**BRIEF THERAPY The Bruges Model**

**Manual for the ‘Bruges Model’ of psychotherapy
applied to children and adolescents**

**Myriam Le Fevere de Ten Hove**

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INTRODUCTION

The idea 'Brief Therapy' was introduced by the Palo Alto-school: John Weakland and Don Jackson and later on Paul Watzlawick, Dick Fisch and Carlos Sluski.

In this book, the Bruges Model of Solution Focused Brief Therapy is described. It has been developed by the Korzybski institute in Bruges (Belgium) and Paris with dr. Luc Isebaert, dr. Marie-Christine Cabié, Erwin De Bisscop, Louis Cauffman and dr. Myriam Le Fevere de Ten Hove, starting with the professional friendship between Luc and Myriam since 1978, exploring what works in therapy. Godfather and godmothers are Steve de Shazer, Insoo Kim Berg and Yvonne Dolan, who have been publishing this solution focused approach since 1984. Since 1990, an intense friendship and co-creation has developed between the inspirers of the Brief Family Therapy Center BFTC and those of the Korzybski Institute.

'Brief' is not the purpose in itself, but the natural consequence of a respectful approach of the client, by which he again discovers the possibility of making a choice in his thinking and doing, in controlling his life, and so escaping the straitjacket of symptoms. Having the conviction that the client has the most know how in this matter, but often not realizes he has, as therapists we don't give ourselves the task of accompanying the client until the problem is completely solved. We stop when the client has found sufficiently his way to continue. This cooperative approach between the client and the therapist avoids creating resistance.

When back in 1984 at the newly founded Korzybski Institute, we started brainstorming about what works in psychotherapy, and about what is essential and sufficient in the therapeutic conversations, none of us could have imagined this was the beginning of a worldwide Solution Focused approach. Meeting Steve de Shazer in 1990 unleashed the creation of a Solution Focused model, a USA-European co-construction, that got distributed worldwide, thanks to the traveling zeal of Steve and Insoo.

In the Bruges Model we describe the basics of solution focused work as we learned from Milton Erickson, Ludwig Wittgenstein and Alfred Korzybski, and we present our flowchart of therapeutic relationships, promoted by Steve and Insoo as the ‘Bruges Flowchart’ (in 1996, during ‘Therapeutic Conversations II at Denver, Colorado, USA). The name ‘Bruges Model’ was given by the participants of this congress, and the Korzybski team was renamed 'The Bruges Group'. Meanwhile, different accents were developed, subjects were eliminated and added, or focused on in different ways.

Now, more than 35 years later, there is a global network of solutions-inspired initiatives and organizations. Solution-focused professional associations are forming an inspiring network. Their enthusiasm is contagious. The solution-focused virus turns out to be highly contagious, not only in the workplace, but also in daily life. This poses a serious risk to a happier life.
One should feel warned.

*Myriam Le Fevere de Ten Hove, 2020*

BRIEF THERAPY, the Bruges Model

***"A good book changes the view of reality***

***No book is a mirror of reality,***

***but something that is added to reality".***

*Jorge Luis Borges - teacher of Garcia Marquez*

The term ‘brief therapy' does not leave anyone in the therapeutic world indifferent. It ranges from general rejection to wild enthusiasm, depending on the idea that each of us has about brief therapy and about the role of the therapist.

The first to officially introduce the idea of 'brief therapy' were the founders of the Palo Alto school: John Weakland and Don Jackson; and later Paul Watzlawick, Dick Fish, Carlos Sluski. They promoted this concept to an important value in systemic thinking. For them, "psychotherapy had to leave its grandiose projects and focus on the suffering of every day. Its task should be limited to making the patients more capable of useful action as soon as possible, so that they can proceed with their lives without constantly having to face the same problems".

They focused on paradoxes, prescribing symptoms, and they found that something was seriously wrong when a therapy was not over after ten sessions. In their opinion, if the therapeutic system had not achieved the desired goal, it was due to either laziness of the therapist or to an unrealistic or badly defined goal.

The term 'brief' is ‘sick’ that way. It is vague and says nothing about the wide variety of approaches. Most family and behavioural therapists and hypnotherapists limit their interventions in time, even though they do not call it 'brief'. Even in psychoanalysis, brief therapy exists. It is the master himself who is responsible for the most amazing feat: legend has it that Freud cured Mahler of his potency disorders in one day.

‘Brief’ places too much emphasis on the duration as primum movens. In The Bruges Model, 'brief' is the obvious consequence, rather than the condition. Moreover, 'brief' is relative. Chronic psychosis, PTSD (post-traumatic stress disorder) or obsessional disorder cannot be resolved in four sessions. ‘Brief' then means: not longer than necessary, to allow the patient to take his life back into his own hands.

But even this definition is not devoid of vagueness. This approach could just as well be called 'solution focused', although it is radically different from what is usually understood by this term. No ready-made solutions are offered. Rather, the client is asked to identify the appropriate solutions, which he is already applying without realising it. This brings us closer to 'resource focused'[[1]](#footnote-1), a strategy that helps people discover and use their resources. But even these terms do not cover the load. More essential, it seems to us, is to help people realize that they can make new choices. Symptom behavior is often accompanied by the oppressive feeling of not being able to do anything else, of having no alternatives, of not being able to choose anymore. We observe this symptom behavior is usually promptly abandoned as soon as the possibility of choosing is seen again: could we call it 'a therapy centred on choice'?

Based on our conviction that the patient has the most 'know-how', but often does not have the awareness or the strategy to use it, we do not instruct ourselves to accompany him until the problem is completely solved. When he's sufficiently put on the right track, we can stop. Very often we find that patients themselves stop as soon as things get better. They feel able to continue on their own. We think it is useful in such situations to honour their choice, and to make ourselves available if the client wishes to contact us again.

Some clients see the therapist as a superman/woman, who will solve everything for them. The temptation is great, if not irresistible, to take over the reins in all areas and to determine the goals and strategies ourselves. This is how the therapy becomes that of the therapist and not that of the client. When this does not lead to what the client wants, which is most likely, he will protest, ‘resist’, thus frustrating the overzealous therapist.

This "resistance" is a gift to the therapist. It shows us that the client finds our interventions important, because one does not resist a trivial thing. It also shows us that the content of the intervention is not adapted to the client's purpose, or to his possibilities at the moment. It is a wealth of useful information, in which the client guides us in the direction of his goal, in a way that is feasible for him: the ingredients for a successful therapy. Not to make use of it is pure therapeutic masochism, in which we risk being left exhausted on a battlefield of resistances, realizing too late that we were shooting at a friendly army.

This 'brief' approach is not only justified in financial terms. It also uses the energy of both the client and the therapist sparingly. By aligning their efforts, the client's goal is achieved more quickly. It also teaches him to tap into his own resources, to find his own solutions, so there is a good chance that in the future he will have to rely less on expert help.

But there is not only the economic aspect. Ethically too, 'the shorter the better' counts, especially when the results are comparable. There is no need to make people suffer longer, to saddle them with a sense of failure and with a multitude of strategies that are alien to their lives, if the suffering can be alleviated more quickly, by using their own unique tools. A heart-boosting discovery!

However, the 'brief' is not a purpose in itself. It stems from a respectful approach to the client, in which his goal is honoured, his resources reactivated and in which he rediscovers the possibility to choose, both in his actions and his thinking. This cooperative approach between client and therapist avoids the creation of resistance and thus promotes the therapeutic process.

The Bruges model

The 'Bruges model' is intended as a manual for the therapist, in which the process of acquiring solutions by the client is guided, i.e. "How to teach people to discover and use their resources in solving their problems". This model aims to be a guideline for the mobilisation of these resources.

Milton Erickson is the main source of inspiration. His brief therapies, in which he used highly efficient, unusual techniques, defied the curiosity of many therapists. Erickson refused any form of theorisation, claiming that each person is unique, and would therefore require a separate theory.

The origin of the problems, the possible cause, the pathogenesis, the etiology were subjects that did not interest him at all. He considered the symptoms more as abilities, useful survival strategies, than as expressions of some underlying pathology. And he didn't hesitate to use these symptoms for therapeutic purposes. This 'utilization' is one of Milton Erickson's most original contributions. They can be described as a process of integrating the client's perception and behavior into the therapeutic work (Y. Dolan, 1985).

He thought that every good therapist should behave like an ecologically conscious gardener. He must use in therapy everything the client introduces, even when it presents itself as weeds. Whether it's about resistance, symptoms, rigid thinking patterns, they are all essential elements, useful in constructing a solution.

Ernest Rossi, one of his students, summed it up as follows: "Erickson thought he was simply helping people to use their own resources, to solve their problems in the way that was right for them."

Erickson taught us that it is not useful to guide the patient through the entire therapeutic process. Setting this process in motion is sufficient and more respectful. In this way, the therapist shows that he believes in the patient's abilities. Giving him back the opportunity to make choices from various acceptable alternatives frees him from the compelling straitjacket of 'good or evil', where only one way is the true one.

In Milwaukee Steve de Shazer and Insoo Kim Berg developed a solution-oriented therapy model from a number of Ericksonian techniques. In doing so, they set themselves the goal of distilling only the essential.

Some of their propositions are:

* *"The class of problems does not belong to the class of solutions".* The analysis of the problems is therefore not useful for finding solutions. The analysis of the client's solutions is all the more so.
* *"The patient is the expert of his therapy."* He is the one who determines his goal, and the way to achieve it.
* *"If it ain’t broke, don’t fix it"*. Hands off of what's going well in the patient's experience.
* *“If something works, continue like this",* even if it's something completely different from what the therapist had expected.
* *"If something doesn't work, do something else",* more of the same serves nothing.

All this led us to ask ourselves what is essential in the therapeutic process. What are the minimum but sufficient ingredients for an efficient therapy? What questions should we, as therapists, ask ourselves in order to know what to do, and especially what not to do?

The distillation of these thoughts was concentrated in this 'Bruges Model'. Like every model, the Bruges model has its axioms.

