# Brief Family Therapy

**Entry for *The SAGE Encyclopedia of Marriage, Family, and Couples Counseling***

**Douglas Flemons, Ph.D.**

Brief Family Therapy, more commonly known as Brief Therapy, did not evolve out of an earlier, longer-term family therapy approach but rather was one of the originating orientations of the field. Primarily associated with the model developed at the Mental Research Institute (MRI) in Palo Alto in the 1960s, Brief Therapy is sometimes used more encompassingly to refer also to Jay Haley's Strategic Therapy, Steve de Shazer and Insoo Kim Berg's Solution-Focused Brief Family Therapy (SFBFT), and the work of the Milan Associates. This entry concentrates primarily on the contributions of the MRI clinicians, but when relevant, it explores conceptual and practice-based connections to the other brief models.

## History

The beginnings of brief therapy can be traced to a research project. Between 1952 and 1962, Gregory Bateson led a research team in Palo Alto devoted to understanding multi-level communicational complexities in a variety of phenomena, including humor, schizophrenia, play, families, and hypnosis. John Weakland and Jay Haley were the first and primary members of the team. William Fry, a psychiatrist, joined them for a year (until leaving for military service), and Don Jackson served as their psychiatric consultant starting in 1954.

In 1955, Haley and Weakland decided to pursue an investigation of hypnosis. With Bateson's support they approached Milton Erickson, a Phoenix-based psychiatrist who, at the time, was the most respected medical hypnotist in the country. They attended his clinical demonstrations, and, over the next several years, they made regular trips to Phoenix to interview him about his ideas and techniques. (Haley continued going for17 years, and he wrote several books about Erickson's work, including *Uncommon Therapy.*) In time, Haley and Weakland

developed a sound understanding of Erickson's hypnotic methods, incorporating them in their work with clients and teaching them to other clinicians.

In 1958, Don Jackson, wanting to support and participate in a continuation of the Bateson group's research focus, particularly as it related to family therapy, founded the Mental Research Institute. Bateson served as a consultant, and his wife Lois, along with Haley, Weakland, and Fry, came on as research associates. Virginia Satir joined as the first director of training. Richard Fisch was brought on board soon after, and Paul Watzlawick arrived in 1960. In 1965, Fisch proposed the launching of a research project into a brief approach to family therapy. Using communicational ideas gleaned from the Bateson project and therapeutic strategies and interventions derived from Erickson's work, the brief therapy team articulated an approach to intervention that was time-limited, goal directed, strategically oriented, and change focused. The therapeutic principles they established and the practices they developed, known as the MRI model, were broadly influential, and the developers of the model were personally helpful in mentoring others. For example, Watzlawick served as a consultant to the Milan Team when they were first developing their ideas about using paradox strategically in the treatment of families with a schizophrenic member, and John Weakland was a teacher and friend of Steve de Shazer, who credited Bateson, Erickson, and the MRI team with providing the inspiration for his later development of SFBFT.

## Organizing Principles

The developers of the brief model articulated several foundational assumptions about the nature of communication, problems, and problem resolution that gave rise to or provided theoretical support for a variety of innovative therapeutic practices that will be discussed below.

**Communication**

Bateson asserted that "you can't not communicate." The double-negative structure of this claim underscores the fact that in any relationship, everything said and done, as well as everything not said and not done, serves to communicate something to the other(s). The attempt to negate or deny or avoid communication is inevitably just another form of communication.

**Paradox**

Communication is inherently multi-leveled. One statement can be *about* another (e.g., "When you say that, I feel sad"), and a non-verbal message (e.g., a raised eyebrow) can be a comment on, a *metacommunication* about, both. Another way multiple levels are generated is through self-reference, which inevitably produces paradox. For example, the statement "I am lying" classifies itself. If the claim is true, that is, if the person is truly lying, then by virtue of being true, it is false. And if it is a lie that the person is lying, then the statement is true. Which makes it false. And so on.

The MRI group took such complexities seriously, recognizing, for example, the paradoxical results of one person's demand for another to act in a spontaneous manner. Consider, for example, the effect of a person saying to his or her spouse, "I want you to tell me you love me, but not because I'm telling you to do so." Any purposeful effort on the part of the spouse to comply with such an injunction will paradoxically undermine itself: compliant or obedient spontaneity is an oxymoron. Such paradoxical dilemmas can create great suffering; indeed, the Bateson project specifically investigated how painful relationship paradoxes—what they termed *double binds*—contribute to severe mental distress. However, as will be discussed below, brief and strategic therapists have also recognized the potential of using therapeutic paradoxes or double binds for inspiring change.

