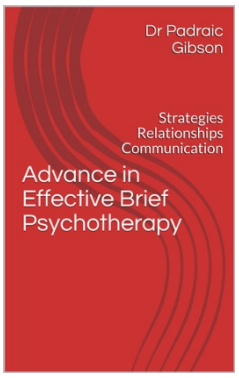

Foreword

Imelda McCarthy - 2019

It is a delight to be asked to write the forward for this book by Dr Padraic Gibson which both re-visits many of the gold nuggets of the systemic field of therapies and offers new gems in a well-researched Brief Strategic Therapy for this time. Throughout the book the history of the ideas and practices are threaded through and interwoven with today's creativities. Chapter one traces the history from the MRI to the Centro di Terapia Strategica in Italy and the move away from pathological and historic orientations to presented problems. Now the therapeutic orientation was no longer solely on the individual but on empirically based observations in their relational and communicational contexts in the present for brief periods of treatment (circa 10 sessions). However, the time frame has become more flexible while the notion of between 7 – 10 sessions is simultaneously held. This marks out the model presented in this book as one which is flexible and adaptable and one which can also engage in longer term brief therapy for some of life's more intractable challenges.

The development of cybernetic, communications and systems thinking in the 1940s and 1950s provided rich alternative frames from the previous concentrations on individual and historic developments of pathologies. The complexity of human life and causality was expanded from the more simple cause and effect individual models to a more relational and interactional patterning and inter-weaving of person in context scenarios. Laying out simply the difference between cybernetics and systems theory, linear and circular causalities in the contexts of a therapy is a very useful reminder to us of the importance of both these approaches in our systemic work. Focusing on more complex causalities leads us away from linear blame games and invites us into a curious frame of mind and exploration. Throughout the text we are called to acknowledge and see that communications are strategic and have pragmatic consequence. Within this complex web we are also re-introduced into the paradoxes, metaphors and 'rules' which can govern our lives over time, setting up habits which become unseen by us and our communicational and relational partners. Credit is given to Georgio Nordone's who, under the mentoring of Paul Watzlawick and John Weakland of the Mental Research Istitute in California, continued and developed many of their earlier thinking and practices. In spite of the almost inevitable creative tensions that arise when there are bifurcations in original allegiances the work was continued within the new brief strategic model developed by Nordone at the Centro di Therapia Stragecia. It has flourished in its new soil, finding its independence and spread but, in the context of its historical roots.

Orienting Theories

After a brief illustrated comparison of some major psychotherapy approaches, their treatment orientations, methods and orientation Padraic Gibson goes on to outline the theory which informs his Brief Strategic Approach. From the get go an absolutist, realist view of reality is shattered and a more pragmatic constructivist viewing is espoused. This of course means that we have to give up any notions of any true reality 'out there' reality independent of us as observers. However, in spite of this, I love the invocation of the Bateson team's work in saying that in spite of there being no rules governing human behaviour it was still possible to observe and track interactional patterns. Of course, it goes without saying that all such

observations are held lightly and in service of those we are in a so called therapeutic conversation with. If something works we can keep doing it and if it doesn't we change it. There is nothing that succeeds like success or even at times 'excess' as Oscar Wilde might have said. There is nothing arrogant in this, there is no top down approach. It is a truly evidence based bottom up endeavour. There may be some that will say that the approach runs the risk of reducing the complexity of human dilemmas but I think we can all empathise with a situation of acute suffering where, while we acknowledge it as part of a complex ecology of human living we also want relief and now! None of us wants to prolong our suffering and pain. So sometimes, the simpler a solution appears the better while never forgetting to be observant for other unintended consequences. The latter does not take away from the premise that if it works keep doing it while keeping an eye on surrounding contexts simultaneously. Therefore, theory and understanding problems take a back seat to actions, interactions, experience and communications that work to alleviate suffering. An understanding of causes and solutions may come later but that then is the client's own choice. They, not therapists can take decisions to review the complexities which may have contributed to the emergence of their problem. Nothing is certain except uncertainty, curiosity, research and the success of problem alleviation. Setting up situations for client's to experience a different result than suffering is more like suggesting a recipe for someone to experience the taste of a cake for example.

