Integrating Poststructuralist Models of Brief Therapy

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Abstract

The article presents guidelines for Brief Family Therapy that focuses on the presented problem and its solution within the context of resources the family has to solve problems. Based on Systemic Brief Therapy models (MRI's Brief Therapy Model, Solution Oriented Models, Narrative approaches ...), our work does not put high emphasis on pathological structures underneath the problem (e.g. unconscious conflicts, pathological family structure,...), but on the present interaction between family members and their stories around the problem. With a simple and brief method of treatment we have had remarkable success in working with family problems, including eating disorders, enuresis, school refusal, tics, sleeping disorders, aggression, drug abuse and various forms of psychosomatic diseases. Guidelines for clinical work with children, adolescents and their families will be presented. An evaluation of our work will be reported within the context of child psychotherapy in a Pediatric Clinic and in a Family Therapy Institute.

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Integrating poststructuralist models of therapy

In our work we have managed to integrate three major directions in Brief Family Therapy - the Problem-Focused Brief Therapy approach of the Mental Research Institute (MRI) in Palo Alto (Weakland, Fisch, Watzlawick and Bodin, 1974; Watzlawick, Weakland and Fisch, 1974; Fisch, Weakland and Segal, 1982), the Solution-Focused Brief Therapy approach developed by de Shazer and his colleagues in Milwaukee (de Shazer, 1982, 1985, 1988, 1991, 1994; de Shazer et al., 1986; Gingerich and de Shazer, 1991; Weiner-Davis,M., de Shazer,S. and Gingerich, 1987; Gingerich et al., 1988) with the further developements in this approach by O'Hanlon and Weiner-Davis (O'Hanlon, 1993; O'Hanlon and Weiner-Davis,1989; Weiner-Davis, 1993), and the Narrative approach of White (1984, 1985, 1986, 1987, 1988, 1993) and Epston (White and Epston, 1990; Epston, 1993; Durrant and Coles, 1991).

Besides all the differences between the three approaches there are some similarities that make them comparable and complementary in various ways. All three models do not put high emphasis on pathological structures underneath the symptom or the problem like other traditional models of therapy. Unconscious conflicts or pathological family structures are of little or no interest to the therapists working in these models. Their focus rather lies on the present interaction between family members and their stories around the problem.

De Shazer (1991, 1994) and Berg (Berg and de Shazer, 1993) were the first to use the term "poststructuralist" to describe those models of therapy that are mainly concerned with what the clients tell the therapist and eachother - with the interaction between the "text", the "reader" and the "writer" of those stories constructed in therapy.

"While structuralism sees truth as being "behind" or "within" a text, post-structuralism stresses the interaction of reader and text as a productivity" (Sarup, 1989).

Of interest for this theoretical position is the work of Jacques Derrida (1978), Paul de Man (1979), Richard Harland (1987) and Ludwig Wittgenstein (1980). A summary can be found in de Shazer's last two books (de Shazer, 1991; 1994).

Being influenced by the clinical work of the great hypnotist Milton H. Erickson (Erickson, 1954, 1964; Erickson and Rossi, 1983) and the theoretical ideas of Gregory Bateson (1972, 1980) the representatives of the models mentioned above share an enormous interest in language as the main mean of therapy. Especially the newest literature in the field deals with language and therapy explicitly (de Shazer, 1993, 1994; Weakland, 1993; White and Epston, 1990), although with the use of a slightly different terminology in each of the contributions. But there can be no doubt that the "text analogy" will have further impact on the developement of Brief Family Therapy (Geyerhofer and Komori, 1995).

For us the three models are not only similar in their expressions of poststructuralist thinking and their high emphasis on language, they also seem complementary on two other dimensions - the dimension "problem" versus "solution" and the dimension "behavior" versus "cognition". While the MRI approach and de Shazer's work not exclusively but mainly focus on the behavior of the people involved in the problem interaction, White and Epston are more interested in their cognition and the descriptions of their thinking and viewing in terms of "stories". Their "deconstruction- and reconstruction questions" (White, 1988; White and Epston, 1990; White, 1993) can roughly be placed on the cognitive side of a problem-included description. The questions they use for "rewriting" the client's story (White, 1988; White and Epston, 1990, Epston, 1993) on the other side can be viewed as the cognitive form of a solution-oriented course. The MRI approach can clearly be placed

on a behavior oriented and problem focused course. The only technique with a direct targeting towards peoples viewing of problems are the "reframing techniques". All other questions and interventions (problem description, description of interactional patterns, description of attempted solutions, 180 degree interventions ...) are clearly behavior oriented. By getting a concrete description of the problem behavior ("Who does what?") and the attempted solutions of everybody involved, therapists are lead towards a possible 180 degree intervention which is utilized in the sessions or given to the clients as a homework task. The Solution Oriented approach of the team around de Shazer (Milwaukee team) almost as clearly can be placed (see figure below) on the behavioral and solution focused part of the diagram. Solution oriented therapists are less or not at all interested in a clear problem description. From the very first session Steve de Shazer and his colleagues are looking for exceptions and solutions. Figure 1 tries to show the complementary differences described in this paragraph.