### The mandate[[2]](#footnote-2) given by the client must be respected above all

This sounds obvious, only it rarely happens. Most of the time, we ourselves, based on our own therapeutic model, have definite ideas about what would be useful to this family or that patient. This therapeutic model gives us such a hold that we are in danger of forgetting that these ideas, useful as they may be, are hypotheses and constructions, not truths, and that they only have value to the extent that they are useful. It was Bateson who warned us of the pitfalls of the 'dormitive principles'[[3]](#footnote-3): 'only the facts, the events, take place in the reality; the interpretations occur in our heads.’ These interpretations allow us to give meaning to our observations, to see connections, to structure. A useful fact, as long as we realize they're interpretations.

***Sofie, 14 years old, invariably has to go to the bathroom when her mother starts washing the dishes.****A possible hypothesis is that she is regressing, resorting to anal preoccupations. There must be something wrong with the mother-daughter relationship, a traumatic event in her early childhood? Is psychoanalysis appropriate?*

*Other hypothesis:
Sophie did not learn to control her bladder function sufficiently. The toilet training was a bit nonchalant. Her mother didn't react consistently enough. Even now she only gives occasional punitive remarks about Sofie's urge to urinate at inappropriate moments. This way Sofie gets negative attention! Wouldn't a behavioral therapy approach based on a reward system be preferable? This way, Sofie can learn to develop more pleasant methods for getting attention.*

*Another hypothesis:
Sofie's behavior makes her mother complain to her father, a rather absent figure. Does she act as a 'lightning rod' within this family system, as a stabilizer that ensures that the cooled-down relationship between father and mother is revived? Are we starting a Minuchinian family therapy or a couple therapy?*

Taking into account what the client asks, and limiting ourselves to what he asks for, is not always in line with our 'helpful' attitude, in which the risk of patronising is never far away. The annoying thing about this 'we know what's good for you, we'll help you', is that we're making it hard for ourselves. We declare ourselves almost God Almighty, able to carry the burdens of the world and know what is good for others. There's a good chance we'll fall off our pedestals.

In addition, it gives an extra dent to our client's already weak sense of self-worth. We know, he doesn't. And it is precisely this sense of self-worth, this belief in one's own resources, that we so desperately need in order to make progress in therapy. Showing respect for his question inevitably makes him an adequate person who asks for help for his problems, but no more. This does not imply that anything the client asks for is pursued indiscriminately. It is not the 'wish medicine' in which the starting point is no longer the healing or the solution of a problem, but the realization of unfulfilled, often unrealistic wishes***.[[4]](#footnote-4)***

It is also not a "customer-friendliness that consists in submission to the wishes of the customer, who is king. "[[5]](#footnote-5)When his goal is not clear or unrealistic to us and we take the time to negotiate with him, we continue to approach him respectfully. There is a good chance that together we will reach a clear and realistic goal, and that he will give us more mandate.

A second trap lies in our commitment to the medical model: "When we find the cause of the disease, the solution is obvious". This medical-scientific model is so obvious that it seems universally applicable. In case of psychological problems, this only turns out to be half true. The clients' story about their complete or partial solutions shows us that many efficient solutions have nothing to do with the cause of the disease. We note that they are the experts in what is useful to them at the moment. Only they're not always aware of it. Our expertise consists of teaching them to discover and use their potential of resources.

***Tom, 10 years old, has disturbing compulsive thoughts****.
He tries to conjure them up by means of extensive rituals, in which he excessively checks the closing of the doors every evening, and obliges his parents, at the risk of a decibel scene, to redo his checks. It all started a year ago after seeing a film about Martians. The nights after, he had bad dreams about bullying males. And although he realizes that they are 'only dreams', and the movie 'only a movie’, he keeps repeating to himself the Martians will come. The parents decided that he shouldn't watch horror films anymore, because that was the cause of the ailment, they thought. It was to no avail. They would show Tom the difference between fantasy and reality, because it bothers him, but that didn't make any difference either.*

*When Tom was asked for exceptions to this compulsive behaviour, he told that he was thinking less on those annoying Martians when he had his eye on exciting, fun things, such as playing soccer. The parents had also noticed this. It was agreed that he would expand his repertoire of exciting fun things. In order to remember this assignment, he was given a calendar system, in which he could choose a drawing every night that he would earn by thinking about possible alternative things in the evening. This worked out nicely. At a subsequent consultation, two weeks later, there had only been three more ‘disaster nights’.*

### The client has autopoietic, self-healing abilities

The therapist who applied this in the most consistent way is probably Milton Erickson. He was so convinced of the uniqueness of each person and of his unique ability to find solutions that he rejected any theory of psychic functioning and psychopathology. He established that the etiology of the problems is totally irrelevant to the therapy. Not looking at the past, but at the future, offers solutions. He developed various indirect methods to help patients set concrete achievable goals. For this, he used 'visualisation', a technique derived from hypnosis, in which he asked patients to imagine a vision of the future in which their problems had been solved. He then asked them to propose a consultation in which they explained how they had managed to solve their problems. According to him, moving into a future in which the problems have been solved was much more useful than analysing the problem. It brought the patients to their resources. He was firmly convinced that every patient, consciously or unconsciously, had sufficient resources to solve the problems for which he sought help. He helped people mobilize their own resources to solve their problems in their own way.[[6]](#footnote-6)

We see our task as a therapist in this Ericksonian way: to help people discover and use their resources and thus give them a strategy that can also be used in other problem situations.

### Being able to make choices is a measure of healthy psychological functioning

Problems often arise because clients are no longer able to choose. They're stuck in rigid patterns of behavior or thinking that cause them suffering. They have the impression that they are no longer able to make choices, or in fact, that they no longer have choices.

It is as if they only have one way on their world map (cf. Korzybski), as if their 'semantic reaction'[[7]](#footnote-7) contains only one meaning, and if it doesn’t fit with their experience, they get confused: the only way on their world map is blocked. They don't see any alternatives.

Simply offering alternatives is seldom useful. "You use heroin when you're having a hard time, you’d better talk to your friends, or work out", is a piece of advice most people will not benefit from.

Moreover, we may wonder whether we should always make conscious choices in order to call ourselves mentally healthy. How wonderful are the daily automatisms, where we don't have to ask ourselves again and again whether we should first brush our teeth when we get up, then wash ourselves or vice versa, dress ourselves first and then have breakfast, or vice versa. We won't be inclined to call this pathological.

So what's the difference between "normal" and "pathological"? When we allow ourselves to be carried away by our habits, we choose not to choose, to switch to 'autopilot'. It makes us feel comfortable that things go by themselves, that we don't have to think about them anymore.

It is very different when we are blocked in a behavior or a thought that we feel is 'stronger than ourselves'. Here we can no longer choose not to choose. This is where the choice itself falls away. There's only one thing. An elevator is an obstructing prison cage for a lift phobic, and only that. As soon as he can give other meanings to the elevator, he can choose which meaning is most comfortable for him.

When a context is created in which the clients can choose again, we find that most of them choose to completely or partially omit their symptoms. This ability to choose seems to us to be an essential and at the same time sufficient condition in order to be able to let go of symptoms.

A context of choices

It's hard to understand people apart from the reality in which they live. That's what we learned from systemic thinking. But beyond this systemic thinking, in which only the relationships between people are considered, our approach also studies what goes on within the individual: his way of giving meaning and his way of acting. This artificial division into thinking and doing makes it possible for us to orient our therapeutic interventions.

## GIVING A MEANING

At the side of the **observation** we can see that this is not to be separated from the meaning we give to this observation. This meaning seems so obvious to us that we decode it as 'true'. We are no longer aware of the fact that it is our meaning, one of many, our map of the world, and that "the map is not the territory" (Korzybski, 1933).

Korzybski describes the first reaction in perceiving something as "the semantic reaction". Here we give a meaning to reality. This complex reaction, in which emotional feeling, logical understanding and practical understanding are still perceived as a whole, is the closest to objective reality. By naming that reality, by giving it a name, we are already putting ourselves on a different level, further from the objective facts. We decode these according to our own 'map'.

Our own card determines our comfort in experiencing things. If it only gives us one possible meaning of a given, we are unlucky if this meaning is problematic for us. There's only one road, and that road is blocked. It feels very different when other ways are available. Then we have choices, and the ability to choose the path that brings us where we want to be in the most comfortable way.

***Jan, 10 years old, comes to consult with his most worried parents.*** *For a few months now, he's been reacting grumpily. He's not in the mood for anything anymore. His grades at school took a big dip. The teacher catches him daydreaming. At home, he's harassing his twin brother. Every proposal of his parents always comes with a no. He's talking about death. On the road to a family visit, he makes a scene where he threatens to jump out of the car. That’s when Jan’s mother decides he’s depressed. She has been reading a book on depression in children and thinks she recognizes a lot of the symptoms described in it.*

*For Jan's mother, there's only one way, one meaning. Jan is depressed. She is extra sweet to him, tries to satisfy his every wish, doesn't dare to leave when Jan protests. She tries to convince his father and brother and sister that this is the way to help Jan.*

*How can we guide our clients to expand their map so that they see different ways, different choices that can lead to a solution?*

## A few rules of thumb

### Start from a positive vision

When looking at the world, we inevitably make assumptions, hypotheses. One of the most insidious traps is that we give ourselves the task of finding 'the truth'. We often forget that these are presuppositions that enable us to make connections, to give meanings. In other words they are fantasies, that enable us to organise reality in our own way. The terms 'correct' or 'incorrect' are not relevant here. They remain abstractions of reality.

These fantasies can be more or less useful to orientate us, and to find solutions. However, they can just as easily give rise to feelings of despair and hopelessness. The story of the half-full and half-empty bottle.

Positive hypotheses have the great advantage of matching the client's resources. They start from their good intentions, and if they are not explicitly present, they tell something about the therapist's belief in the client's possibilities. Moreover, they make it clear that the symptom is also one of the solutions, not something that is bad and therefore has to go away, not the ultimate blunder or the shameful failure as the clients fear, but a useful, albeit sometimes painful, survival strategy.

