CHAPTER 17

Our Clients *Are* Able and Strong

MRI Problem-Solving Brief Therapy in Action

Karin Schlanger and Esther Krohner

"My daughter sent me to see you and, because I am a good mother, I had to do as she asked me to and I requested an appointment. You are highly recommended, but you should know that I have had a lot of therapy in my life!" This is how Catalina, a 59-year-old Chilean woman, introduced her problem in the first session at the Brief Therapy Center of the Mental Research Institute (MRI) in Palo Alto, California. "My daughter believes – and I agree with her – that I am in an abusive relationship. I walk on eggshells around my husband because if I happen to say something that he doesn't like – and I never know what that might be – he yells at me, becomes threatening and abusive. He has never hit me but I am nervous, insecure, and feel vulnerable."

Karin ascertained that Catalina was out of physical danger, at least for the immediate future. Catalina said she had a place to go if she felt threatened, had confided in people around her, and it was clear that when these arguments took place, she felt confident enough to stand up to her husband. Her actions, however, just made the situation more inflammatory and prone to escalation. How does the MRI Problem-Solving Brief Therapy (PSBT) model organize this information and frame the rest of treatment?

When therapists think in an *interactional* way, the focus of treatment is always *the relationship*. Because dangerous behavior for the most part occurs in a context in which people act, react, and respond to what is happening, the client is not just a victim, but also an actor. If the therapist can become curious about the dangerous situation and ask details about the process that culminated in the aggression, both the therapist and the client will be able to construct a new reality around the dreaded incident. People can either be seen as resilient and able to cope or can be seen as victims in need of being put in a protective box, where the only person who has a key is the therapist. The belief in a client's strengths is how the PSBT model *works with the client* to define a problem, chosen by the client to be significant to *them* and that *they* want to change. Working with the client to define the problem is one of the key differences between the PSBT model and many other approaches to therapy.

Another important distinction to point out is that with PSBT a therapist can easily work with one member of the system alone, preferably the person who is the most motivated to change the status quo. Therefore, it will become quite clear that, in Case #1, all the work was done with Catalina. Karin actually never met Henry.

The next significant principle in the model is that of *attempted solutions* (Watzlawick et al., 1974; Fisch et al., 1982). They are defined as communicative actions, thoughts or behaviors performed intentionally and repeated by people within a system of cultural significance. Their intent is to solve a difficulty, but ironically their actions lead them to get stuck*:* the repeated attempts end up *creating* a problem, perpetuating it and making it worse. When the pattern becomes too painful to the client or someone around them is when a therapist usually gets a phone call requesting help.

Catalina described in great detail that she thought of herself as being a survivor: she had arrived in the US from Chile as a young woman, following her first husband. She had realized soon after having her second daughter that her husband was unfaithful, so she divorced him and relocated to California with her daughters when they were four and six. She supported her family by teaching private music lessons and told Karin she was particularly proud of having been able to afford a house. She had explained that what originally had attracted her to her current husband, Henry, was his sense of humor and his loyalty. She had requested an appointment at MRI because, although her daughter was worried, she knew that Henry would do anything to *keep* this relationship: he felt like a failure because he already had one divorce in his history. He did not want a second.

Near the end of the session, Catalina elaborated:

> I married my current husband, Henry, only five years ago and have lived with him now for seven years. He is not the father of my adult girls because their father was a dead-beat whom I left when they were very little. I have managed my life just fine without Henry, but I didn't want my girls to have to deal with me when I was old. Henry is from the Old Country and when he gets mad he yells loudly and becomes threatening and frightening. I have tried to talk to him at different times, told him to let me know in a calmer voice when I say something he doesn't like. I have even looked at moving out: I went to a real estate office to look at options. After a while that he has been yelling at me, I tell him I am sorry, but I say it in a bad way because I am angry. I just don't want to live this way anymore. I want peace in my life and, ironically, I think he does, too!

Hearing all this story, at the end of the session, Karin said *what*?

