depressed about her handicap for the first time in her life. In looking at herself the way she thought others saw her and comparing herself to other attractive women her age, she found herself lacking. So, she started to make efforts whenever possible to hide her handicap by placing the crutch out of sight.

The major focus of intervention was the client's efforts to hide her crutch (de Shazer, 1979a). Once she started to *use* canes that were unusual in design, color, or shape and once she started to *display* these openly, she projected an unusual amount of strength. This new behavior made an impression on people which resulted in their treating her differently. Subsequently, she was also able to attract the kind of man she desired. As she put it during the last session, "I am no longer letting my handicap cripple me."

The label of "cripple" helped to determine her approach to people and situations, just as the new label and frame of

"strength" helped to promote new and different behavior. Since the new frame elicited and promoted more rewarding responses and created expectations of more rewarding responses, she was able to maintain it.

This example points out the interactional aspects of frames and their labels. She saw other people seeing her as crippled, adopted the label, and started to behave as crippled. The more she behaved as crippled (by hiding the crutch as much as possible), the more people saw her as crippled, and the vicious cycle maintained itself. When she started to do something different (keeping her decorative canes in open view), others saw her as strong, and she started to see them see her as strong (promoting expectations of more strong behaviors), and a more virtuous cycle began to maintain itself. Importantly, a change in frames and labels can start anywhere in an interactive system. If other people had started to see her behaving in a strong way before she had seen herself doing it, then they might have initiated the "strength" frame for her. Of course, in therapy, initiating a new frame is part of the task of the therapist, and there is a need for the therapist to be reasonably sure that the new frame will fit and the new behavior will be "reinforced" by others.

A distinction needs to be drawn here. Although the effective behavior is different and appears random, the selection of what to do differently is not a matter of chance. A chance happening might be irrelevant. For instance, if her usual crutch was broken and she, therefore, used a decorative cane but continued to hide it, the difference might not be such that it made any difference in how people perceived her or in how she saw other people perceiving her. In fact, once she saw herself as strong, a return to her normal crutch in certain circumstances did not undermine the solution because she did not hide it – she was doing something differently.

Handicaps can cripple, but they can also show strength, and the difference is far from trivial. Therapy, through reframing, provides a type of mirror which can help people to see situations differently and thus behave differently. Although two

(or more) labels can be applied to the same situation, all labels are not equal. Some promote detrimental behaviors while others seem to promote more beneficial behaviors.

Assumption Six

> *Brief therapists tend to give primary importance to the systemic concept of wholism: A change in one element of a system or in one of the relationships between elements will affect the other elements and relationships which together comprise the system.*

Since interactive patterns can be seen as both individual habits and "systemic" habits, it seems only reasonable that all it takes is for one person to behave differently to break the collective habit.

A Model of Complaints, Part Six

If the parents of the bed wetter are split along the lines of either (a) it is a problem or (b) it is normal, or either (a) the child is bad or (b) he is mad, or either (a) it is a physical problem or (b) it is a psychological problem, then a change in the relationship between the parents might serve to stop the bed-wetting. It does not need to be the case that somehow or other the parents' fight is a "cause" of the bed-wetting or that the fights are seen as "caused" by the bed-wetting. Nor does the therapist need to see the bed-wetting as serving the function of keeping the parents together based on the premise that if they were not fighting, then they would break up. Rather, it is simply the case that the bed-wetting and the fighting are recursively related. The sequence can be punctuated as (1) the more the child wets the bed, the more the parents fight and/or (2) the more the parents fight, the more the child wets. Regardless, the sequence over time is wet bed/fight/wet bed/fight, etc. The concept of wholism suggests that stopping the fights might stop the wet beds and/or stopping the wet beds might stop the fights.