*Mother's image of Jan can be accepted with a small nuance: he reacts in a depressed way (not he is depressed). This nuance translates a state image (being depressed) into a reaction pattern (acting depressed). A reaction to something feels very different from something that is unshakeable. Maybe he's a very sensitive boy who cares about his family. Maybe he's worried about something, rightfully or wrongly.*

### Place the symptom behavior in a broader context

By seeing the symptom more broadly than within the client alone, we often discover new, useful elements. This is what we learned from Bateson. These are usually repetitive patterns, which inevitably represent a useful function in a system, even when this sometimes involves suffering. For the clients or their systems, this is not obvious. When they are helped to see this, it becomes clear to them that the symptom is perhaps the least harmful choice at this time.

*Until recently, Jan achieved the best school results at home. He was therefore applauded, and set as an example for his twin brother. Now that Jan is doing less well, the parents see more of his brother's efforts. Was Jan worried about his brother? Is he attempting to give him an honorable place in the family?*

*His parents have a busy life. Both are highly committed teachers. His father plays in the local theatre group and his mother is tutoring. Since Jan's been having a hard time, they've been talking to each other a lot more. They're at home more often. Is Jan worried about his parents? Is that how he's trying to get them closer together? And even though this was not his intention, it does have this positive effect.*

### Preferably make circular and allocentric hypotheses

These circular hypotheses, which look at how A influences B, and vice versa, protect us from the hunt for the why, for ‘the culprit’. Identifying such a 'guilty party' is a stalemate in therapy. What if the guilty party is unavailable, unable or unwilling to change? Is the client doomed to suffer for the rest of his life?

After all, it's not he who has to change, it's the other. The feeling of relief that arises when the client is deculpabilised in this way quickly turns into an oppressive impotence: he can only undergo the situation. He has to wait for the other one to change.

###### Searching for the "why"

*Jan can be diagnosed as a self-weak boy with a low frustration tolerance. Hereditary factors undoubtedly play a role, because an uncle on his father’s side committed suicide.*

*Or does it have to do with his mother, who prefers her busy activities to the household? Isn't she the type of 'neglecting mother', causing Jan to develop a negative self-image and his father to flee the house?*

*Or is it rather his father who gets too involved in his work and then looks for pleasure in his theatre company instead of at home? Is he perhaps neglecting his wife and children, and is Jan, the most vulnerable one, perhaps reacting to that with a depression?*

###### And what about the "how"

When we replace the 'why' with 'how' we get very different answers. There are no longer any guilty parties, but people who influence each other and who can each do their bit for a different scenario.

*When Jan gets depressed, his mother reacts with concern and his father comforts her, which make Jan protest even more vehemently. His twin brother urges him to stop screaming. When an escalation looms, the mother reacts with panic. His father gets angry and tells Jan he has to stop, to which the mother agrees, and Jan stops.*

*In this sequence, different strategies are tried out (crying, worrying, panicking, comforting, admonishing, reacting resolutely). By looking in detail at the ‘how’, solutions emerge that did not emerge from the 'why?'.*

Allocentric hypotheses seek the useful things that the client does for the other members of the system, by producing his symptoms. It brings us to the resources in this symptom behavior. It provides inspiration for useful alternatives, and thus more choices.

*If Jan's worried about his twin brother, how can he show it in a different way? How can mother and father help?*

*If Jan is worried about his parents, how can they reassure him? How can Jan show that he appreciates their efforts to stay at home more often? How can he get his parents to talk more to each other ?*

### Inducing the client's own responsibility and decisions

The stories that clients come up with in therapy are rarely success stories. They talk about failure, not being able to do anything, not being able to do anything else, feeling powerless. Their stories are often told in a passive form: the client has the feeling he is no longer the subject, but the object of his life. He feels as if he is being lived, because of his symptoms. His story of impossibilities hypnotizes him to even greater feelings of insufficiency, and he becomes blind to his resources.

The risk of being sucked into such a convincing hypnosis as a therapist is not inconceivable .
Reversing the story in: "That's your responsibility. You choose it", is not very respectful and risks ending up in a one-session therapy, in which the client does not feel understood. How can we respectfully induce that own responsibility? While listening attentively to the story, small reformulations can drip into nuances that gradually free the client of the ‘all or nothing’ radicalism and open gates to change.

Mother: "Jan is seriously depressed. He's afraid. He's grumpy from morning to night".
Therapist: "Jan behaves depressed. He often acts grumpy. You have the impression that he's afraid of something."

Acting depressed has a different connotation than being depressed. Being is an immovable state, a property, like brown hair. Behaving means that one can also behave differently. Equally, in his mother's words: "Jan is moody" is an absolute fact, while "does very often" implies that there are other moments as well. Fear is difficult to grasp. Fear of something, of what? You can do something with that.

These reformulations give a new grip on reality. Someone who's depressed will undergo the situation. Someone who behaves depressed does something, is 'subject' again, makes a certain choice, even when it is not comfortable. Feelings of powerlessness often prevent clients from seeing that they are making useful choices.

*Lies, 15 years old, is smoking joints. Especially when she's alone in her room, she can't resist the urge. She only stops when she is called at the table, or when a friend calls: "the phone makes me stop."*

*Therapist: "When a friend calls, you choose to quit smoking, to listen to her."*

## ACTING

In addition to observing and giving meaning, there is the **behavior, the act**. Having choices in giving meanings is sometimes sufficient to let go of symptom behavior, but not always. How to create a context of choices along this do-pool?

Some techniques related to the practical organisation of conversations help to induce choices:

### The client decides which members of the system come along and when

Unlike most system approaches, we leave the choice to the client.

*"You know the situation very well. You are in the best position to decide which people you find useful to bring along."* Usually the clients make a useful choice.
To know their motive, you can ask what they expect from this special session, now that they have brought X with them. When we find it useful to see more people ourselves, we can ask: *"I care how X responds to this situation, how he can help you?"*
When the client refuses, this is accepted: *"You must have a good reason not to bring X with you. You're very diligent. You want to take all the therapeutic work on your shoulders."*

### The client sets priorities between the different therapeutic objectives

Often clients have different objectives. By letting them choose their own priorities, we make them clear they are responsible for their therapy. We can guide them, ask them to start with a small, achievable goal, or something that others can help with. The final decision lies with them. They make the choices.

### The client determines the time of the next appointment

Rather than decide for him when the client should come back, we ask him when he wants to see us again. *"When will it be useful for us to see each other again?"* This gives him responsibility for the time spent in therapy. We also ask him to understand our agenda limits. Only when people react in a very depressed way is it advisable to propose a new meeting in the relatively near future, so that they feel taken seriously. These people often find themselves 'not worth the trouble', and are highly susceptible to anything that could endorse this vision.

The intervals between sessions can be very different. They do not appear to be relevant for therapeutic efficiency.

### The client makes the choice between various assignments

Tasks have the implicit message that the therapy continues, outside of the session, and even more, that the client does his own therapy. By giving him a choice between different tasks, he not only discovers he makes choices, but he also takes responsibility for the therapy, and for his choice. He's going to be "the subject" of his life again. Moreover, he is seen as an expert in his own therapy. He decides what he finds most useful.

### The client decides whether or not to carry out the tasks

And what if the client kindly refuses those tasks? As an expert of his own therapy he doesn’t find any of them useful, and chooses not to execute them. Honouring this choice is particularly useful: the patient establishes that he has made a choice. What's more: suggesting that not doing is also a possibility, and that we wonder what he will do, when choosing something completely different, or a part of one of the assignments or a variation, makes cooperation inescapable. No matter what the client does: he makes choices and he cooperates.

### Permissive formulations

Permissive formulations have the advantage that they allow the client to choose if he wants to perform a task more or less rigorously, or come up with his own variations. This creativity promotes the therapeutic process. Thus ‘perform this as a task’ can be nuanced to*: ‘I wonder which task you will choose and how you will execute it.’* *Or’ I’m curious what will happen when you …’*. This indirect approach not only stimulates the client’s creativity. It also enhances his sense of responsibility. He makes the choices. This approach focuses on the observation what will happen when the task is carried out, rather than on the execution itself. This circumvents resistance.

### Future projections - Scales

**\*Future projections** allow the client to describe how he sees his life without the problems he is searching help for. They help him to describe concrete alternatives, i.e. other options. Steve de Shazer taught us the 'miracle question' (the Shazer 1988, 1991):

"Let us assume that there are miracles, and that they happen tonight or one of the following nights. This miracle makes that the problems you came for are solved. And they are solved while you are asleep, you're not aware of anything. How do you find out the next morning that the miracle happened? What do the people around you find out?" By guiding clients in describing concrete scenarios, the morning after the miracle, they create images of alternatives. In other words: other choices.

**\*Scales** help to achieve this vision of the future in several stages. "Can you imagine a scale from zero to ten, when zero is the moment you made an appointment, and ten when the miracle happened? Where are you now, between zero and ten? What are you doing differently from when you were at zero?"

The scenario at level X is already a stage in the realisation of the miracle and therefore offers more choices than at level zero. *"What else will you do at level X + 1?"* New choices are being viewed.

**\*Describing one day, one year after making a difficult choice**, is useful when clients find it difficult to choose between different options, mostly because they are insufficiently aware of the consequences of their choices. Describing such a concrete day gives them the opportunity to empathize with the different scenarios and the concrete consequences of such a choice.