> Please go home and prepare two sets of flash cards, one in Spanish and another in Bulgarian (where Henry was originally from) with phrases that

say things like: "I'm sorry, I'm sorry, I'm sorry" and have a drawing of a smiley face on it; another one could say "Maybe next time"; yet another one could say "I love you." If you are feeling creative, you could make one that said something along the lines of, "When you act this way, you really turn me on!'"

Catalina listened carefully, looked intrigued and said: "I think this is going to work!"

What Were We Thinking?

From the point of view of the MRI PSBT model, it is always important to take into account the clients' worldview, *their* reality. In this regard, three important principles influence therapists' thinking. First, Heinz von Foerster's Constructivism (see Watzlawick, 1984): we can only approximate pure and objective truth so, *reality* and *truth* become an *individual construction* because they interact with our context and the relationships we create with it. From this premise, the PSBT approach allows the therapist to believe that the clients are experts in their own lives, and it is therefore the therapist's job to learn the details about what is important to the client. That knowledge then gets incorporated into whatever intervention the therapist will use to steer the client in a different, more productive, less painful direction.

Secondly, Gregory Bateson (1972; Ruesch & Bateson, 1951) in his early work talked about how human beings relate to each other: each action is motivated by the other's response and so on, in an infinite loop of interaction. This way of looking at humans changed the view from an intrapsychic one to a relational one: "A process of differentiation in the norms of individual behavior which results in cumulative interactions among individuals" (Bateson, 1958, p. 175). From this premise flows the therapist's point of view that even in some cases of abuse, while the client might appear to be the one suffering abuse, it happens within the context of a relationship in which there are at least two actors. It is of utmost importance to protect individuals from danger and it is helpful to be able to step back to look at the relationship in order to open the doors to new, more productive interactions, in which the abuse no longer has a role to play.

The final important influence on the work of the MRI Brief Therapy Center is the skillful use of language, ideated by Milton Erickson and promulgated especially by John Weakland. Listening to what words clients use to describe themselves, their realities, and how they see problems gives therapists key insights into how to direct the process of therapy in a useful direction. By definition the contextual frame of a session gives the therapist the role of expert and guide in the process. To promote positive change, it is up to the therapist to pay attention to, and learn, the client's language (what actual words they use to describe themselves, not their mother tongue) and to fit within the client's frame of reference. Therapists have long been taught that if patients – as

they are called in conventional models – don't follow the therapist's prescriptions, there must be a resistance to the prescriptions that comes into play. Alternatively, in the PSBT model, resistance occurs when the therapist has moved too fast, neglecting the time and energy to adequately listen for what is important to the client. While these practices may take some time at the beginning of the therapy process, they are well worth the investment, since doing so will allow the communication between the therapist and the client to be more effective when it comes time for the therapist to suggest a different course of action. The client will be able to comply with the suggestions because they will be phrased in a way the client can actually *hear*.

With all of these pieces of the therapy puzzle in place, it is easier to understand that the MRI brief therapist can work with any case that walks in the door. "*You do not need to be a chicken to know when an egg is rotten*," says an Argentinean friend of Karin's. There is little need to become a specialist in any particular issue – alcohol and drugs, gay/lesbian/transgender, family versus individual, cultural sensitivity training, racial equality, phobias, eating disorders, attendance and learning problems, etc. If therapists are willing to listen and have the humility to learn from their clients, the way problems are constructed, de-constructed, and solved is applicable to any system. This represents radical thinking in the 21st century with its growing segregation into specialties and attempts to create protocols and work sheets that put clients in category boxes with labels rather than looking at them as individuals. Although it is ideal to speak a client's native language, it is not imperative if you are willing to listen for cultural differences and allow yourself to be educated. For example, if a therapist tries to convince a Pacific Island family, in any language, that putting grandma into a nursing home is best for everyone, the therapist should not be surprised when the family fails to return for their next appointment: they will not have felt heard and understood. We hope to have made our thinking clear and John Weakland's remark comes to mind (personal communication, 1985) that "Too often we get lost in *explanations* and in so doing we lose track of the *actions* that need to be taken in every particular case in order to promote change."