Since frames and the punctuation of sequences are related, the therapeutic approach can differ along the same lines. For instance, if the family punctuates the sequence as "wet beds lead to fights," and they frame the situation as "wet beds are the result of either madness or badness," then seeing the whole family together and interrupting the sequence by inserting some new behaviors between the time of the wet bed and the time of the fight and/or between the time of the fight and the time of the wet bed might be effective. However, seeing just the parents might not be effective since they assume the wet bed is the child's fault. In fact, seeing the child alone might be called for, particularly if the child wants to stop wetting the bed for his own reasons. If the parents use the other punctuation, which implicitly explains the wet bed as a result of parental discord, then seeing the parents without the child(ren) and stopping the fights probably would be effective, i.e., resulting in a dry bed.

In fact, the concept of wholism can be taken further. In some cases, only mother might come for therapy and describe the wet bed/fight sequence as problematic for her. She might describe her husband as not interested in getting help because he thinks the wet bed is normal and contends that if she would only agree to see things in the "right way," then both the fights and the wet beds would cease. Therefore, both are *her* complaints. In this situation the therapist might help her to change her behavior in the fight pattern and/or to change her reaction to the wet bed. Which to work on first is determined by the goals the woman and the therapist set up. If she punctuates the sequence as "wet beds lead to fights," the initial goal needs to focus on her response to the wet bed. If she punctuates the sequence as "fights lead to wet beds," then the initial goal needs to focus on her behaviors in the fight sequence. A change in her behavior vis-à-vis the wet bed might also have the ripple effect of solving the fight problem.

Creating Expectations of Change

As the BFTC team continued to work together and a distinct, unique philosophy developed, a shift occurred from our

being interested in "problems/complaints and how to solve them" to "solutions and how they work." We looked at what is on the other side of the locked doors and started to figure out how we and the clients got there.

Having a team behind the mirror is almost like providing the client with more than one crystal ball to use in building a successful solution. The various team members each join with the client in constructing alternative problem realities and, therefore, alternative solutions. As a result, my colleagues and I have learned that each complaint can be constructed into many different problems that can have many possible solutions, and that any intervention which successfully prompts different behavior and/or a different way of looking at things might lead to any one of the hypothesized solutions. Sometimes the team members can agree about what to do but have different ideas about what the results might be.

Once the therapist has created (or helped to create) expectations that things are going to be different, next in importance is what the client expects to be different after the complaint is gone. That is, what you expect to happen influences what you do; therefore, if you expect something different to happen, then doing something different (to perhaps make it happen) makes sense. Of course, what you specifically want to have happen might not, but since you did something different, at least something different will happen and, therefore, you might feel more satisfied. Which door the client chooses is determined by what things he desires to be different when his complaint is resolved.

Recent work has pushed our understanding of solutions and how they work even further. In some rare cases, even when the complaint remains vaguely defined, and even when detailed goals or specific ideas about what will be different after the complaint is gone are lacking, a satisfactory solution can spontaneously develop. What seems crucial here is that solutions develop when the therapist and client are able to construct the expectation of a useful and satisfactory change. The expectation of change or the making of a different future salient to the present (Berger, Cohen, and Zelditch,

1966; de Shazer, 1978a) seems to be a skeleton key to opening the door to solution. This is not, of course, some sort of magic. It makes sense 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, and just being somewhere different may be satisfactory in itself.

To sum up, the most useful way to decide which door can be opened to get to a solution is by getting a description of what the client will be doing differently and/or what sorts of things will be happening that are different when the problem is solved, and thus, creating the expectation of beneficial change. The client's language while describing some alternative futures and the details of the differences after solution seem more important than the details about the locked room of the complaint. With possible alternative futures in mind, the client can join the therapist in constructing a viable set of solutions.

CONCLUSION

The 12 building blocks of complaints and the six basic assumptions allow brief therapists to draw maps of clients' complaints in such a way that solutions to the problem can be quickly found. What the assumption and building blocks lack in detail they make up for in utility. These constructions are only high-level generalizations and seem to lack the fine detail generally suggested for problem-solving (Mayer, 1983). However, most problem-solving models seem to attempt a *match*, in von Glasersfeld's terms (1984a), between problem and solution, rather than a *fit*, and only a fit might prove necessary in experimental situations as well. On the other hand, the complaints therapists set out to solve might somehow be different from other types of problems that have been experimentally studied.