It is not a case of understanding of how things work but of doing things that create experiences of relief. This may not always be according to accepted logic of 'why don't you try something different?' It has rather a quality of being asked to do the same but this time to observe it and participate in it. This is a little, if you forgive me, like a meditation practice. The meditator is not asked to change anything but to participate and become an observer so that the characteristics of the problem may lead to its falling away. We stay close to the problem as a guide through the maze and turn its constraints into resources for solution. There is an old humorous story told about the Irish Saint Kevin who asked a man how his mother was doing. The man replied that his mother wasn't in good health to which the saint replied, 'may she be worse tomorrow'. This exchange continued for a few days until the man said she was doing better and St. Kevin replying, 'may she be better tomorrow'! In my own work I have talked about 'questioning at the extremes' of the logic of the other (McCarthy & Byrne 2007). By accepting our client's logic and then inviting them to walk towards the edge of their logical premises and sit there with them as they do this has given very tangible evidence of the logic itself at its extreme being actually untenable. The logic topples under the weight of its own premises (McCarthy & Byrne 1988) We do not contradict the client's logic but sit with them as they explore the worst possible scenarios of it with them. I see it a bit like going onto the ledge that someone stands on as they threaten to take their own life. You put all your own premises at risk as it were and privilege the client's current logic and life experiences. Jiu jitzu practitioners will recognise such moves whereby gently the moves of the other are used against them rather than one's own force. Also I am reminded of the 'be spontaneous' paradox whereby if you ask someone to be happy, sad, etc. they cannot produce the state spontaneously. While we might know that paradoxes can be enormously powerful we can also never predict specific outcomes. These are always unique to the context and person involved. However, Gibson also points out, and I agree, that such interventions need to replicable and have lasting results to be justifiable practices.

Diagnosis as a platform for change and knowledge.

In discussing the place of diagnosis in BST Gibson highlights how the role of DSM5 and ICD10 in our modern Western preoccupation with labelling, pathologizing and individualising creates in each revision of the manuals expands markets for corporate exploitation. Each revision makes it 'appear as if' the manuals can become ever more accurate in a zero sum game of increasing the pathologizing consequences of the seeming solutions. The normal quickly becomes disfigured by virtue of its ubiquity and ability to be categorised and perhaps medicalised for pharmaceutical purposes!? The procrustean bed lives on. However, the author warns against falling between the Charybdis of over identification of problems and the Scylla of eschewing any researchable patterning. This book provides a middle way of inviting us as practitioners to begin to 'see' predictive patternings to build flexible yet sustainable models of teachable, learnable and replicable therapies.

One of the other cleavages that Padraic Gibson highlights was the sad one in the Mental Research Institute of Palo. This disagreement arose, particularly between Jay Haley and Gregory Bateson around intervention strategies that could promote relationships of 'power' and/or chop up the ecology of the person and their context into 'bits'. As I have stated this book offers a middle way in avoiding such dichotomies through working within the ecology of logic of the person or persons seeking help and allowing that ecology wiggle room to find its own way through its paradoxes of living and being. There are no predetermined solutions, no 'oughts', no 'shoulds', no manualised or 'expert' ways of doing things. However, there is a rigorous defining of the problem the person is experiencing in collaboration with them, a building of knowledge of previous attempted solutions and their results. In spite of such rigour there is a constant guard against the spectre of confirming preconstructed 'realities' or what we might call a theory based practice. In such 'diagnostic' practice the theory predominates in the face of the lived experiences of both clients and therapists in the present moment. BST values curiosity over certainty in their explorations of problem presentations. In this way we are the inventor and the invention but in a continuous, open circle of curiosity, reflexivity and constant feedback. This book takes us through possible steps and shows a way that avoids the certainty trap of a top down expert knowledge. In chapter three the author asks the important question, *"how, can we have such knowledge of complex problems and how can we consider that knowledge meaningful?*".

Uncertain but competent – feeling our ways forward together.

The work of German physicist, Werner Heisenberg, who was one of the pioneers of quantum mechanics is invoked to remind the reader that when we interact with any system we effect that system. There are no casual interventions. Therefore, we are called to a vigilance of the effects of what we do and say. The vigilance also includes an attention to (a) 'unintended consequences' of any actions we might be involved in and, (b) isomorphisms across the contexts surrounding the problem. What this means is that we may behave in a way that is redundant to the change/non-change dilemma by non-consciously mirroring what is already being tried by way of solutions or has been tried unsuccessfully in the past. Today in our treatment worlds there is great store set by diagnoses which presuppose a mechanical understanding of complex living systems operating according to simple, linear modes of cause and effect. It is part of the 'expert' and 'fix it' mentality of our world today. While this in itself is not necessarily an ethically negative intention in the easing of human suffering, it can have disastrous effects when applied in a 'one model fits all' approach. It ignores the reality that statistical results refer to groups and not to individual situations. Statistics can never be reduced to a value free understanding of the unique ecologies of the

lives of individuals. The unintended consequences of such linear interventions or indeed we might even dare to say 'intended consequences' of them and the over reach of diagnostic manuals are an increase in the reliance on pharmacological 'solutions'.