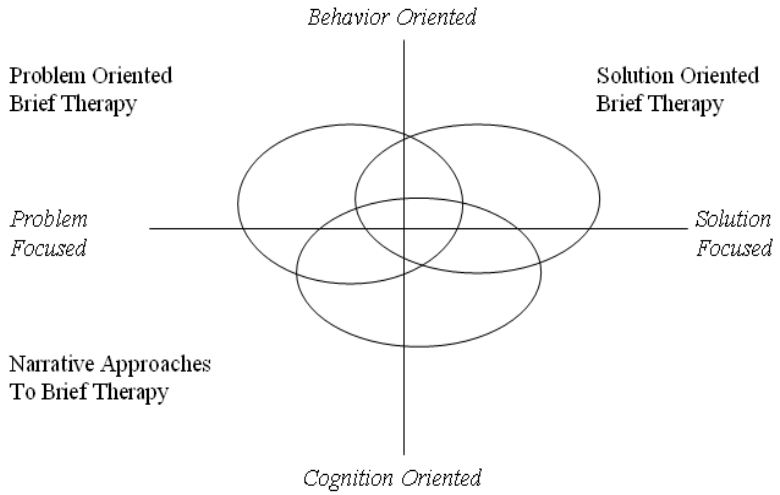


Figure 1: Integrating Poststructuralist Models of Brief Family Therapy on two dimensions

For us an integration of the three models along these two dimensions turned out to be useful and helpful in our clinical work. Not only did it open up new possibilities for treatment, we have also gotten better chances to meet the clients' needs and expectations. By working in one model only, therapists all too often limit themselves in their own thinking and acting. Clinical models and models of therapy not only function as guidelines through the process of treatment, they naturally restrain us from doing things differently. The moment our approach is helping us, it also gets in our way. And none of our clients want a therapist, who is limited in his/her own possibilities of viewing, thinking and acting. Besides all understanding, clients expect their therapist to view things differently and to

open up possibilities for new ways of acting. A therapist with many restraints is all too often not helpful.

We do not want to get into the danger of an unreflected eclecticism. On the contrary: Therapists should be guided by a consistent clinical theory in all moments of therapy. And systemic brief therapy has offered these theoretical guidelines for many years - in all its variations. So why limit ourselves to only one of these successful variations, especially when they fit together and add themselves up so perfectly. If a client is ready to look at exceptions and resources, why stick with the definition of possible problems? If a clients needs more time complaining (for many families we saw, one session was not enough) or more time to describe their suffering, why move towards solutions, miracles or first signs of improvement? Working in a pure solution focused approach clients often are left behind with the feeling that their suffering and their year long struggle have not been acknowledged enough. When Brief Family Therapy has opened up the full range between a problem and a solution oriented course, why not use the full spectrum? If we are able to move freely on the whole spectrum of this dimension (see figure 1) we have the best chance to meet clients' needs and expectations. The thing that's left, is to listen carefully what clients tell us, and let them guide us towards a solution of their problem in the time they need.

Sometimes clients reach a different understanding of their problem at a very early stage in therapy. Reframing techniques or the externalisation of problems (White, 1988; White and Epston, 1990) are powerful means to shift peoples viewing of their problem situation. By this, the chance for a behavioral change increases. When we view things differently, we all are less likely to act the same. But not always does a change in our thinking and viewing automatically lead to a change in our behavior. A mother might see her "guilt" as responsibility, that she shares with many others involved in the situation, but still have the same difficulties in setting up rules for parenting. On the other side, a change in behavior not necessarily leads to a different idea or viewpoint about the problem or ones personal abilities in problem solving. A client that has never been to a party before and has always been afraid of meeting people, came back to our next session reporting: "I am sorry I did not do the homework (she was sent out to observe how other people get in contact with eachother) you gave me. The party I went to was so funny. I got to know some really interesting people that night and I completely forgot to observe. But my social phobia is still the same." In this case a change in her "doing" has not lead to a change in her "viewing". The therapist was guided away from a focus on her behavior and no further behavioral perscription was given for the next four sessions. Instead he continued working on the client's understanding of her "social phobia", the meaning of it in her past and present life.

The integration of behavior and cognition ("doing" and "viewing") withing narrative and strategic approaches has been described by Eron and Lund (1993) and within all approaches of Systemic Family Therapy by Geyerhofer (1995). A detailed elaboration on this topic is already in progress.

By integrating the models mentioned above we can use the mutual influence of behavior and cognition in wider varieties, and are able to move more freely from "problem talk" to "solution talk" and back again - if it seems to fit the clients' perspective any better. The spectrum on the two dimensions (see figure 1) has been enlarged, limitations have been removed without the loss of a consistent theoretical background that is guiding us through the process of therapy. The practical guidelines below will explain some of the details.

Many of the questions and techniques described will not be new to the reader. We have never intended to develope anything new. We never felt a need for it. "If it ain't broke, don't fix it!" These words often said by Steve de Shazer in his workshops, also apply for what we felt and experienced in doing Brief Therapy. It was not the techniques or the questions that got in our way, it was the limitations and the restraints of the models. We only felt the strong need to give all these useful questions and techniques the space and the time they deserve and they need.