Catalina returned to her next session, two weeks later. She was smiling broadly and could barely contain her excitement.

Catalina: I was very much looking forward to coming back to tell you how well things have been at home. We have not argued at all! After my last session here I went home and told Henry what you had told me here: that I maybe play a part in our arguments and his getting abusive. You know? His face relaxed! I could see a sense of relief in him that I had never seen before. Since then, he has yelled much less and never has he lost his temper and threatened me. It's been incredible: it's back to when we first met. We are having conversations and our sex life is … well … much improved!

Karin: And did you take the time to make the cards as we had suggested?

Catalina: Yes, I did. I had a great time doing them, but I haven't needed to use them. I guess I'll keep them for a rainy day. When you asked me to make those cards I realized that they were going to say the same things I had been telling him but it was not going to be in the middle of an argument. I was going to be in a better place and that made all the difference.

Karin: I have to admit that I am surprised and a little unnerved by the sudden change, so I suggest that you keep those close because sustainable change happens slowly and with ups and downs.

Karin saw Catalina two more times to make sure that the change was established and durable. She then terminated sessions by leaving the door open, in a typical Brief Therapy Center fashion:

Karin: We agree that our work here is done. If you ever need anything in the future, you know where to find us!

Catalina has continued to send us referrals, which is the best indicator of a satisfied client.

Another Case Example

Professionals using the MRI approach have often endured the criticism that this model can only be used with "uncomplicated" or "light" cases. For this reason, we have picked another, more challenging or "intimidating" (Fisch & Schlanger, 1999) situation to round out this chapter.

Chris was a 15-year-old who had been seen by various therapists in different settings for more than three years to address obsessions/compulsions, suicidal ideation, sleep problems, anxiety, and depression. He was referred to Esther by a psychiatric hospital in the Bay Area where she works in an outpatient clinic. His parents had most recently taken him to the local ER for suicidal ideation and risk of self-harm. The hospitalization was further complicated by the staff having to file a Child Protective Services (CPS) report.

Esther initially met with the whole family. Chris had been trying to manage suicidal ideation for quite some time and had been able to stay out of the hospital, so she inquired: "Are you aware of what contributed to being hospitalized this time? What made it different than the many other times you have had suicidal thoughts?" Chris pointed out that on the day he went to the hospital, he had told his parents about his thoughts and then started banging his head against the wall. In an attempt to restrain him, his father, Tim, had forcibly pulled him to the ground, and eventually both parents brought him to be evaluated at the emergency room. The parents agreed with the basic description of events that Chris had told the therapist. Tim said, "Chris disclosed his thoughts, and he started to bang his head and I stepped in by restraining him

while his mom was crying." The parents were mortified that CPS had been called. "CPS criticized us for restraining our son, which was our only option." It is noteworthy that Chris felt very guilty that he had "gotten my parents in trouble, they are really trying their best to help me." All of this was disclosed within the first meeting.

Throughout the description of the events that led to the hospitalization, Chris made statements that his parents had done their best and that he was very sick and out of control. He talked a lot about how depression, obsessions, and compulsions leave him feeling empty and angry. When Esther explored more about what got him angry, he replied by excusing the things that got him angry. For example, "My parents really want me to be social and get great grades, and I see why that is more important to them than having friends and being happier. They want me to have a good education and I am really messing up the investment they have made in sending me to private school, even though I don't like it and people I go to school with use drugs, are mean, and are hard to be around." He also said, "People at school don't want to be friends with me and it is really my fault because I am so anxious in social situations and I get why they would not want me around." Esther noticed the contrast that co-existed between his anger towards his parents and his words to defend their actions.