*Joanna, 18 years old, has had a new friend for several months. He's a sweet, somewhat shy boy. She has the impression that he would do just about anything for her. Secretly she keeps thinking about her former boyfriend, a smooth charming guy that all her girlfriends 'want to go with'. He was rich and he always knew how to tell her sweet things that made her feel unique: "you are the woman of my life", "if you weren't born, I would invent you" and so on. But a year into their relationship she found out that he was trying to win his next conquest with the exact same words... She broke off the relationship, fearing she'd never find anyone as charming again. She couldn't expect such winged statements from her new boyfriend. He wasn't very popular with other girls either. Wasn't the other one the man of her life? It was suggested to Joanna to describe a day, a year after she had made her final choice: for the first friend, with all his charms; his success with so many women, which he eagerly discusses, even in her presence; a life of luxury with a lot of variation. Or for the second friend who lacks fine words. A more austere life, less luxury, less jealous looks from other women, but more stability and loyalty.*

*After this exercise, Joanna chooses the second friend: "my first friend would have been the ideal man, if he meant what he said, only, it wasn't real... they were just smooth words to conquer women's hearts..."*

### Exceptions to symptom behavior

The search for exceptions to symptom behavior is a flawless strategy to help clients discover that they are already making choices, and that they already have solutions available. There are almost always exceptions. No symptom is present around the clock, any day of the year. *"Are there times when the problem is less present, or not present at all? When? What happens then?"*

*Tom, 10 years, notes that his compulsive thoughts diminish or even disappear when he thinks of fun, exciting things like football. That's when he's in control of his problem. When the compulsive thoughts come up, he can choose to let them come or concentrate on an exciting activity.*

**‘Pre-therapeutic changes'** are in the same line. It is not uncommon for clients to notice a certain improvement between the time of the appointment and the first consultation. Usually they are not aware of it and if they are, they won't tell you spontaneously. They assume that therapists are only interested in problems, and the small improvements are not worth mentioning in their eyes. ***When you ask them where they are on the scale from zero to ten, when zero is the moment they request the consultation, and ten is the moment they want to stop the therapy,*** they sometimes come to the surprising discovery that they rate themselves higher than zero. Their problem is already partly solved. So they have made choices and found solutions, in their own way, without therapy.

### To stop in a symptom sequence

Dissecting the end of a symptom sequence gives similar information. Rarely are clients aware that they manage to stop over and over again, and that they have developed different methods to make this possible.
An **observation assignment** that asks how they stop, and what is useful in doing so, often provides, at first sight, useless answers. "The phone just rang", or "my dad came in", or "I had to go to bed", or "the weather was nice”

**"How did you manage to stop when the phone rang?** What made you choose to pick it up? You could've just let it ring. What made you decide to go to bed? To stop when your father came in? To enjoy the beautiful weather?"

These questions make the clients realize that they are not robots that are dictated by external impulses, but that they themselves choose to take up the offer from outside. They take their responsibility. They make choices.

###  Strong induction of the awareness of choices: the choice to come to a consultation

Every consultation implicates a choice. At a certain moment the decision is made, an appointment is made. Even when this happens at the insistence of a parent, a partner, a general practitioner or under the pressure of the law, there is always the possibility not to respond to it. Maybe the client doesn't have a request for help himself, he decides to go only once: he took the step. *"How did he do this? What helped him do that? Who? How come he did take that step now?..."* Questions that make him realize that he makes choices and takes on his own responsibilities.

And in practice? An intervention schedule

## A circular mandate

In this 'brief' form of therapy, our main objective is to find a formula for cooperation with the client that allows him to develop his own therapy. You don't get a cooperative like that for free. First of all, you have to develop what is called a 'therapeutic relationship', in which the client gives confidence and a mandate. He gives us a form of power by coming to our office. This becomes even clearer when he explicitly asks for help. In this form of therapy we accept this complementary relationship in which the client puts the therapist in the expert position and puts himself in the 'low', questioning position. From his expert seat, the therapist will not fail to seize every opportunity to promote the client to the position of expert in his therapy. This varying complementarity between the therapist as 'expert in therapeutic matters' and the client as 'expert of his therapy' creates a circular mandate: the therapist is given the mandate to return it to the client from his position. That's how he's guided from "help me" to "help me to help myself". Monitoring this circularity is a guarantee for finding an efficient collaboration formula.

Minuchin taught us that joining[[8]](#footnote-8) is an important skill for obtaining a mandate. Active listening, reformulation and acceptance of the way in which the client formulates his or her problems are so many ways of making it clear that he or she is being taken seriously. By adapting to his rhythm, his attitude, the hierarchy within the family, the client feels respected. It doesn't all have to change

It becomes even more comfortable for him when you make the effort to speak his specific language. Some people 'see' all kinds of things, while others 'hear' and still others 'feel'. From NLP[[9]](#footnote-9) ***(9)*** we know how useful it is to use this privileged sense. "I see you" then becomes "I see what you mean" or "I hear what you say" or "I feel for you". An experience is "something that surprises you", or "something that makes you listen" or "something that touches you." There are also specific sayings from the city, the countryside, their profession, metaphors that our clients offer us for free, and which we should gratefully accept and make use of.

## An intervention schedule

The 'joining' alone has not yet achieved the circular mandate. This helps us to obtain our mandate, but we often overestimate what we get. A good therapeutic relationship is not a safe-conduct for any intervention. And it is precisely when we see hesitation on the part of the client that we risk offering our solutions too diligently... a trap, where we usually have to conclude the client is reducing his mandate. We call this 'resistance', but you might as well call it an assertive reaction on the part of the client. He comes to our shop to ask for information about a chair, and we try to convince him that it is better for him to buy a sofa.

How do we avoid this trap? How do we maintain a cooperative relationship and avoid provoking resistance?

With this in mind, **an intervention schedule** was developed. It aims to be a guide for the therapist that provides information about the therapist-client relationship, and about the possible useful interventions. A symbolic name was given to each level of the relationship: ***a passer-by in a non-committal relationship, a searcher in a searching relationship, a buyer in a consulting relationship, a co-expert in a co-expert relationship.*** The amount of mandate given by the client increases as the therapeutic relationship progresses.

But before turning our attention to the given mandate, we make a distinction between **problems** and **limitations**. This is an essential step in determining achievable objectives.



**The Bruges Model Flowchart**

The intervention schedule is guided by four questions:

1. Is there a possible solution for this complaint?
2. Is there a request for help?
3. Is it a workable request for help?
4. Are there any suitable resources available?

For each affirmative answer, the next question will be answered. When the answer is negative, it is useful to limit the interventions to that level. When more mandate is obtained, and the answer changes in the affirmative, we move on to the next question.

### Is there a possible solution?

People come to therapy with a series of complaints, difficulties. For some difficulties, there is no viable solution. Traumatic events of the past, disabilities, are irreversible. This also applies to the consequences of previous choices: the choice of our partner, the number of children, our studies, our profession. There are also limits linked to culture, gender and age, the place and era in which we live, our socio-cultural background, our upbringing.
We call them **limitations**. Limitations cannot be solved, they cannot be undone. One can learn to live with them, and choose how much place they take in our existence. One can also look at the resources and survival strategies that made it possible to live with these limitations.

Solutions to **problems** are possible.

This distinction between problems and limitations prevents us from wanting to solve the latter. This is a 'mission impossible' that can only lead to a barrel full of frustrations: a frustrated therapist, a disillusioned patient, who runs the risk of being left with a feeling of victimisation from this precarious undertaking. "Hadn't my father been so negative, …" "If my uncle had left me alone, ..." "If only I hadn't had that accident, ..." The feelings of powerlessness bubble up.

In the case of both limitations and problems, we move on to the next question.

### Is there a request for help?

Some clients say they don't have a problem of their own. Someone else has a problem with them: their partner, their family doctor, the court. Others say they have a problem of a kind we as therapists can not solve. Many people with psychosomatic symptoms belong in this group.

We call these clients, who have no request for help for us, passers-by. It is more accurate to speak of ***a passer-by relationship*** between therapist and client, or rather, a non-committal relationship between therapist and client. This reminds us of the very limited mandate given to us by the client. Advice and assignments are not useful or disrespectful here. They can only generate justified resistance.

Rather, we are trying to create a context in which a request for help becomes possible. Not infrequently these are people who have lost all faith in themselves and in the ability to solve their problems. They fear a devastating diagnosis, yet another conviction. Through broad positive connotations of the things they do, including those separate from their problems, we show our appreciation. This is all the more significant when it comes from an 'expert', from whom they expect a disapproval. Perhaps this will make them feel more respected, more confident and safe, to such an extent that it will be possible for them to ask for help.

In the same vein, we reformulate what the client says in a positive way.

Client. *"I'm here because my mother insisted."*

Therapist: *"You have a lot of respect for your mother."*

We outline alternative scenarios of problems that show that he hasn't made such a bad choice. Therapist: *"It's good to have cooled down your anger on the door, and not on a coincidental passer-by."*

Making positive connotations about the absent members of the system induces positive nuances in the client's vision. It's not just a matter of taking possible loyalties into account. Very often these others are also the helpers. By mentioning their good intentions, the bond between the two is strengthened. It refers to the confidence of the referrers in the capacities of the clients.

Therapist: *"Your teacher is convinced that you are capable of doing something about your problem. He believes in you. Otherwise, he wouldn't send you."*

An objective can also be negotiated **in *a non-committal relationship***.
Either the passers-by see the good intentions of the referrers and are prepared to pursue their objectives, or they remain annoying nuisances that they want to get rid of as quickly as possible.

Therapist: *"How can I help you so that you can satisfy your referrer sufficiently, so that he no longer finds it necessary for you to come."*

When there is no request for help, we continue to approach the client as a passer-by, and the relationship as non-committal. In the case of a referral by a third party, we invite him back to find out how he can convince the referrer that it is no longer necessary to come. After all, these third parties are then the clients**. When there is no request for help at all, it may be useful to work with these clients.** They have a request for help and are prepared to do something.

When there is a question for help, we ask the following question:

### Is there a workable request for help?

People often have a vague request for help. "I'm depressed, tired, anxious. I feel bad about myself... My child is disobedient". They are unable to formulate their question in a more concrete way.

Others have a more described, but unworkable, request for help, because they rule out a solution. "I have compulsive thoughts, but you won't be able to help me", or, "There's nothing I can do about it. It's stronger than me."

This is what we call ***a searching relationship***.

The client gives us more mandate than at the previous level, but here, too, there is a risk that advice will not be adequate and that we will encounter resistance. After all, it is not clear where the client wants to go, not for us, but neither for himself. Our task at this level is to induce a workable request for help, i.e. a request for help with **clear objectives**.

A few criteria will help us to achieve this request.

1. ***It should be realistic***: to be happy or obedient all the time, those are extremely unusual situations. Always communicating verbally can lead to a state of exhaustion. There is something manic about always being in shape... Often our clients need some help to find the ordinary things in life ordinary, and to adapt their objectives accordingly.
Therapist: *"Always being happy is as unusual as always being sad. One is called manic and the other depressed. What would an ordinary day look like on that level?"*

"Always obedient... Wouldn't you be a little worried about Wim?"