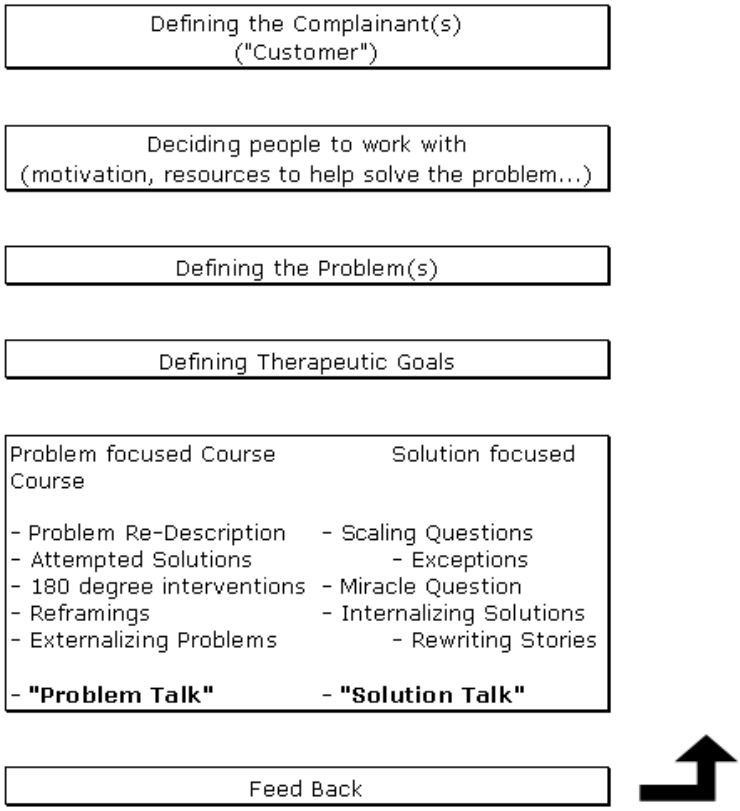
While the discussion around a theoretical integration of the three models of Brief Therapy has been started a while ago, therapists all over the world have successfully integrated them in their practical clinical work (Chang and Phillips, 1993; Todd and Selekman, 1991; Eron and Lund, 1993; Furman and Ahola, 1992; Furman, 1991). One of the most interesting books to show the practical usefullness of an integration of poststructuralist therapy models, is Selekman's book "Pathways to Change - Brief Therapy Solutions with Difficult Adolescents" (Selekman, 1993).

The following chapters will present our practical integration of the three approaches and a first study on the efficiency of it within the context of child psychotherapy.

Guidelines for Brief Family Therapy

Difficult adolescents and their families can be a challenge to every therapist. But they do not have to be hard to treat if there is a conscious effort with each new case to: (1) avoid the use of labeling; (2) expect that clients have the strength and resources to change; (3) view therapy as a collaborative enterprise in which clients determine the goals for treatment; (4) find out what clients liked and disliked about former therapy experiences; (5) give the adolescent individual session time to assess his or her needs, goals, and expectations; (6) actively involve concerned helpers from larger systems, and (7) be therapeutically flexible and improvise when necessary (Selekman, 1993).

The following steps help as guidelines for the first and the subsequent sessions with the families that come to see us. Even the first contact (very often on the telephone) and the decisions to be made during this initial contact are guided by these steps. Of course they rarely can be followed exactly step by step. People in general, and families even more, cannot be pressed into any sort of scheme for treatmant. And that never was the intention of it anyways. The steps mentioned below are only guidelines in the therapist's process of formulating questions and making decisions. Each step taken feeds back the necessary information for this process. Therefore it occurs quite frequent that the therapist is guided back for one or even more steps, if necessary.



At the very first contact we are trying to get information on who might be defined as a complainant. A complainant for us is any person who describes a problem and asks us for some kind of help to solve it. All others that might join the complainants at their meetings with us could be called "visitors". This does not mean that we would refuse to work with "visitors". On the contrary - even when asked on the telephone who should come along to the first session, we had very good experiences by answering: "Everybody in the family (or even outside of the family) who wants to help solve the problem."

Nevertheless some questions have been found to be quite useful on the way to defining the complainants. Here are some examples:

"Who has the problem?"
"Who else thinks that this is a problem?"
"Who in your family is suffering the most?"
"Who else in your family is looking for help?"
"Who wants to see a therapist, who does not?"

According to these questions and to the answers we get, we are experiencing a huge variety of combinations of people in our therapy rooms. If the kids don't see any problem

and they don't want any help from us, we do not hesitate to work with the parents alone. If they all see a problem in their family and they all are willing to help, we have them come in together. In our practice it never occured that a boy or a girl called and asked for help. Up to the age of 16 whenever there is a child- or an adolescent problem in a family, the parents are always complainants as well. In a big amount of cases we found the parents (or one of the parents) to be the only complainants.

Very often the question is asked: "Who shall we bring along to the first meeting?" We might ask some questions related to the motivation of family members for therapy, but in general we leave the decision to the family. To help the family make this decision we might offer questions such as:

> "Who would be willing to come in and help solve the problem?"
> "If I were to ask you to come in as a family, who would be the most likely to refuse?"
> "Who wants to come with you, who does not?"

Since a long time, Brief Family Therapy has moved away from seeing families conjointly only. We never found it necessary to have the whole family come in. Often therapeutic goals can be met a lot easier and faster when some members of the family (especially those who don't want to come to therapy) are not present. This we even found to be the case when the child or the adolescent who is defined to be "the problem" refuses to come in for therapy. Our interactional way of looking at a family's problem and the interventions related to it, make changes possible no matter how many members of a family are present in the therapy room (Komori and Geyerhofer, 1993). The combination that we found to be the best to work with, is the one where everybody willing and able to help solve the problem is present. Interestingly this is not found to be related to the number of problems defined later on in therapy.

Families with child- or adolescent problems frequently had previous encounters with various representatives of helping systems (school psychologists, physicians, drug rehabilitation programs, mental health clinics, local police departments...). At the Institute for Systemic Therapy in Vienna, Austria 67,6% percent of all families report previous contacts (for the same problem) with other professional experts including psychologists, physicians and psychotherapists. Often some of these experts (especially teachers, physicians,...) are still interested and willing to help, but in the past of Family Therapy seldom have they been asked to join the family and the therapist in their newest attempts to solve the problem. Not only can they be a useful resource for information about what has and what has not worked in the past, they also can provide a mature base for establishing new stories, new exceptions and outcomes once things are starting to change. In his book "Pathways to Change - Brief Therapy Solutions with Difficult Adolescents" Selekman (1993) describes possible ways for collaboration with helpers from larger systems.