Chris periodically justified Tim's restraining him, referred to other times his father had used physical force to restrain him and commented about the effect these incidents had on his mother, Diana: "I feel bad that I stress my mom out and that makes her breathe heavy and cry." This attempt to justify and excuse his parents' behavior and take on so much self-depreciation struck the therapist, especially considering that many of his obsessive thoughts surrounded beating one or the other of his parents and harming himself. These interactions shed light on the client's frame of reference and the way he was making sense of his interactions. He was describing himself as being out of control in many areas and therefore undeserving of the things he wanted and hopeless enough that he wanted to disappear. He excused the people who treated him contrary to how he wanted to be treated and in turn used it as further evidence that he was terrible. Esther's interventions were informed by the interactional loop and use of language that was focused on words of protection, effort, guilt and powerlessness.

This case presented a particular challenge because of the life-threatening nature of the problems, yet the MRI PSBT model operates by an "open only one door at a time" premise, which still stood true. Esther spent the first two sessions gathering information from Chris, his parents, and subsequently from his previous therapy providers and psychiatrist. It was clear that the parents were worried and also angry to have their child, to whom they had given everything, threaten them with suicide. To them it was a grand gesture of "*Screw You!*" Diana had a family member who had completed suicide, and Chris sent her into emotional upset when he brought up his thoughts about disappearing.

There were conflicting reactions around Chris' emotions. Diana switched between being angry/spiteful and overly fearful/coddling. Tim had a more unequivocal position on the problem: he interpreted his son's suicidal actions as an offense to him and his wife, and maintained much of the frustrated efforts to "get our son into shape" because Tim himself had suffered from depression and OCD in high school and therefore knew what Chris needed to do to get better. He often expressed his view that "Chris has everything he could possibly need, yet he is suicidal, ditching school, smoking pot and avoiding his responsibilities. He needs more accountability." When the parents were together, Diana would side with Tim, but also send the opposite message immediately after. "No! Chris is very sick and we need to let him work though this stuff, or he might be the kid we read about in the papers who jumped in front of a train."

Chris's report in the first two sessions painted his world as feeling "out of control." He wanted to have fewer outbursts in which he would yell or hit his head against the wall, have fewer tremors and panic, wanted to sleep better and go to school on time. He was willing to stop smoking pot. He said:

> I tried all of the CBT [cognitive-behavioral therapy] interventions. They make me feel even worse. I try to stop my anxious thoughts and the gory obsessive images, but they come back stronger. I try to go to sleep and follow a sleep hygiene routine, but I feel more panicked. I have forced myself to watch the images, and let them be there and apply mindfulness when they come up by tracking the thoughts and noticing them and letting them ride out and paying attention to my breathing [exposure and response prevention therapy], and I have also practiced having the thoughts and images and letting them be there and then using the calming techniques but I feel terrible for having them. I'm a terrible person. My parents are right.

Chris' gory thoughts were about beating his parents or jumping in front of a train or some variant of these two images. He felt extremely guilty and painted a picture of helplessness due to his inability to use the techniques to his advantage. He saw the images as a further indication that he was "bad" and out of control.

In the third session, Chris and his parents agreed that the obsessive thoughts of harm in all its variants were the main problem, and therefore the door was opened to start to promote change. While the parents didn't fully agree about the reason Chris was having suicidal ideation, they both agreed that they did want what was best for him. Because Chris was a client, Esther decided to work mostly with him. Her goal was to build a strong relationship with Chris in preparation for when the parents would be more a part of the therapy and could be more certain they could "commit" to another way of relating to Chris. Also, Esther had a sense that the parents were not being transparent

and were withholding information. Chris had mentioned other times when Tim had intervened physically, which the parents had omitted mentioning, as well as reports about Diana's crying fits, which had also been omitted when Esther had inquired about the other times that Chris had threatened/scared them with suicide and how they had handled it. Lastly, because the parents had different frames – Diana saw Chris as more sick and was scared, and Tim was more threatened and angry – Esther wanted to take time to approach this difference and develop language that would enhance their interactional options.