**Context**

The context within which a communication is experienced classifies the communication and thus determines its meaning. For example, a husband's understanding of his wife's telling him "I love you" will vary tremendously, depending on whether a) they've just had great sex; b) they've just had disappointing sex; c) he has just told her he's been having an affair; d) she has just told him that she's been having an affair; e) she's pointing a gun at him; f) she's just given birth to their baby. Bateson proposed the metaphor of *frame* as a way of characterizing the defining nature of context. Put an ordinary household item inside a frame, say as part of a collage, as Picasso and the Cubists did, and put the framed item inside an art gallery, and the item takes on an entirely different meaning: It becomes, as a result of this framing, this contextualizing, an *objet trouvé*—a "found object" work of art. This recognition of the importance of contexts or frames gave rise to the therapeutic idea, which will be discussed below, that a change of frame—a *reframe*—can have reverberating effects on the way a symptom is understood and experienced.

**Problems**

From a communicational perspective, a problem can only be made sense of within the context(s) informing how it is being experienced. Thus, rather that defining problems in terms of the reified categories found in the Diagnostic and Statistical Manual (DSM), brief therapists attend to the interactive context within which a person suffers. What has the person and his or her significant others been doing in response to the problem? How have they been trying to alleviate, control, or eliminate it? Such a contextual approach allows the recognition that many of the symptoms that bring people to therapy begin as everyday life difficulties that escalate into intractable problems as a result of their best attempts to fix them. Thus, therapeutic interventions

must address not only the problem as distinguished in language (e.g., the client's "panic attacks" or a couple's "fighting"), but also the interactive efforts to do something about it.

**Patterns of Interaction**

The medical model wisely directs clinicians to intervene only after they've correctly diagnosed the illness or disease afflicting the body of the patient. Medical diagnosticians are highly valued, as their ability to isolate and locate the causes of bodily distress ensure that interventions are as targeted and potent as possible. Once the practitioner correctly diagnoses, say, cancer or diabetes or Lyme's disease, precise treatment protocols can follow. However, in the world of mind, where emotional and psychological problems prevail, the medical model becomes highly problematic, for it is blind to the complexities of reflexivity and interaction. A woman, for example, may not only feel anxious, but also feel anxious *about* feeling anxious. And any anxious efforts she mounts to control her mounting anxiety will of course contribute still more anxiety to the mix. It is in this way that problems tend to self-referentially escalate. More complexity is added when other people get involved in trying to help. A man, for example, will not only feel angry, but will also feel angry that his partner is angry at him for displaying his anger. He may also feel sad and desperately repentant when the partner threatens to leave in response to what the man proclaimed during their angry exchange.

Sensitive to such relational complexities, brief therapists avoid trying to establish diagnosable causes of such distress, focusing their curiosity instead on the *patterns of interaction* that play out within and between people when someone's attention is drawn to a difficulty of some kind. Whereas insight-oriented therapists try to establish the reasons *why* a symptom is present, believing that this will be somehow "curative," brief therapists attend to *how* a symptom is being maintained, directing their therapeutic interventions toward interrupting the patterns that

relationally contextualize and constitute the suffering. When such patterns unravel, problems unravel.

## Therapeutic Practices

Brief therapists' communicational orientation and interactional ideas inform their sensitivity to the way their clients are orienting to therapy, to the therapist, and to the possibility of change. They seek to determine early on in the first session who in a couple or family is invested in being in the therapist's office and who is not, and they assiduously avoid offering suggestions to anyone who is not a "customer" for change. Unlike those family therapists who require everyone in the family to attend every session, brief family therapists are comfortable working with only those members who decide it is important to come in. And because they don't want the clients' experience of the therapist to get in the way of their participation in therapy, they downplay their own knowledge and importance in the therapeutic enterprise, preferring instead to underscore the clients' expertise and resources. Adopting this non-defensive *one-down* position serves to help clients have an easier time of accepting and incorporating the therapist's suggestions.