While sometimes the first two steps are already taken during the first telephone call, the third step of our guidelines usually keeps the therapist and the family busy for most of the first session.

> "What exactly is the problem that brings you in today?"
> "What made you pick up the telephone to call me?"
> "Who decided to go to therapy?"

"What would you like to be different?"

These questions are typical questions asked to get a first picture of what might be defined as the problem. Most times after joining with each family member seperately, the therapist asks questions related to the problem, or better the family members' views of the problems that bring them to therapy. To get a concrete and specific idea of the problem is not always an easy task for the therapist. In some cases this is taken us more than one session.

Often followed by the problem's definition is the definition of a goal for treatment. Frequently though both definitions are worked out mutually. On the one hand clients in many cases cannot offer a concrete description of the problem, as we would like to get it from them. On the other hand, to picture a situation in life where the problem is not there anymore, often helps to get a better understanding of clients' suffering, the symptoms and their stories around the problem they are facing. Questions that help to picture and describe a life without the problem can be....

"How shall things be different?"
"How do you want things to change?"
"How would your life be different, when the problem is solved?"
"What would you be doing differently, when the problem is not bugging you anymore?"
"How would your family notice that you start to fight off the symptoms?"
"What would they do differently?"
"If you are not fighting the problem anymore, what would you do instead?"
"If I were at your house, how would I notice that you are on the right track?"
"How would your parents notice, how the teachers?"

....or the classic question often given by MRI's Brief Therapists as a first session homework assignement:

"What would be a first, small sign, that would tell you, you are moving in the right direction?"

Most of these questions, the answers to them and the whole therapeutic conversation around them not only help to set a concrete goal for treatment (Komori and Geyerhofer, 1993), but often go a step further. They change the conversation from a problem saturated one to a conversation where change not only becomes possible, but visible, explainable, talkable, expectable and therefore in many cases inevitable. The whole conversation in the therapist's room begins to turn from "problem talk" to "solution talk". This can set the stage for change. And sometimes this is the only change needed.

The integration of problem focused and solution oriented approaches od Brief Therapy allows us to find the right time for this crucial shift in therapy. As mentioned above, a purely problem focused course often runs danger to get stuck in the complaints and the stories around problems and symptoms. A pure focus on exceptions, recources and solutions often does not meet the clients' needs for complaining, their expectations to finally be able to tell the whole story of suffering to an expert, who hopefully will be able to understand it all. All too often the solution of the problem is not the first thing clients

expect when they come to see a therapist. Especially in therapy with difficult adolescents, parents and kids appreciate to find a neutral context for their complaints, their suffering and their individual stories of fighting a problem that has been interfering with their lifes for quite some time. And a problem that has followed a family for more than a year, that has survived all their attempts to solve it, and then gets solved within a few sessions with a therapist, not only is a miracle and a relief. It also can be viewed as a personal insult for ones neverending attempts to fight it off all the years in the past.

Problem and solution oriented models of Brief Therapy can be seen as complementary parts within the difficult business of problem solving. The narrative metaphor of White and Epston (1990) has been a useful tool describing these two parts on the level of language and cognition.

During the ongoing course of therapy the two directions of focus are not seen as excluding each other, but rather supporting each other. Constantly the therapist evaluates the usefulness of the course taken by the clients' feed back to the questions or suggestions. In the process of cocreating the best stage for further changes, the clients and the therapist therefore are influencing each other mutually. And the "power" of this complementary and inevitable influence might be more equal than often doubted, as best described by Weakland (1993):

"The client needs the therapist's expertise and help, but the therapist needs his fee and the client is the customer - "hierarchy" cuts both ways. The case is similar even for "expertise". In our approach (MRI's Brief Therapy) the client defines the problem, even though the therapist may take a considerable part in clarifying just what behavior is involved and in focusing on what is most important to the client but initially expressed in a vague or confused manner. That is, the client is the expert on the basic determiner of the ends of treatment. The therapist is the expert on the means of achieving these ends. On the pragmatic basis of experience, the therapist may also have some expertise about the incompatibility of certain desired ends, or of certain means and ends (Cade, 1994; Fisch, Weakland and Segal, 1982)."

During therapy the conversation between clients and therapist might shift from "problem talk" to "solution talk" and back again. Although in some cases the course chosen after the definition of the treatment goal has been followed until the end of therapy. "If something works, do more of it", is the simple rule behind this observation.

While in most of our therapeutic work it might be hard to distinguish between the problem- and the solution focused course, there still are specific interventions characteristic for each course. As listed above in a classic problem focused course of treatment we would spend a lot of time to find out about "what has not worked so far" - that is, the attempted solutions of all family members and other helpers involved. Correspondingly, we will try to interdict these attempts, either by replacing them with new and different behaviors (Watzlawick, Weakland and Fisch, 1974; Fisch, Weakland and Segal, 1982) - so called "180 degree interventions", or by reevaluating the original behaviors of concern as "no significant problem" (Weakland, 1993). The second describes the more cognitive side of the MRI approach and is usually achieved by changing the client's cognition about the problem behavior through "reframing techniques" (Watzlawick et al, 1974).