1. ***It should be small rather than large.*** Curing a psychosis is quite a chore. Learning to deal with the voices or the images is more feasible. These smaller goals are easier to achieve. They strengthen the client's belief in his own abilities and thus increase the possibility of successfully solving other problems or learning to deal with limitations.

*Inge, 17 years old, was diagnosed with puberty psychosis. She's suffering from voices that are stubbornly worrying about her health. They say "you'll get sick". They especially bother her when she's alone, or in a group of strangers. That's when Inge feels sick. She feels stuffy, starts sweating, her heart is running wild, she feels dizzy. Her mother, who is a nurse, is very worried. It is not so much the palpitations that worry her, but rather the voices in Inge's head. Her father recognizes much of himself. He's been treated for an obsessive-compulsive disorder for about 10 years... but with Inge it's even worse. There are those voices
 An observation homework is given to Inge. Are there moments those voices bother her more? And less? When? What's helpful? Or who? What else does she do? Sometimes she manages to do other things. Her parents and her boyfriend are helping her with that, but they can’t help her all the time. She prefers to get rid of the voices altogether, but her father claims this is too ambitious. What can she do when the voices are there, what can make it easier for her? Finally she gives the voices the meaning of ‘guardians who remind her to breathe quietly with her belly in order to stay healthy.’*

Obeying is not easy. What do mom and dad mean by that? And is it always possible, anywhere?

*Jan, 10 years old, is registered as "never obedient". He does not clean up his room, does not want to make his bed, only helps to wash the dishes after five minutes of animated protest, gets out of bed three times, on average, etc. When we aim to do all of this under the heading of 'becoming obedient', we risk discouraging the parents, with an increasingly inadequate result. Together with them we look for a smaller, achievable assignment for Jan, something that already may have worked in the past. Together with Jan, they are looking for ways to make it work a few times. Could he still do that? How many times does he think he'll be able to do it next time?*

These smaller goals are easier to achieve. They strengthen the client's belief in his own abilities and thus increase the possibility of successfully solving other problems or learning to deal with limitations.

1. **That it is important for the client and not so much for the therapist**

This is how we respect the autopoietic capacities of the client. He is an expert in what is good for him; we are in discovering how he can achieve this. Our objectives should be limited to guiding this process. Therapists often set themselves substantive objectives, inspired by their theoretical framework. This can be a useful guide, insofar as it does not encourage us to overzealous interventions, in which we overshoot the goal of our client. When we call this 'non-cooperation' or 'resistance', we become completely obnoxious. Rather, it has to do with the healthy assertiveness of our client, who will not allow himself to be swallowed up by a sofa when he only wants a chair, even when there’s a discount on the sofa.

1. **It requires a great deal of effort to achieve this goal**

At the very least, it is important for the client to be convinced that we are convinced that it requires a great deal of effort. It’s an elementary form of respect. After all, it is not because the solution seems simple to us that they also seem simple to the client. Usually the clients have already tried all kinds of things to solve their problems. When they ask for help and are told that "this is how it will be quickly solved", they lose face. Were they so stupid that they couldn't figure out the solution themselves? This undermines their sense of self-worth, and it is precisely this that is precious in enabling them to cope with their own problems.

Concrete, we make things easy for ourselves and our clients by formulating the goal:

1. ***In behavioral terms, describing a clear, detailed scenario of what happens when the goal is reached***.

This doesn't mean that feelings are unimportant. They are only difficult to define in concrete terms. Feelings are inherent in behavior. Describing in terms of behaviour also has the advantage of activating the often static emotional description. This makes it easier to achieve the goal. "Feeling less sad" can be translated into "getting up on time, taking a shower, having breakfast, whistling a tune, reading the newspaper, etc." By editing this scenario, an image of the desired situation can be drawn. The suggestive effect of visualization is known. It significantly increases the chance that the scenario will unfold in this way.

1. ***In the presence of something.*** Very often, clients formulate their objectives in the form of what they don’t want: no more worrying, disobedience, bedwetting, smoking. This formulation is a treacherous trap. We tend to imagine things concretely and, as we know, the image has a serious chance to be realized.

What if we imagine no bedwetting, no smoking, no worrying?

Then we see bedwetting, smoking, worrying, because 'not' can't be imagined concretely. What if you get the assignment: don't think of a pink elephant with green stripes. It’s already there! A child who goes to sleep with the task of 'not urinating in his bed', and who wants to do his best not to, has the image of 'urinating in his bed' and here, too, the suggestive effect of the visualisation works. So we'd better ask, "What do you see yourself doing instead of...?" By formulating the goal in the form of a presence: the dry bed, or the smart guard of the muscle that closes the bladder, this suggestive image can steer him in the desired direction.

1. ***The beginning of a solution***. The belief in the client's self-healing capacities leads us to limit our therapeutic task to create a context in which he can choose again. Once he allows himself that possibility, he usually finds his own way. Guiding clients to the full realization of their goal implies that we do not fully believe in their abilities. We learned from Heisenberg[[10]](#footnote-10) how powerful such implicit suggestions are. It makes them insecure, depending on the therapist. This is precisely the opposite of what is useful in this kind of therapy, which is aimed at emancipating the client, so that he can take control of his own life.

***Various questions are useful in order to arrive at concrete objectives.***

* + 1. **From Steve de Shazer we learned the miracle question**:
		"This evening you go to sleep, and in your sleep a miracle happens, so the problems you come here for are sufficiently solved, so you don't have to come here anymore. You don't know that miracle happened. What will you know in the morning? What will you do when you wake up? What will your roommates notice?"

Here the clients are invited to describe a concrete scenario of the day after the miracle. Sometimes it is useful to guide them and to ensure that the criteria just described are complied with.

**Scales can add even more nuance to this description.**

**Scale of progress**: "When in a scale from zero to ten, zero is the moment the problem weighed the heaviest, and ten the moment the miracle happened, where are you now between zero and ten?

"How do I notice that? You're on X. How does X differ from zero? What's different, better? How did you manage to get to X already? What, who helped you?"
These questions protect clients and therapists from the all-or-nothing pitfall: you're either okay, or you're doing badly. By naming symbolic levels they realize that there are nuances, intermediate steps. Moreover, asking these questions suggests they are already on the good track and should not start from scratch. In their own way they have succeeded in doing useful things that bring them closer to their goal, a reassuring thought.
By asking for "the smallest difference that makes a difference in the direction of the desired goal", and the invitation to describe a concrete scenario of level X + 1, a visualization is again created with the known suggestive effect. In this way, the intermediate steps are also drawn out.

In addition to this scale that symbolizes progress in therapy, scales of faith, of motivation, of survival can also be used.

**Scale of faith**: "when zero is ‘I don't believe at all that I can reach my goal’, and ten is ‘I have the full faith that I can reach it’, where are you now between zero and ten?"
This scale indicates the measure in which the client thinks he is able to achieve his goal. Even when it's low, e.g. at two, don't despair... You can ask him what makes him move to two instead of zero, and what would be useful to be able to move to two and a half.

**Scale of motivation:** "When zero is ‘I don't feel motivated to reach my goal’ and ten is ‘I'll do anything to reach my goal’, where do you stand between zero and ten?"
When a low figure is mentioned, it is possible that we have overestimated our therapeutic mandate. Maybe this is a non-committal relationship, and we thought that the client had a request for help. This client doesn't want to get involved in a therapy, so there's no point in asking him anything
Here, passer-by interventions are more useful. Another possibility is that his belief in achieving his goal is so weak that he logically limits his efforts. This distinction is clearer when we start with the "scale of faith’.

**Scale of survival:** when clients tell us that they can't keep up with the situation anymore, that they are at the end of their possibilities: *"You're having a very hard time. I wonder how you're holding up. On a scale of zero to ten, when zero is the most difficult moment you've experienced, and ten is the moment when your problems are solved to such an extent that you can breathe again, where are you between zero and ten?"* To make it clear that we recognise the seriousness of the difficulties, a symbolic scale of -10 to zero can be used. When they are at -10 we can try to figure out together how they have managed not to feel even worse in such a difficult situation. Where do they get the strength to survive at -10? How are they doing? What helps? Who's helping? This 'survival scale' promotes these people, who usually feel like victims, to survivors, and helps them realize that they have resources, and more than a few, to survive in such a difficult situation.

* + 1. ***The continuation question*** (the Shazer, 1985, 'formula first session task') has the important advantage that it helps the client to look at the things in his life he likes, and at his resources. Steve the Shazer formulates them like this: *"We'd like you to observe, by the next conversation, what's going on in your family life that you want to preserve”.*

In addition to the 'joining' effect, it reassures the client: not everything has to change, not everything is bad.

In a more explicit way: 'You want to change a lot of things, that's what you've come for, and those things are what you're thinking about now. Besides it's important to keep the things that are good. We can't risk to throw the kid out with the bathwater. Those good things in your life are too precious. Would you like to think about that? Maybe five minutes every night? What are the things in your life as it is now that you want to preserve?" Often the content of what is found is not spectacular, but it helps to see more clearly what is preferred to be changed, and there is a good chance that the target will stand out more clearly.

When a concrete goal was described and thus a workable question for help, we ask the fourth and last question:

### Are there any suitable resources available?

Appropriate resources are those capacities that make it possible to achieve the goal. We speak of a **consulting relationship** when these resources are not immediately clear. They are usually present, but our clients are not aware of it. At this level of therapy the client gives us a big mandate. He is willing to 'buy' all kinds of things from us, to learn useful techniques that allow him to use his resources to the full to solve his problem.

Asking for **exceptions** to the problem behavior provides valuable information about the partial or non-partial solutions that are already available. You find them every time you ask for them. No symptom is there day and night, from January 1st to December 31st.

"At what time of day do you not feel afraid? Or less scared? Then what do you do?"