It was also noteworthy that the parents allowed Chris to defend their behavior at his expense (he took on the blame for being out of control even though his mother would be emotionally overwrought and his father would be enraged and pin him on the ground when things escalated). They were an important piece of the interactional structure and their responses to Chris were influencing what he saw as possible. However, Esther needed to get more of Chris's words to use with the parents, so they could have less opportunity to skirt the issues or for Tim to blame and Diana to baby Chris. Esther saw this as the confusing behavior by his parents that was leaving Chris both in control and powerless through his own eyes.

It was clear to both Chris and Esther that Chris harbored contradictory feelings towards his parents: he thought he was spoiled by his parents and at the same time wanted to hit them, which made *him* a bad person. Esther tried to reframe this perception in a way that might be more useful to him: he was managing to pass all of his high-level classes despite missing school and had maintained A grades in a highly competitive prep school. As a part of the reframe, Esther worked with Chris on actions that would still express his anger without having to threaten suicide to his parents. He would accomplish getting their attention in a more positive way. She had worked at establishing credibility with Chris, getting him to feel/understand that she was on his side in fighting this problem. She said:

> These thoughts actually seem to be some sort of protection against actually beating your parents. They seem to be a very creative way to show you are pissed but also staying in control from actually hitting and physically hurting them. Yet they come at the high cost of everyone feeling out of control and quite useless. What if we were to consider that these thoughts and urges have become undeniably *entertaining* to you? You are obviously bored since you can complete all of your schoolwork in a short time and you spend loads of time in bed with these gruesome yet entertaining images. It's like they keep you company! Perhaps you're needing other things to entertain yourself and other ways to deal with what is angering you.

Esther came to this interpretation by comparing and combining the tension between Chris wanting to defend his parents and his seeing himself as terrible

as well as him feeling very angry and wanting to get them "off my back." Esther used this intervention, as well, to help lay the tracks for teaching other ways to face what was making him angry as well as to collaborate with his parents on life choices and behavioral choices that he was making. The therapist was trying to level the playing field a bit and create an image (reframe) that made the "out of control" thoughts seem like he could actually control them and that they were a sign of restraint rather than being "out of control."

Chris looked perplexed. He thought, then said:

> I never thought about it that way and you are right – I am very angry at my parents! They say they want me to be happy, but any choice I make they don't like. They push me and threaten me and tease me. They say they want me to share what is going on with me, but I feel very guilty when I admit to feeling depressed or anxious and yes, I am so bored, especially now that I am not returning to my school.

As John Weakland said (personal communication, 1983), "Never drop a winning game," so in the next couple of sessions Esther continued with the approach of looking at the suicidal ideation as an understandable result of being bored and confused and needing more options socially, academically, and communicatively.

As a consequence of the intervention, while the images would still pop up, they were less frequent and less severe. Chris began to see these images as a reminder that he needed to speak up and make some choices about his future. Subsequently, he wanted to spend sessions talking about what he was angry about, and this led to building an interactional picture of how the various symptoms were in some way protecting him and his parents from working through their conflicts around school choices, social choices, substance use and lifestyle choices like exercise and entertainment.

The main difference between the MRI PSBT and the CBT that Chris and his family had experienced previously was that we provided an empowering reframe that the thoughts/feeling were helpful/protective – this made them less disturbing and exposure to them less burdensome, and planted a seed for other ways to protect and advocate for himself. The previous attempted solutions had led Chris and his parents to avoid the suicidal ideation at all costs whereas the PSBT therapist encouraged him to look the suicidal thoughts in the face. The CBT model had talked about exposure but only to drive it away: when the thoughts came, Chris was supposed to relax or in other ways "make them go away." From the PSBT perspective that is a more elaborate way of still avoiding the feelings, which did not work. The avoidance of the thoughts/feelings had become the rut in which Chris was trapped; the new solution used his feelings and thoughts to his advantage as he learned communication skills as well as harnessed his motivation around what he wanted to move toward in his life.