Typical interventions used in a solution focused course of treatment are the search for exceptions (de Shazer, 1988; Gingerich and de Shazer, 1991; de Shazer, 1991) where the

therapist and the clients investigate times in the clients' life where the problem was not there. These exceptions can then be used for further redescriptions of the clients' relationships with the problem (White, 1988; White 1989). Externalizing the problem (White, 1989; White and Epston, 1990, Epston, 1993) has turned out to be one of the most powerful techniques in working with difficult adolescents and their families. Almost as much attention has been given to the possibility of internalizing solutions when positive steps have been taken by the family members and parts of the treatment goals have been met. White's "redescription questions" and "possibility questions" (White, 1988; White and Epston, 1990, Epston, 1993) are useful tools in rewriting the stories that bring families to therapy.

"Scaling questions" (Berg and de Shazer, 1993) and the famous "miracle question" (De Shazer, 1988) help the therapist and the clients to visualize the steps that they already took, the resources that they have and possible solutions in the future. In the "miracle question" clients are asked the following:

"Suppose you were to go home tonight, and while you were asleep, a miracle happened and this problem was solved. How will you know the miracle happened? What will be different?" (De Shazer, 1988, page 5).

This and other questions are used to utilize the future to co-construct hypothetical solutions with clients.

Over the whole course of therapy the answers or nonverbal reactions of clients serve as a feed back for the therapist. This feed back provides necessary information about the directions and the progress of treatment. They not only feed back to the focus of interventions, but may also force the therapist to reevaluate the definition of goals or problems, the definition of the complainants and the people invited to help solve the problem.

These guidelines have served as a useful help in working with all kinds of problems. They have been approved within individual-, couple- and family therapy. In all settings they have helped to keep the treatment brief with an average of sessions below 10. The following chapter presents an evaluation study of our work with children, adolescents and their families, including problems (or symptoms) like eating disorders, aggression, enuresis, school refusal, tics, drug abuse and various forms of psychosomatic diseases.

Research on Outcome in two different, clinical Settings

Following the guidelines for Brief Family Therapy illustrated above, we have conducted two parallel evaluation studies over a fixed period of time. The conjoint study was not designed as real clinical research and therefore does not meet many of the standards for modern research in psychotherapy. Is was mostly designed as an evaluation of clients' satisfaction with the outcome of treatment, their own personal and subjective evaluation of the process.

In a private Family Therapy Institute (Institut für Systemische Therapie in Vienna, Austria*) and a Pediatric Clinic (Psychosomatic Clinic at Gifu University, School of Medicine, Department of Pediatrics) the following questions have been used to follow up on the clients' judgements on the outcome of treatment 6 months after the last session.

QUESTION FORMAT FOR FOLLOW UP

1. When you first came to the hospital (institute), you were concerned about.....(brief description of problems and symptoms presented in the first session) ..... Is this concern now more, the same, less?

2. Since you stopped treatment, have any new problems occured (for you, the patient or any other family member)?

3. Since you stopped treatment, have there been any improvements or solutions in other problems?

4. Since you stopped treatment, have you or any other family members received further treatment? If yes, for what problem? What kind of treatment?

The questions chosen for our 6 months telephone follow up are quite similar to the ones used in previous studies (Weakland, Fisch, Watzlawick, Bodin, 1974; de Shazer, 1991; Nardone and Watzlawick, 1993; Macdonald, 1994). The results could therefore be compared and discussed in a larger context.

Within the study period 34 mothers or fathers with complaints about at least one of their children called the Institute for Systemic Therapy (I.S.T.) to schedule a first appointment. The first meeting was arranged with the complainants and everybody else willing to help solve the problem. They were seen in three different settings. 17 clients or families (50%) were seen by an individual therapist (Stefan Geyerhofer or Johannes Ebmer), 6 of them (17,6%) had two therapists (S.Geyerhofer or J.Ebmer plus another therapist of the IST - team) in the therapy room trying to help, and 11 (32,4%) were seen in the so called "Brief Therapy Center" (either S.Geyerhofer or J.Ebmer in the room, the other one behind the mirror - available for reflections or consultations). In all 34 cases the approach used for therapy was the same, only the setting was different. The average length of treatment was 2 months (9 months maximum) with an average number of 3 sessions (minimum: 1 session, maximum: 11 sessions). 23 families (67,6%) reported previous contacts with other health professionals, including general physicians, pediatricians, psychologists or other psychotherapists. Half of the families (50%) said that the problem has been interfering with their lifes and relationships since more than a year. The problems presented showed a huge variety of kids' and adolescent problems including anorexia, sleeping disorders, child depression, school refusal, tics, drug abuse, adolescent crises, fears and obsessions, aggression, eating problems and psychosomatic disorders. With 20 clients (58,8%) therapy was terminated conjointly and in agreement. After spending the last session internalising the solutions established by all family members, listing up all the resources the family has in fighting the problem, or counting up all the possibilities to make things worse again, clients were told that they can call to schedule another session whenever they feel the need to. The other 14 clients terminated therapy on their own. They either called and said that there is no more need for therapy, or they just did not show up for the scheduled appointment. Two families could not be reached for the 6 month follow up

(they had moved to a different area), two others had been refered to another institute after the initial session and were not contacted. The other 30 families were contacted by telephone 6 months after the last session and gave answers to our follow up questions.