It is useful to have exceptions described **in great detail** and to help clients determine how the problem could be reduced or stopped. They inevitably end up with their resources or with the resources of their environment and how they can make use of them.
When clients do not immediately find exceptions, it helps to ask them in detail about their problem. Exceptions are always present in these descriptions. It comes down to seeing them.

*Marie, 18, has anorexia nervosa. All day long she thinks about food, about calories, about ways to lose weight. When she sees someone, she compares herself to that person, his supposed weight. She's picking out booklets about diets. This prevents her from studying, reading a novel, taking a break, because there is always the spectre of the kilos. She has one hobby: solving crossword puzzles. Once she is up and running, she doesn't want to be disturbed by anyone. At that moment only one thing can captivate her: to solve this crossword puzzle, and preferably as quickly as possible. This is also the only time that Marie forgets her calorie concerns.*

*How does she manage to concentrate so intensely at that moment? Marie can't answer that. In an observation assignment, she is asked to look at how she succeeds and for how long.*

A special form of these exceptions **are the pre-consultation changes**: the improvements that often take place between the moment the appointment is made and the appointment itself. Rarely these changes are mentioned spontaneously. After all, people come to talk about difficulties, not about what is better.

Questioning these changes is particularly interesting, because they give both the client and ourselves information about the solutions he has found, without any outside intervention.... a precarious way to help the client discover his resources.

"On a scale of zero to ten, with zero being the moment you set the appointment, and ten the moment you no longer feel the need to come, where are you now?"

Any rating higher than zero indicates that the client has already started his therapy, with success. Asking about the **'how'** brings him to the way in which he expertly used his resources.

**Predictions** asking for a forecast of the level of the scale in the coming day will relieve performance-oriented clients of their fear of failure. It focuses their attention on guessing, rather than doing. Besides, it doesn't have to get better all the time. Even when you have predicted a lesser day correctly, you will at least show good judgment. Asking for predictions is especially useful for clients who have the impression that they don't have a grip on their own life. When it's bad they're unlucky; when it's better, it just happens to be so, they are lucky. For these people, their predictions often have the effect of a self-fulfilling prophecy. Such a prediction evokes images of what one predicts. A process starts that makes the realization of these images more likely. This is reinforced by the demand to observe its effect.

**Observation assignments** are usually used to gain a clearer insight into problems, but it becomes even more interesting when the client is asked for exceptions, the stopping of the symptom sequences, the degree of control over the symptom.

For this assignment some questions can be useful:

* *When* did the symptom occur?
* \*the day: are there symptom-free days?
* \*the hour: do the symptoms manifest themselves throughout the whole day, or do they sometimes

disappear, or diminish? This already indicates a form of control.

* *What* exactly happened? Was it the entire symptom sequence or a part of it?
* *With whom?* Was the client alone? Was there any family? Friends? Who? This gives us an overview of the important relationships, which may be useful as a resource when looking for a solution.
* *What gave rise to the problem behavior?* Sometimes this symptom is a solution to another problem. It's useful to know this.
* *How did you stop?* How did you get control, and to what extent? This very useful question helps the client not only realize that he can stop or gain control. The 'how?' helps him discover the proper use of his resources.

Not all answers are equally relevant, e.g. *"I fell asleep, I was stoned",* but most of the time some data are useful, e.g. *"I ran out of drugs":* what helped him decide not to go back on the drug hunt that day? In this way the client is promoted to the 'subject' of his life. He made the decision. Besides, he made a choice. He already has some form of control over his problem. It comes down to building on this.

Occasionally it is useful to provide additional skills such as in phobias, PTSD (Post Traumatic Stress Disorders), mourning. At this stage of the therapy, when the client gives us a considerable mandate, asking for additional resources, it is possible to negotiate with him which skills he finds useful and which ones he wants to learn. Here, techniques from behavioural therapy, hypnosis, gestalt therapy can provide useful tools.

During this exploration of resources, we remain attentive to the installation of options

* by giving different assignments from which the client can choose
* by giving different meanings to the problem
* by allowing him to choose who he brings with him
* by letting him decide how often he comes to the appointment
* a context is created in which the possibility to choose becomes evident.

When the client has the appropriate resources at his disposal, we call him **a co-expert in an expert relationship**. We could also describe him as a **manager** of his own life, who is aware of his resources and is able to mobilize them in a useful way when needed. Here's the assignment: "Keep up the good work".

The therapeutic intervention is limited to helping the client to apply his own solutions, when he asks for it. For diligent therapists, this can be frustrating. We had so many sophisticated strategies in our arsenal. However, it would be a complete mockery of what we have been aiming for all this time: to help the client develop his own solution strategies, so that our help becomes superfluous.

RESISTANCE, a useful ally

Sometimes our clients overwhelm us with their - at first sight - unsolvable problems. They're expecting a magic solution from us. They want to get 'better' without having to change anything. They exhibit behavior that apparently does not contribute to any therapeutic goal: this is what we call 'resistance' to our interventions. They keep us trapped in their failure strategy. Are we fatally condemned to becoming victims of burnout? Or is it possible to deal with such frustrations?
Or, even better is it possible to turn this resistance into a form of cooperation?

But what we call resistance does not only create frustration. It's also convenient for us: this client, this family, won't cooperate. After all, they're not motivated. Anyway, we therapists did what we could. We have nothing to blame ourselves for. When we think that way, we put the resistance in the hands of the client, or in his family system. We consider this resistance to be a property of the client or the system itself.

But that’s already the first trap. When we claim the client does not want to cooperate in a certain therapeutic approach, then the cause is attributed to the client... A very linear and causal way of thinking! It forces us to work out all kinds of very complicated theories in order to explain the emergence - and disappearance - of this resistance.

## Circularity

Let's take another step in our minds. When we broaden our field of vision and take into account things like context and interactions, we can conclude the following: it is always against something or someone, against a certain intervention by a certain therapist, at a certain moment in the therapy, in a certain context.... that the client is resisting.

This is not an intrinsic characteristic of the client - or of his system - but **a relational event**. By applying systemic theory, with its circular way of thinking, we can escape the traps of desperate situations: the client reacts when the therapist does something, or vice versa: the client does something and the therapist reacts.

In systemic-oriented therapy we have a good habit of paying attention to this circularity. But when things seem difficult, the temptation is great to return to the linear way of thinking, which is so enticing and reassuring... at least at first sight, because this reassurance ("it's all the client's fault") is only short-lived. It blocks us and it deprives us of the opportunity to do useful work.

Let's assume that we have the courage to stick to the way of systemic thinking. This gives us at least one advantage: we can choose at which point we enter the circle of interactions. What if we enter this circularity not through the client, but through the therapist? When the therapist does something, the client reacts... The advantage of this is that the therapist has, once again, the opportunity to do something. He is no longer blocked by an intrinsic characteristic of the client, over which he has no influence. We decode the client's behavior as a message and in this way we get information about our own intervention and about what our intervention evokes in him: a very systemic-oriented idea: the symptoms convey a message.

That's the magic key to solve resistance. All we have to do is apply the systemic theory consistently and decode the client's behavior as information. No one can deny that a client who provides information is a client who cooperates!

Decoding information, but how? What's it telling us? It is informing us that our interventions are not in line with what the client wants or can do here and now. Our proposals may be too difficult or not helpful. Or we didn't get a proper mandate.

## More mandate

Very often we would like to have more mandate than the client gives us. Pretending, however, is a big blunder. It smells of authoritarianism on our side, as if we are not taking the client seriously. It's not surprising this is causing resistance. Saying no is a healthy response by the client to our attempt to impose more on him than what he himself asks for. From this point of view, it is unreasonable to criticise clients for having the guts to be clear.

In order to adapt our therapeutic interventions to the mandate obtained, we use the intervention schedule (p. 28). It helps us to measure this mandate and to adapt our interventions accordingly. At every level other interventions are useful in order to broaden the scope of the mandate. This is a first escape route from the jungle of resistance.

## Self-regulation

Sometimes, despite these interventions, clients continue to proceed in a way we decode as resistance. Then we must ask ourselves whether the interventions or assignments are not too difficult, or perhaps not appropriate at that time in therapy.

How can we make useful adjustments in this regard? From Maturana and Varela we have learned that human systems are endowed with a capacity for self-regulation. They have considerable growth potential and remarkable creativity. However, families seeking help are often caught up in stereotypical interactions, which block their ability to develop and to adapt to the successive stages of their lives.

The ability to 'self-regulate' means that families themselves are most expert at bringing about the changes that matter most to them. De Shazer puts it this way: "It is not we, the therapists, who are experts in the healing of our clients, but they themselves. They themselves know best what is most useful to them, what is possible at a given moment. However, they do not always realise that they know this. And it's our job to help them find out that they know."

How are we supposed to help them get that information about their abilities when they haven't yet discovered it? ...And that information that can help them to **"see a difference that makes a difference"** (Bateson)? In other words, information that helps them to see other things, and therefore to be able to act differently.

**Three types of questions are useful here:**

* + 1. questions that allow them to discover their own resources
		2. questions that allow them to make projections in the future
		3. questions that allow them to find what makes the smallest possible 'difference that makes a difference' for them.

### In search of resources

The questions about the **exceptions to the symptomatic behavior** (are there moments when it doesn't occur or doesn't occur as often?) enable them to discover that there are already moments where partial solutions are present. They may even be able to behave differently: an argument can lead to excessive drinking, but also to a flight or a discussion... The family or client may find out it is possible to change symptomatic behavior: by reducing it, by changing something about the place, the moment, or the way of dealing with others.

Mulling or compulsive thinking can be limited to a specific place. They look for a place that only serves for this brooding, a 'brooding chair' perhaps. Every time the compulsive thoughts or the brooding comes up, and it is not possible to think of anything else, there is the chair. It is agreed that the client can choose how long he sits on this chair, provided that he will have to be brooding, or concentrating on the compulsive ideas. As soon as he gets up, he does other things.

Mulling can also be **limited in time**. Tools can be useful here, such as agreeing on a ‘peak time’. Perhaps they manage to postpone their thoughts to every last five minutes of half an hour, or, if they are less massive, to twice a quarter of an hour a day. You can’t help having those naughty thoughts. You can have a grip on letting go.