### Attending to Expectancy

Brief therapists don't presume to know what is best for their clients, so they work collaboratively with them to define where the clients are headed in therapy and how they will know that their goals have been reached. Many brief therapists also put an explicit cap on the total number of sessions they are willing to see their clients. The originators of the model at MRI put this limit at 10; others say no more than 20, and some practice single-session therapy and so put the cap at *one* session. HMOs prefer a session-limiting approach for cost-saving purposes; however, brief therapists take this position not out of a commitment to reduce insurance

companies' health-care spending but out of respect for their own and their clients' expectancy. By organizing everything that happens in terms of defined, time-limited goals, brief therapists help ensure that the sessions are efficient and more likely to produce discernable change.

**Doing Something Different**

Brief therapists typically adopt a minimalist approach to intervening. First establishing what the clients have been doing unsuccessfully to try and solve their problem, they take care not to contribute to more of the same. And recognizing that change depends on clients *doing something different,* they often encourage clients to conduct outside-of-session experiments (commonly called *homework assignments*). For example, a depressed man who has been failing to cheer himself up by diligently practicing positive affirmations throughout his day might be asked to find out what happens when he protects 15 minutes (but no more) every morning or evening (but not both) to becoming curious about and acknowledging the legitimacy of his sadness. It might be further suggested that he find a way to express his sadness in some meaningful, but different way, perhaps through writing about it or painting it.

When brief therapists give such homework assignments, they take care to follow up the following week. Did the clients undertake the suggestion(s)? What happened? What differences, if any, have the clients been noticing in their experience since carrying out the experiment(s)? Such questions contribute to clients' expectations that change is possible, but they also help clients discern subtle changes that have the potential of increasing and intensifying. If what they did made a difference, then the therapist may suggest they continue with it; if it didn't make a difference or made things worse, then the therapist will explore alternative possibilities.

**Reframing**

Very often clients' understanding of their problem changes as a result of their doing something different in response to it. However, sometimes a change in behavior is most easily introduced and enacted as a result of the therapist's re-contextualizing or reframing the problem. For example, parents who view their son's refusal to go to school to be the result of his being lazy will likely increase the intensity and frequency of their exhortations and punishments when they are unsuccessful in getting him out the door in the morning. And when louder yelling and harsher consequences don't work, they may come to the conclusion that, in addition to laziness, he is being problematically oppositional.

If the parents bring their son to a brief therapist, he or she will likely normalize the child's truancy, commenting, perhaps, on how common it is among boys at this stage of brain and emotional development. Normalizing is a generic form of reframing that serves to depathologize the client's behavior, thereby making it possible, in this case, for the parents to relax their ineffective solution attempts and the son to relax his efforts to protect himself from their harsh reproach. A further reframe might then be explored, with the therapist possibly determining, based on other information gathered in the conversation with the family, that the son, far from being lazy, appears to be overly concerned about doing well. If this were accurate, then, afraid to fail, he might have found himself avoiding school in an effort to avoid disappointing his parents. With such a reframe in place, the parents would be able to quite easily forego the yelling and punishments, encouraging him instead to improve his ability to "learn from mistakes." With the parents relating to him differently and with the son not recoiling from their vociferous efforts to change him, returning to school could be accomplished painlessly.

**Prescribing the Symptom**

Brief therapists, along with strategic therapists, are noted for prescribing clients' symptoms as a means of helping them change. A woman who blushes excessively, worried what people are thinking of her, might be asked to intentionally commit some public blunder that will draw previously unwanted attention. A young man who wets the bed at night might be directed to purposefully urinate on the sheets before falling asleep on them. Or a couple worried that their upcoming vacation will be marred, like many in the past, by a series of small petty fights, might be asked to arrange a significant fight the first night of their trip. The therapist might add that the fight should be significant enough to require "really great make-up sex" the next morning, and with that precedent established, they should, anytime either of them feels amorous, arrange to create a spat so that another occasion for make-up sex, this time *before* the next morning, can follow. Such suggestions dramatically reframe the meaning of the fights, laying the foundation for a significant change in how the couple orients to "fighting."

Many brief therapists consider symptom prescription to be a species of paradoxical intervention, specifically what they term a "Be spontaneous!" paradox. Because symptoms, being unwanted and uncontrollable, always occur unintentionally, then, the reasoning goes, purposefully undertaking to create the symptom—blushing, wetting the bed, fighting—puts the client in a paradoxical situation, the result of which is often the non-occurrence or disappearance of the symptom. Other brief therapists recognize the therapeutic benefits of prescribing the symptom, but they are less inclined to attribute the change to the transformative effects of paradox. Instead, they recognize that changing a strategy of effortful avoidance (trying so very hard not to blush, not to pee, not to fight) to one of effortless inclusion (encouraging blushing,

peeing, fighting) meaningfully alters the pattern of interaction defining the problem. From this perspective, it is the shift in pattern that occasions the change.