In the same period of time 34 children with so-called psychosomatic disorders had been transfered to the Psychosomatic Clinic at Gifu University, School of Medicine, Department of Pediatrics from general physicians in the Gifu area, from pediatricians at the City Hospital in Gifu or from colleagues at the University Hospital. 26 of them received Brief Family Therapy in an outpatient setting by the same therapist (Yasunaga Komori), the other kids received medical treatment or had to be transfered to the psychiatric department. All initial sessions had a duration of 60 minutes, all following meetings lasted 30 minutes. Usually the clients were seen every second week (14 days interval). The average number of sessions at the clinic was 4, with a minimum of 1 session and a maximum of 10 sessions. The diagnoses included polakisuria (urinating problem - where clients feel a need to urinate in an abnormal frequency - e.g. every five or ten minutes), eating disorders, enuresis, school refusal, tics and various forms of psychosomatic symptoms. 4 families droped out and no follow up was made. The other 22 families were contacted by telephone 6 months after the last session.

The follow up was done with the complainants. The following system was used to classify the answers to our questions and the general utility of our approach.

SYSTEM of CLASSIFICATION

Success:
Both, the symptom (problem) and the concern have disappeared. No further treatment was needed.

Improvement:
Either the symptom or the concern are still there.

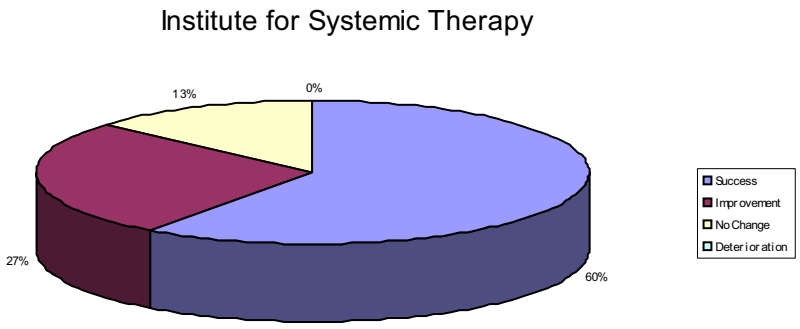
No Change:
Question 1: "the same", or further treatment for the same problem was needed.

Deterioration:
Question 1: "more", or hospitalization of patient.

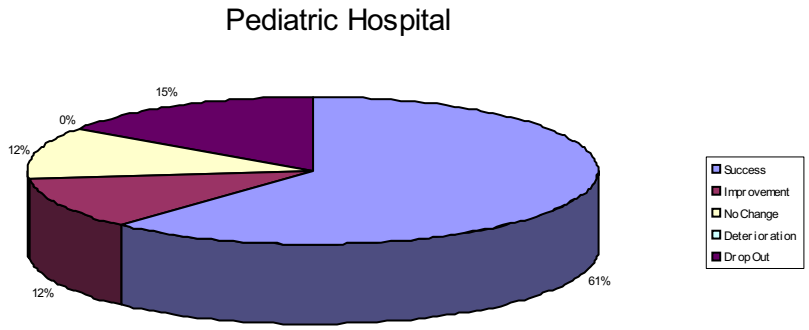
The following list compares significant variables and results from the two locations:

	Family Therapy Institute	Pediatric Hospital
Variables:		
Average of sessions	3	4
Minimum of sessions	1	1
Maximum of sessions	11	10
Number of cases	34	26
Results:		
Success	18 (60%)	16 (61%)
Improvement	8 (27%)	3 (12%)
No Change	4 (13%)	3 (12%)
Deterioration	-	-
Drop out	4	4

60% at the IST and 61% of the complainants (mostly parents) at the pediatric clinic reported significant change. The problem they had been fighting with was resolved and no further treatment was needed. There was no more concerne about the difficulty that brought them to therapy.



Graphic 1. Results at the Family Therapy Institute
(Institut für Systemische Therapie, Vienna, Austria)



Graphic 2. Results at the pediatric clinic
(Dep. of Pediatrics, Gifu University, School of Medicine, Gifu, Japan)

Similar to ours, previous studies (Weakland et al., 1974; de Shazer, 1991; Macdonald, 1994) have shown as well, that in some cases the occurance of problems in other areas had been reported during the follow up interviews (question 2 in the format). At the I.S.T. 17 people (56,7%) reported such problems. Interestingly, 16 of them (55,2%) also said, that they have been able to deal with them in a way that either solved the problem or that they feel in control of the problem. This effect of generalisation after treatment (question 3 in the format) is well known in literature. When there has been improvement in the problem area, positive changes in other areas are reported as well.

26,7 in the Family Therapy institute and 12% of all cases in the pediatric clinic had been coded as "significant improvement" (see graphics above). In these cases either the problem (symptom) or the concern about it had disappeared, and no further treatment was reported. Over all, the rates of positive outcome (success or improvement) in both locations (86,7% in the Family Therapy institute, 73% in the pediatric clinic) sustain the results of previous studies in the field of Systemic Brief Therapy (Weakland et.al., 1974; de Shazer, 1991; Nardone and Watzlawick, 1993; Macdonald, 1994). The tables below show some of the data and the results listed in details.