‘Have you ever seen them suddenly go, or decrease? What did you do? Are there any other things that help you to set your mind to something else?’

In this way tools are sought that make it possible to postpone the peak of thoughts until the agreed peak time. For the overzealous therapist there is a pitfall here. He might be tempted to abolish the peak time altogether. Then he burdens his client with an impossible task: don’t think about… We will be troubled by the pink elephant with green stripes.

These 'experiments' help clients discover that they have more influence on their thinking patterns than they suspect. Almost always there can be concluded that **(partial) solutions** are present in the symptomatic behavior: excessive drinking can help to reduce the aggressive feelings, to alleviate the grief.

We can look for these resources with the client, in his family, in his environment, in the family where he was born, using a **solution-oriented genogram**, by creating a family tree that brings out the resources specific to this family. Genograms are generally used to detect pathology. In the solution-oriented genogram, one goes a step further: how did the person or the family deal with these problems? What were their solutions, their survival strategies? What are the strengths of the Janssens? What talents do they have? What resources? Are they more caring people: teachers, nurses, doctors? Do they take care of their parents, family members? Or do they have a good nose for business? Do they have a great deal of perseverance to start over and over again in case of failure?.... etc. In this way, people discover their family resources. They feel more connected to their roots, they get a place and a responsibility in family history.

Also **scales** are useful here, especially scales about progress in therapy.

"At what signals do you know that you're at X? What else do you do? How did you manage to get to X? What helped you? How did you use that help?"

Clients who tend to place themselves at the bottom of the scale will benefit from questions like: ***"How do you manage to carry on?".*** They will help them to find out that, without knowing, they are using resources they didn’t suspect existed: "How do you manage to cope with all that? How can you sustain all that?"

The search for **a pre-session change**: "Has something changed since you made this appointment?" helps to discover the solutions that the family has already found on their own.

**Observation tasks** on the disappearance or reduction of the symptom ensure that these own solutions and resources are discovered, without the symptoms having to disappear or diminish. On the contrary: in order to determine how a symptom sequence decreases or stops, it must be produced! This **indirect symptom prescription** puts the clients on a meta-level with regard to their problems and thus gives them more control over what happens.

### Future projections

With the help of the scales, all questions that allow them to see a difference between a state N and the state N+1 can be used.

"You're on level 2. What would it look like one step closer to your goal, at 2½ for example?".

The scenario described at 2½ creates a new and achievable picture of the **first intermediate step**, on the way to the client's goal. Moreover, it is an intermediate step of the client, not of us, which makes it more likely to be feasible. Sometimes clients put on their seven-mile boots, and at 2½ they describe a scenario that we expect at 7 or 8. It’s good to congratulate them on their zeal, and to ask if this really is **the smallest step** that makes the difference. Usually they manage to slow down a bit.

The **'miracle question'** (Steve de Shazer) is an elegant way to create a picture of the future in a non-threatening way. After all, it's a miracle.

Various formulations are possible.

"Let us assume that there are miracles, and that one night, such a miracle occurs. It ensures that the problems which made you come here are solved. How will you know the next morning? How will your partner, your children, your parents, etc. notice? What else will you do?"

Or
"(...) It ensures that the problems which made you contact us are solved to such an extent that you no longer feel the need to come here any longer (...).”

This formulation has the advantage of making it clear to people that they do not need to go on therapy until their problems are completely solved. It appoints them as experts, who decide for how long the therapy is useful.

 Or
"Soon you'll go home, and you'll probably have another bite to eat, you'll do a few more things. Then you go to sleep and in your sleep, when you are unaware, some kind of miracle happens... (...)”.

By initiating a **'Yes set'**, a series of questions that are necessarily answered with 'yes' each time, we induce a slight trance state, in which it is very likely that a 'yes' will also follow the following suggestions.

Although it is something imaginary, asking these questions implies that we, as therapists, are convinced that there is a future. Many clients are so fixated on the present or on their past, looking for the causes of their problems, that they live as if there is no future. They keep coming back to their fixations and create the breeding ground for a self-fulfilling prophecy (Watzlawick), which leads them to achieve exactly what they fear the most.

By introducing them to make **projections in the future**, we help our clients to become aware of the existence of this future, to make it concrete, and thus to take a step in the direction of the breeding ground for a positive self-fulfilling prediction. Moreover, the client outlines his own progress in a very concrete way, by focusing on what is feasible for him in his own way.

It is very reassuring for him to discover he can achieve his own goal and his own way of working is supported. By doing so, by describing the next step in concrete terms himself, he succeeds in getting a picture of the next phase. The hypnosis has taught us to which extent this has a suggestive effect: what we envisage in concrete terms tends to become reality. Especially in a negative way: we think of the self-fulfilling predictions, and the hypnotic effect of a ban (not drinking, not doing this or that, etc.)

One of the advantages of this strategy is the clients do not show any resistance, because it is they who indicate, in negotiation with the therapist, what the next step in the therapy will be

A circular mandate - in the strict sense - is at work here.

### The smallest noticeable difference

* When, on a scale of progress in therapy, 3 is defined as an improvement compared to 2,
* What is the smallest possible difference that allows you to decide that you place yourself on 3?
* What's that going to tell you?
* What else will you do?
* How will your friends, your partner, etc. know you're on 3?

By asking those questions we bring a new framework (redefinition), perhaps in its most elegant form. In the end we create a context for creativity, for pragmatic usefulness, for meaning, instead of psychopathology, uselessness, blocking. A context in which new ways of perceiving, thinking, doing, emerge. In this way, the myth that symptoms occur spontaneously in a passive, powerless patient is dismantled. These questions gradually give rise to an active and positive alternative, and the resources of the client and the family are brought into play.

When the clients nevertheless exhibit behavior that we, in an unguarded reflex, might again like to interpret as resistance, then nothing keeps us from returning to systemic thinking and asking ourselves what information the client is giving us in this way. And for the information you received, you express your gratitude: a positive connotation is in order here.

These **positive connotations** are very different in nature than giving a compliment. They give a positive meaning to what the client says or does, making this a manner of cooperation, instead of resistance.

A few examples:

* Someone invariably arrives late for the appointment: "You are someone who thinks, a critical person, and that is useful in an enterprise like this". Or: "Maybe you've felt that you don't need a full consultation, that you'll be satisfied with the remaining time."
* Someone has unrealistic, over-the-top objectives: "You want to work hard on it."
* Someone gives very little information: "You're very careful, you don't want to say everything right away, you don't want to overload me."
* Someone gives too much information: "You want to help me by telling me a lot."
* Someone doesn't want to bring important partners with him, in our opinion. "You want to save your partner, and work twice as hard yourself."
* Someone is constantly in charge of the therapy: "You have a personality. You know what you want and you want to work hard."
* Someone who declares himself powerless: *"You're very charming to the people around you. You give them the opportunity to feel useful and to show how much they like you."*
* Someone who always declares himself guilty: *"You are someone who wants to take your responsibility in the therapy, you spare the others."*

What is sought for in these positive connotations is:

* How is what the client does useful to continue in therapy
* How does he protect someone else?
* How does he prevent worse?

Such an attitude has several advantages:

* It helps us to realize that the client gives us information. And so he's cooperating
* It puts us, as a therapist, more at ease and gives us less frustration: who wouldn't feel comfortable with a cooperative client,
* In addition, it creates a therapeutic double bind, the best antidote to pathological double binds[[11]](#footnote-11).

When we redefine everything the client does in a positive way, he can only be cooperative. In contrast to the pathological double binds, where there are only losers, here there are only winners.

* Either he continues to show the same behavior and so he continues to cooperate by giving information
* Or he changes his behavior in such a way that it makes a useful contribution to the progress of his therapy: we have no reason to complain!

In this approach, the common thread is respect for the client, for his resources, and for the way in which he views things. By introducing a shared - and therefore circular - mandate, we allow him to define his own goals and his own ways of making progress. That is why it is wise to gratefully seize the information he gives us.

What's going on?

**From problem-oriented to solution-oriented observations**

This Bruges Model describes a **process**, a therapeutic procedure. The content is determined by the client. This puts it on a meta-level.

By asking questions in this way, the clients are oriented from **problem**-oriented to **solution**-oriented observations.

The questions asked in the therapy are mostly about the problem, its cause, how it gets worse, how it keeps coming back. The client is only rarely asked how it improves, what is useful in this respect, how he manages in order to sustain or to solve the problem or a part of it.

In addition to the usefulness of listening respectfully to the client's story, in order to make clear to him that we take his problem seriously, there is something illogical about being solely interested in the failure of our clients. *"Tell me how you get into trouble and do it over and over again"*. We only focus on the sequencing of ‘downhill’ and ignore the ‘uphill’. How they get out of trouble or how they manage to survive painful events doesn't seem to interest us. And yet every therapist will agree that this is the ultimate goal of the therapy.

The exclusive focus on the downhill sequences puts both ourselves and our client in a difficult position. Heisenberg, remember...

#### The observer influences the observed

That which is being focused on, becomes larger. It goes without saying that clients emphasise problems. That's what they came for. Limiting ourselves to deepening only this story strengthens them in the belief that there are only problems. They are more and more convinced that their 'map of the world' is the only one. Bradford Keeney called it reification: the words one uses to name a given become a thing, something that is really there.

*Peter, 14 years old, is registered as "lazy". This was the teacher's complaint. It takes him a long time to get his school supplies together. When the teacher says something, he doesn't react immediately, he forgets to take his school tasks home. He never finishes them at the requested time.*

*Peter's parents hadn't looked at it that way. They think he gets off to a slow start in the morning, that you often have to repeat things. A "muddle-headed professor", his mother says. However, the teacher's statement makes her doubt. Maybe he's not muddle-headed but just lazy. That laziness needs to be addressed urgently.*

By asking other questions*: "Are there any exceptions?", "What's different?", "How do you manage to do that?",* other observations emerge, in which existing solutions and useful resources are discovered and in which it becomes clear to the clients they are not the fools they feared they were, but do-it-yourself experts who are already well on their way and who, as adequate people do, also make use of the resources outside them.