Once the suicidal ideation had subsided, Esther, Chris, Tim, and Diana reconvened and spent multiple sessions talking about how they could "get off Chris' back" so he could figure out what he wanted and so they could figure out what they really wanted for their son. Tim and Diana needed to back off, considerable coaching, and "proof" that their son was willing/able to change. Esther, the parents, and Chris worked on one behavior at a time. The first was figuring out a school option that would allow for Chris to complete the school year. The parents needed help coming to terms with their son not continuing in the high-pressure environment of the school. He was smart, capable, and could potentially return to the higher lanes at a later date, but that for the remainder of the school year it was not a viable option to continue pushing him.

The work became for Chris to use his voice in expressing what was important to him and using his intellect to create options as well as finding things to entertain himself that came at a lower cost than the gruesome images. The work with the parents became giving Chris space and making compromises as well as acknowledging to their son some of the role they played in maintaining the problem. The therapy allowed Chris, Diana, and Tim to mobilize their creativity and find more reasonable ways to influence one another that were less dramatic. Eventually, Chris switched from the highly competitive private school to a public school with an option to start late in the morning, and his sleep improved. Therapy ended when he joined a baseball team and the parents agreed that it was the most important thing for his health since it was something he liked that kept him active and improved his sleep, mood, and sociability.

There has not been any further contact with this family since the decision was made that Chris was so busy with "good" things that it was no longer a necessity to come to therapy.

Conclusion

As seen in the work both with Catalina and with Chris, the MRI PSBT fosters a relationship between the therapist and the client that is flexible, tolerant, sometimes unexpected, and holistic (see Schlanger, 2011, 2013, 2014; Schlanger & Anger-Díaz, 1999). Replacing the fear of sickness or pathology with a search for better problem solving, the therapist can instill hope, creativity, and playfulness into a tense situation, which generates a virtuous cycle propelled by the clients. It is important for the reader to remember, however, that every situation is unique and different, that not every abuse case can be solved with cards, and not every suicidal/OCD situation can be reframed into boredom to promote a different action. We strongly believe that if the therapist chooses to see the clients as able and strong, the message to the client becomes closer to "Yes, we can!"

References

Bateson, G. (1958). *Naven: A survey of the problems suggested by a composite picture of the culture of a New Guinea tribe drawn from three points of view*. Palo Alto, CA: Stanford University Press.

Bateson, G. (1972). *Steps to an ecology of mind*. New York: Ballantine Books.

Fisch, R. & Schlanger, K. (1999). *Brief therapy with intimidating cases: Changing the unchangeable*. San Francisco: Jossey-Bass.

Fisch, R, Weakland, J.H., & Segal, L. (1982). *The tactics of change: Doing therapy briefly*. San Francisco: Jossey-Bass.

Reusch, J., & Bateson, G. (1951). *Communication: The social matrix of psychiatry*. New York: Norton.

Schlanger, K. (2011). Problem-solving brief therapy: The Palo Alto approach to working with a Latino couple. In D. Carson & M. Casado-Kehoe (Eds.). *Case studies in couples therapy* (pp 133–144) New York: Routledge.

Schlanger, K. (2013). Get off your high horse: Reflections of a problem solver in Palo Alto. In M.F. Hoyt (Ed.). *Therapist stories of inspiration, passion and renewal: What's love got to do with it?* (pp. 240–250). New York: Routledge.

Schlanger, K. (2014). Hoy en Palo Alto: Un trabajo en escuelas californianas con población inmigrante. In R. Medina, E. Laso, & E. Hernández (Eds.). *Pensamiento sistémico, nuevas perspectivas y contextos de intervención* (pp. 73–97). Mexico City: Litteris Psicologia.

Schlanger, K., & Anger-Díaz, B. (1999). The brief therapy approach of the Palo Alto group. In D.M. Lawson & F.F. Prevatt (Eds.). *Casebook in family therapy* (pp.146–168). Pacific Grove, CA: Brooks/Cole Publishing.

Watzlawick, P. (Ed.). (1984). *The invented reality: How do we know what we believe we know? (Contributions to constructivism)*. New York: Norton.

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