Nr.	Sex IP	Age IP	Single Child	Eldest Child	Family	Clients	Setting	Session	Duration	Problem/Symptom/Diagn.	Approach	Result
1	male	18	Y	Y	Y	F	Sin.Th.	1		Paranoid Psychosis	PO	I
2	male	19	N	Y	F died	M&P	Sin.Th.	10	9months	Epilepsie,Personal. Disorder	PO	S
3	male	17	Y	Y	Y	F.M.P	Sin.Th.	3	4months	Stealing	PO	S
4	male	10	Y	Y	Y	F&M	Co.Th.	2	1 month	Aggr.Behavior, Sleeping Pr.	Both	S
5	male	8	N	N	Y	Family	Sin.Th.	3	2months	Elective mutism	PO	NC
6	male	8	Y	Y	Divorc.	F&M	Co.Th.	6	3months	Behavioral problem	SO	S
7	male	14	N	N	Divorc.	M	BTC	4	4months	Eating disorder, Depression	PO	S
8	male	13	N	N	Y	M&F	BTC	1		School behavior	Both	S
9	male	10	N	Y	Y	M	Sin.Th.	2	1month	Depression, Suicide attempt	Both	S
10	female	7	N	N	Y	M,P,Si	BTC	1		Runaway	PO	I
11	female	13	N	Y	Y	Fam.	BTC	8	3months	Anorexia nervosa	Both	S
12	male	8	N	Y	Y	M,P,Si	Sin.Th.	11	6months	Asthma	Both	S
13	male	10	Y	Y	Divorc.	M&P	BTC	2	1month		PO	NC
14	male	11	N	N	Y	Fam.	BTC	3	1month	Behavior in School	Both	S
15	female	16	Y	Y	Adopt.	M&F	BTC	3	2months	School refusal	PO	I
16	female	10	N	Y	Y	M,F,P	BTC	3	2months	Anorexia nervosa, Tic	Both	S
17	male	15	Y	Y	Divorc.	F&P	BTC	10	5months	School refusal / Depression	Both	S
18	female	18	N	Y	Y	M	Co.Th.	3	4months	Diabetes	Both	I
19	male	12	Y	Y	Divorc.	M	Sin.Th.	5	3months	School refusal, Soc. Behavior	PO	S
20	male	13	N	Y	Divorc.	M,P,Si	Sin.Th.	2	1month	Aggressive Behavior	PO	NC
21	male	13	Y	Y	Y	Fam.	BTC	5	3months	Obsessive washing, Soc.Beh.	PO	NC
22	male	9	N	Y	Y	M	Sin.Th.	7	7months	Aggr. Behavior	Both	S
23	male	10	N	Y	Divorc.	M	Sin.Th.	1		Behavior in school	SO	I
24	female	13	N	N	Y	F,M,P	Co.Th.	3	1month	Anorexia nervosa	Both	S
25	female	14	N	Y	Y	F,M,P	Sin.Th.	2	2months	Anorexia nervosa	SO	S
26	female	16	Y	Y	Divorc.	M&P	Sin.Th.	5	4months	Depression, Suicide attempt	Both	I
27	male	17	N	Y	Y	M&F	Co.Th.	1		Aggression against father	PO	referal
28	male	6	N	Y	Y	M&F	Sin. Th.	3	2months	Headache	Both	I
29	male	11	Y	Y	Divorc.	M&P	Sin. Th.	1		School refusal	SO	S
30	female	16	N	Y	Y	M	Sin.Th.	7	5months	Drugs	Both	S
31	female	14	Y	Y	Y	M&F	Sin.Th.	1		Drugs	PO	moved
32	male	14	N	N	Divorc.	Family	BTC	3	3months	School refusal / Runaway	Both	moved
33	male	18	N	N	Divorc.	Family	Sin. Th.	3	2months	Drugs	Both	I
34	male	13	Y	Y	Y	Family	Sin.Th.	1			SO	referal
	M: 24	12,76						3				
	F: 10	average						median				

Tabella 1: Casi dell'I.S.T. (Institut für Systemische Therapie) (Y = sì, N = no, F = padre, M = madre, P = paziente, Si = sorella, PO = problem oriented, SO = solution oriented, NC = nessun cambiamento, I = miglioramento, S = successo, DO = drop out)

The tables show some interesting differences in the two locations. At the Austrian institute the number of male patients was higher than the one of females (24 males, 10 females), at the pediatric clinic in Japan it was the opposite (10 males, 16 females). The average age of the children in Austria was 12,7 years, in Japan the kids were 9,6 years in average. There were 4 mothers of preschoolers seen at the pediatric clinic. Looking at our sample, the problems in Austria seem to begin when kids enter school. But most probably this last difference can be explained by the two different settings, specifically with the differences in the referrals.

The tables also give information about the families' situation at the time of the first session (Yes = family is complete, No = not complete; table 1 shows the families' situation in more detail). Interesting differences can also be found in the frequencies of diagnosis. There seem to be characteristic symptoms and problems for males and femals, as well as for the different age groups. All these results are only based on a small number of cases in

each group, and can therefore only be taken as observations without any significant statistical background.