**Focusing on Exceptions**

As the visionary behind the creation of solution-focused brief family therapy (SFBFT), Steve de Shazer made several important contributions to the field of brief family therapy. One of most important was his recognition that therapists and clients can benefit greatly from directing their attention away from the problem and toward *exceptions to the problem*. He would have clients notice what they were doing when the problem wasn't occurring and then would direct them to do more of whatever that was. This shift in perspective is an excellent way of freeing clients up from continuing their unsuccessful attempts to solve their problem through efforts to control or expunge it.

Naïve SFBFTs sometimes pridefully contrast their approach to the MRI model, claiming that whereas they themselves are concerned with solution building, MRI therapists are unfortunately problem focused. In so doing, these naïve therapists lump the MRI approach in with those models that espouse a thorough investigation of the etiology of a problem as a necessary precursor to any efforts at intervention. In fact, the SFBFT and MRI approaches are far more compatible than many people realize. de Shazer considered John Weakland, one of the prime architects of the MRI approach, to be an important mentor, and Weakland, an admirer of de Shazer and his innovations, endorsed the importance of attending to exceptions. Both men clearly recognized that if problems are understood in terms of interactive *patterns*, rather than as isolable entities, then variations in symptom expression will be inevitable.

**Respecting Clients and the Process of Change**

Brief therapists strive for a deeply empathic understanding of their clients' experience. Once they grasp how their clients are talking about and making sense of their predicament, they can offer interventions that fit the clients' language and respect their worldview. Recognizing, in keeping with the SFBFT therapist Eve Lipchik, that a "rush to be brief" can actually make therapy less efficient, they encourage clients to "take it slow," and they focus on introducing small shifts that can subsequently ramify throughout the patterns of interaction that have been keeping the problem in place.

**Douglas Flemons, Ph.D.**

**Cross References**

Homework Assignments; Milan Team; Paradoxes and Paradoxical Interventions; Strategic Family Therapy; Solution-Focused Brief Family Therapy

**Further Readings and References**

Bergman, J. S. (1985). *Fishing for barracuda: Pragmatics of brief systemic therapy.* New York: Norton.

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

de Shazer, S. (1982). *Patterns of brief family therapy.* New York: Guilford.

de Shazer, S. (1988). *Clues: Investigating solutions in brief therapy.* New York: Norton.

Fisch, R., Ray, W. A., & Schlanger, K. (2009). *Focused problem resolution: Selected papers of the MRI Brief Therapy Center.* Phoenix, AZ: Zeig, Tucker, & Theisen.

Fisch, R., Weakland, J. H., & Segal, L. (1982). *Tactics of change: Doing therapy briefly.* New York: Jossey-Bass.

Green, S. K., & Flemons, D. (Eds.). (2007). *Quickies: The handbook of brief sex therapy* (Rev. ed.). New York: Norton.

Haley, J. (1963). *Strategies of psychotherapy.* New York: Grune & Stratton.

Haley, J. (1986). *Uncommon therapy: The psychiatric techniques of Milton H. Erickson, M.D.* New York: Norton.

Hoyt, M. F. (2009). *Brief psychotherapies: Principles & practices.* Phoenix, AZ: Zeig, Tucker, & Theisen.

Hoyt, M. F., & Talmon, M. (Eds.). (2014). *Capturing the moment: Single session therapy and walk-in services.* Bethel, CT: Crown House Publishing.

Rabkin, R. (1977). *Strategic psychotherapy.* New York: Basic Books.

Slive, A., & Bobele, M. (Eds.). (2011). *When one hour is all you have: Effective therapy for walk-in clients.* Phoenix, AZ: Zeig, Tucker, & Theisen.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G., & Prata, G. (1978). *Paradox and counter-paradox.* New York: Jason Aronson.

Ray, W. A., & de Shazer, S. (1999). *Evolving brief therapies*. Galena, IL: Geist & Russell.

Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution.* New York: Norton.

Watzlawick, P. (2009). *Insight may cause blindness, and other essays* (W. A. Ray & G. Nardone, Eds.). Phoenix, AZ: Zeig, Tucker, & Theisen.