*In Peter's case, it turns out that he reacts slowly all the time. He forgets a lot, but his mother can't get rid of the impression that he means well. When he is asked to clean up or help his room, he usually starts doing it, but then he becomes fascinated by something else: a book, a CD, a drawing, and then it's as if he's forgotten all about the task at hand.*

*"He can keep his mind on it, if it doesn't take too long. He usually starts out in good faith. He needs some "support" from us to keep it up."*

Focusing on existing solutions and resources can lead to the misunderstanding that we are not at all interested in the problem story. Nothing could be further from the truth. We will check it thoroughly to make clear that we have heard the story and are taking it seriously. What's more, we'll have it described in detail so that we can distill from it the parts of solutions our clients have already found.

**Detailed examination**

Through this **detailed examination** of the difficult scenarios, we arrive at an equally accurate description of the desired goal and its visualization. As we know, this has a strong suggestive effect, an induction of a self-fulfilling prophecy of the desired type. Most people do not remain insensitive to these suggestions, and children in particular are highly receptive to them. It is a powerful antidote to the negative trance inductions that often occur in families. "He won't say anything," "He won't listen," a cough, a look that induces symptom behavior.[[12]](#footnote-12)

**Using scales**

By **using scales**, we avoid the unworkable, all-or-nothing objectives. The implicit message is: it can't go from zero to ten, and you're already on your way, you don't have to start from the bottom. Clients who set a zero as their current level are also well on their way. They have found the art of survival, despite the fact that the situation seems intolerable to them, and that is just about the hardest thing imaginable.

The questions about 'a difference that makes a difference' (Bateson, 1973), the difference between X and the situation in which they judge that things are going a little better, X+1, help us to see nuances and they also enable us to conclude that they are already on their way to solve their problems.

The description of the scenario on X+1, again creates the suggestive visualization and the ‘how’ question brings them to their resources.

* *"How did you manage to change?"*
* *"How did you manage to stop..."*
* *"Who, what helped you achieve that?"*

**Promoting them as actors of their life**

In addition to discovering their own solutions and their own resources, and those of their system, these questions **promote them as** **actors of their lives**. From passive victims of impulses, urges, setbacks, they become enterprising people who take their fate into their own hands, like the heroes of their life stories, who seek and find solutions and discover their own strength in the survival of traumatic events. They give themselves credit again and their pride is not misplaced.

This approach is first and foremost respectful, not 'respect for the sake of respect', but respect for people, and the unconditional belief in their ability to deal with their problems and limitations: no all-powerful fantasies, no preachy positive-thinking situations, but a realistic belief in the clients' own abilities. This respect is rarely referred to as such. Once again, it is the way of asking questions that elicits this sense of self-worth from the client. By enquiring, in detail, how they managed it, various implicit messages are given:

* *You* did it.
* You did *it your way and it was good and useful.*
* *You are already* finding *solutions.*

Moreover, the question of ‘**how’** is much more intrusive than a congratulation, or a pat on the back. With a compliment, many people feel uncomfortable, especially insecure people. They tend to pass this off: *"It's not that formidable."* The question of ‘how’ gives the compliment in an indirect way, so that it encounters less resistance. It focuses on the resources and on the undeniable fact that they have achieved it. It shows the admiration of us, experts, for what they realized. This indirect appreciation is much easier to accept. It stimulates the clients' belief in themselves and that is one of the dynamic elements in therapy.

#### Resistance

**Resistance** in this respect is useful information provided by the clients. It tells us that we are asking for things that, at the time of the therapy, are not useful. Or perhaps we do not sufficiently respect the mandate given to us by the client, and we are moving too fast with advice and techniques. Resistance is therefore pure cooperation on the part of the client. It tells us that he thinks the therapy is important, if not he wouldn’t react so violently. It is mainly an invitation to mutual coordination. Viewing resistance in this way saves us from endless, sterile rearguard battles. It's a guide, so we can go faster into therapy.

Strategically, this vision can be described as a therapeutic double bind, a fact from which the therapy can only benefit

* Either the clients continue to show resistance and thus provide useful information. It is therefore fair that we thank them for this.
* Either they're improving their therapy.
* Their cooperative attitude is undisputed.

#### A process model

This model can best be described as **a process model**. It's not explanatory or interpretative

The **content** is determined by the client.

The **process** is led by the therapist, in collaboration with the client, a co-construction in which:

* the objectives are clarified into achievable, concrete objectives
* the own resources are discovered, and those of the system to which one belongs
* extra resources are given if the client asks for them

It teaches the clients a method for finding viable and realistic solutions in problem situations, using their own arsenal of solution strategies.

We learned from Luria that learning to use your own arsenal is a useful approach. This Russian neurologist came to the conclusion that in rehabilitation often missing brain functions (or brain parts) were trained, with the expected frustrating consequences. He started by drawing up a 'map' of functioning parts and devised methods to mobilise them, to learn missing skills by training these preserved brain structures.

This approach sometimes gives rise to concerns that it is a symptom treatment model, a pragmatic approach to mini-pathologies. The detailed analysis of the problem scenario, in order to derive the resources from them, can give this impression. On closer inspection, this content is the concrete material through which a procedure is being developed, a meta-model. It can be applied to any pathology, as well to bedwetters as to people with compulsion problems, and to puberty psychosis, because it is the process that is relevant, not the content. It teaches people to distinguish between problems and limitations and in both situations to use their resources to keep it liveable.

### A therapy model for lazy therapists?

No need to make complicated theoretical constructions about hypothetical intrapsychic processes. This can be done as a hobby, but these are still hypotheses.

No need to tire ourselves by devising solutions for our clients. After all, these solutions risk being useful only to ourselves, as they are derived from our own resources and hypotheses, and can thus provoke resistance if we consider them universally applicable.

Our therapeutic work is limited to guiding the process, where our clients discover and learn to use their own resources and solutions, so that they get a grip on their lives again. Thinking of the most famous saying of Alfred Korzybski "The map is not the territory", we give them a map of the world that allows enough choices, so that they are not stuck when the main road is blocked.

The principle may be simple, but its elaboration is not always evident. We're so used to pointing out to our client that one leg he doesn't have... But this is where Heisenberg comes to our aid: when we look for the resources, we find them too, and we strengthen them.

A convenience for the therapist, but also a convenience for the client

* He realizes he has resources.
* He learns to use them efficiently
* He also discovers that his solution strategies are the most efficient for him.
* He gets a grip on his life.
* He notes that he has the ability to choose, a feeling of freedom.
* It gives him self-confidence to deal with his own problems and, if necessary, to make use of external aids
* He escapes the doomsday image of 'chronic psychiatric patient', the main risk of long-term therapy. With long-term treatments, the therapy risks becoming a part of daily life, a privileged relationship that can only be maintained by continuing to produce symptoms.

However, this model requires humility on the part of the therapist. We don’t know best. We are only guides, the process experts, who are constructing, together with the client, the solution with respect for his question, for his rhythm, for his solutions. This modest role can make some of us feel uncomfortable.

1. 'Resources': a notion introduced by Milton Erickson, where he refers to the resources, the strengths that are specific to each person. He assumes that everyone has sufficient resources to solve their problems [↑](#footnote-ref-1)
2. 'Mandate' is described in Van Dale, a Dutch dictionary, as 'a permission by virtue of which one performs a function'. Here we are talking about a delegation of power that is negotiated on every request for help. This mandate is, at the same time, a means of negotiation and its outcome. It is obtained by joining and by seeking agreement on the request for help [↑](#footnote-ref-2)
3. Bradford Keeney: Aesthetics of change, p. 33: "A dormitive principle is a more abstract repacking of a description of the item you claim to be explaining." For example, aggressive behaviour is explained by 'an aggressive instinct', sleep by a 'sleeping principle' or psychotic behaviour by 'madness'. Thus, behavior is explained by a more abstract term for that behavior. The trap lies in the suggestion that this abstraction offers an explanation, whereas it is only what it is: an abstraction. [↑](#footnote-ref-3)
4. Luk Bouckaert: 'Zorg-op-maat', Centre for Economics and Ethics, KU Leuven, 1998. [↑](#footnote-ref-4)
5. P. Van Tongeren: 'Zorg-op-maat', KU Nijmegen 1998 [↑](#footnote-ref-5)
6. These autopoietic capacities were later confirmed biologically by Maturana and Varela, neurobiologists in Santiago de Chile (1980). [↑](#footnote-ref-6)
7. ‘Semantic reaction': concept of A. Korzybski in which he describes the process of giving meaning to reality before the stage of verbalisation: I create my reality by giving it meaning, my meaning, and at the same time this evokes emotions, and a logical understanding and a practical sense. Korzybski's most famous statement is: "The map is not the territory." [↑](#footnote-ref-7)
8. **'Joining'** (Minuchin) is a difficult term to translate. Sometimes it is referred to as the 'insertion process'. However, it is much more than that. It can best be described as the continuous activity of the therapist, consisting of a mixture of intensity, strength, warmth, respect, commitment, authority and empathy. [↑](#footnote-ref-8)
9. **NLP**: Neuro-Linguistic Programming [↑](#footnote-ref-9)
10. Heisenberg (°1901) Nobel Prize winner in 1932 for The creation of quantum mechanics. Heisenberg's field theory or 'uncertainty principle', involves the observer as a necessary parameter in the experiment, and even in the formation of the hypothesis: "The observer influences the observed". [↑](#footnote-ref-10)
11. The term 'double binds' was formulated by Bateson. It was initially seen as the communicative matrix in which schizophrenia takes shape. According to the original theory, a parent sends conflicting messages to the child (e.g. non-verbal encouragement to be rebellious against the other parent, but strong exhortation to show respect if it disobeys that parent). It is essential that this message comes from someone in a position of authority and that the child is not allowed to comment on the contradiction.respect if it disobeys that parent). It is essential that this message comes from someone in a position of authority and that the child is not allowed to comment on the contradiction. [↑](#footnote-ref-11)
12. Michèle Ritterman: Using hypnosis in family therapy (1983), Jossey-Bass, San Francisco [↑](#footnote-ref-12)