Nr.	Sex IP	Age IP	Single Child	Eldest Child	Nuc.Family	Clients	Session	Duration	Problem/Symptom/Diagn.	Approach	Result
1	female	3	N	N/N	N	M	2	1week	Behavioral Prob. "Onanie"	PO	S
2	female	3	Y	Y	Y	M	2	1month	Polakisuria	PO	S
3	female	3	N	Y	Y	M	3	6months	Eating	PO	S
4	female	5	N	Y	Y	M	2	1month	Enuresis	PO	S
5	female	8	N	N/N	Y	M	1		Respiratory Probl.	SO	S
6	female	7	N	N/Y	Y	F	8	2months	Abdominal Pain	Both	S
7	female	8	N	N/Y	N	M	6	6months	School Refusal	SO	S
8	male	9	N	N/N	Y	F	4	6weeks	Tic	Both	I
9	female	9	N	N/N	Y	M	2	2weeks	Pulling out Hair	SO	I
10	male	9	N	N/Y	Y	M	8	5months	Alopecia	SO	NC
11	male	9	N	N/Y	Y	IP	10	5months	Abdominal Pain	Both	S
12	female	10	Y	Y	Y	M	4	6weeks	Cough, Vertigo	PO	S
13	male	10	N	Y	Y	IP	5	7weeks	Behavior Problem	Both	S
14	male	11	N	Y	Y	IP	5	1month	Alopecia	Both	NC
15	female	12				M	5	2months	Abdominal Pain,Nausea	Both	I
16	female	12	N	N/Y	Y	M+IP	10	4months	School Refusal	SO	S
17	female	13	Y	Y	Y	M	1		Vomitting	SO	S
18	male	12	N	N/N	N	M	5	3months	Abdominal Pain,Fatique	SO	S
19	female	14	N	N/N	Y	IP	3	1month	Headache, Fatique	SO	S
20	male	14	N	Y	N	M	3	2months	Decreasing Muscle Power	SO	S
21	male	14	Y	Y	N	M	2	1week	Abdominal Pain	SO	NC
22	male	14	Y	Y	N	M	3	5weeks	School Refusal	SO	S
23	male	3	Y	Y	Y	M	1		Pain in Hands and Feet		DO
24	female	9	Y	Y	N	Gr.M.	2	1week	School Refusal		DO
25	female	12	N	N/N	N	M	4	3weeks	Headache, School Ref.		DO
26	female	16	N	N/N		M	1		Weight		DO
	M: 10	9,577									
	F: 16	average									

Tabella 2: Casi della Pediatric Clinic
(Y = sì, N = no, F = padre, M = madre, P = paziente, Si = sorella, PO = problem oriented, SO = solution oriented, NC = nessun cambiamento, I = miglioramento, S = successo, DO = drop out, Gr.M = nonna, N/N = non figlio maggiore, N/Y = non filgio maggiore ma il più grande del proprio sesso)

Some differences could be explained with the different contexts of referrals at the two locations, others might be due to cultural differences (e.g. frequency of divorce in Japan and Austria). Other differences shown in table 1 and table 2 are due to variations in the therapists actions. At the institute in Vienna the complainants where more frequently joined by other family members - either by the ones willing to help solve the problem (see guidelines above), or by adolescents who were "asked" to come with their parents, since "they are the ones causing all the difficulties". The therapists in Vienna (Stefan Geyerhofer and Johannes Ebmer) rarely insisted on seeing the complainants only. More often the time of sessions was shared, to have seperate time for the parents and for the adolescent

(compare: Selekman, 1993). In Gifu the therapist (Yasunaga Komori) more frequently only worked with the complainant, using the most usual setting of therapy (one therapist). In Vienna three different settings (Single therapist, Co-Therapy, Brief Therapy Center) have been used in the work with families.

The tables also show the duration of therapy, the number of sessions, the result of the follow ups and the direction of the approach taken in the process of treatment. A last difference occured in the handling of drop out cases. At the clinic in Gifu no follow up was conducted with clients that droped out of therapy. "Therapeutic drop outs" automaticly became drop outs for the evaluation study. In Vienna these clients were contacted as well and their data was considered in the study. Four families droped out of the study from other reasons (two moved to a different area, two had been refered after the initial session). To compare the results from both locations, we had to consider the valid percentages (see graphics above) of the Vienna data. In spite of our regular communication between Asia and Europe, we managed to create at least this one "creative misunderstanding" (as de Shazer might call it).

A more detailed analysis of the data was aiming towards possible predictors for success in therapy. Neither the setting, the duration of the problem, the amount of sessions, the diagnosis nor the context of the referral turned out to be good predictors for the outcome of treatment. The way therapy was terminated proved to be the only useful variable for predictions of that kind. Those clients who ended their treatment conjointly with the therapist (independent from the number of sessions) during the last session had a much higher rate of "success" and "improvement" later in the follow ups (compare table 1). "No change" was significantly more frequent ($r = 0,65/ p < 0,001$) in the cases where clients terminated therapy on their own, by canceling or not showing up for the next appointment.

Summary and Conclusions

Like others before and with us (Chang and Phillips, 1993; Todd and Selekman, 1991; Selekman, 1993; Furman and Ahola, 1991) we have managed to integrate the three major approaches in Brief Family Therapy. Not only are they theoretically compatible, they have also opened up a lot of new possibilities for our practical clinical work with families. On the two dimensions "problem versus solution" and "behavior versus cognition" therapists can move freely in coordination with clients' needs and expectations. It is possible to locate single questions and techniques used in Brief Family Therapy on these dimensions and by this reflect on the course that therapy is taking. The practical guidelines described in this article can help to structure the process of treatment along these dimensions, and have proven to be a useful tule in working with individuals, couples and families. The questions that arise from our work could be many. "What is leading us towards a shift of our focus?" "Which reactions of our clients tell us to move towards a clearer focus on problems/ or on solutions?" "How exactly can we utilize the interaction of behavior and cognition in therapy?" "And what role do feelings have in all this?" We will keep on elaborating these questions with others - in two different countries, two different cultures, two different working enviroments - and with eachother.

And while we continue to make these approaches useful for our clients, new goals for research have also been established. In two years from now, we hope to be able to present

more results on the kind of Family Therapy that focuses on resources, strengths, possibilities, stories, problems and their solution, rather than on pathology, inabilities, blame, insight and recrimination. By this we hope to contribute a little to the "shift in the wind" (O'Hanlon, 1993) that is noticeable in the field of Family Therapy since the last 10 years.

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Final note

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