This is where this book is a 'god-send' at this time as it presents a rigorous approach to therapy based on the solution/problem dilemma. By tracking solutions which have not worked, (avoidance, control of situation, delegation/help seeking) what they call a 'reverse diagnostic approach' is utilised. This means that the client begins to know by changing much like when we get to taste a cake after following a recipe and making it. The knowing is not *a priori* but arises in the tracking of the structure and functioning of both the problem and the solutions attempted. In this, clients are fully engaged with the therapist in following clues, trying things out in line with the logic of the problem/solutions. Being a bottom up approach means that collaboration is to the fore – there is no acting on but rather an acting with the other.

Chapter four introduces the important role that emotions play in the generation and resolution of problems. New learnings from neuroscience are referred to in terms of understanding their role in the client's life, how they are managed or more usually their lack of management with concurrent impacts on body and mind. Maturana and Varela (1980) have said that emotions are a social fundament. The Irish writer, James Stephens reminds us that what the heart knows today the head will know tomorrow. (1978). working with stress related issues we also come to know from our clients and our own experiences that it is often not such much and event that triggers stress but how we think and feel about it. The feeling or limbic brain sits in the middle of our brain above the amygdala or 'flight-fight' area of the brain and below the neo-cortex. If we can imagine a closed fist with the thumb held beneath the fingers with the area around the finger nails corresponding to the neo-cortix or more rational area of the brain while the finger knuckles represent the limbic emotional brain and the hand knuckles represent the fight-flight area. When the fight-flight and emotional areas of the brain are over stimulated we often refer to it as flipping our lid. So if you now quickly open your fist you get a good image of a startle response as the hand is exposed and the fingers separate much as might happen when you are suddenly startled. Rational control is dispersed with little protection of feeling managed. Our out of control physiology takes over as it were. Our 'control' centre cannot function as the limbic brain and amygdala cannot 'hear' its cooler reasonings and so it does not hold sway. One is reminded of the words of W. B Yeats (1996) when he talked of impending anarchy:

> Turning and turning in the widening gyre
> The falcon cannot hear the falconer;
> Things fall apart; the centre cannot hold;
> Mere anarchy is loosed upon the world.

Could one say that life and therapy mirror each other in that both are experiences in the management of our senses and emotions? We see the results of a failure to do this all around us so perhaps we can conclude this? As we know there are many ways this has been attempted in therapy from promoting understanding, designing behavioural interventions to co-constructing experiences within the logical frame in which the problems/solutions are presented. This book fits into the latter modes of intervening with understanding becoming an emergent feature of the co-constructed experiences. Working from within the ecology of the client's life and logic change becomes possible via what Watzlawick has termed 'planned chance events' and what the client experiences rather than what the therapists says. The

change thus becomes ecologically more fitting as it were. A delightful example is given where a client with anxiety is asked to note down what is happening each time they have a panic attack, not before it or after it but as it is happening. What happens is that the client becomes distracted by having to note it and describe it and a full-blown attack is averted. They also become observers and that in itself creates an interesting scenario as they become aware as it were that a different part of themselves – one that is not effected by the attack co-exists within them. Reading this brought back memories of a woman client who was attending her psychiatrist and on medication for depression. She told him that she had become aware that sometimes when she was depressed that there was another part of her "looking on" which was not depressed. He kindly explained to her that she was also suffering from a dissociative disorder resulting in this kind of splitting. When she came to me for a family issue, I got curious about this other side of her and we began to explore the side of her that was not depressed and what that allowed her to do. As we did so slowly her depression lifted and she became depression free to the surprise of her psychiatrist. As therapists who deal with trauma and abuse we know that this kind of observing facilitates all sorts of coping mechanisms at one level and also restorative possibilities for clinical conversations. The mechanisms for possible emotional correction are present in the midst of the problem. If *the heart knows today what the head will know tomorrow*, then experiences can become our teachers in our 'self-correction'. Like cures like as in the case example above where the so called dissociative state 'cured' the dissociative state and depression.

While there is an apparent criticism of approaches which cite discourse or narrative change solely as having a causative function in change it is in my understanding merely to underscore the importance of generating clients' experiences as precursor of most problem resolution through replicable and researchable patterns. This is not to suggest that conversation, narrative and collaboration are not to the fore but that they are accompanied by clearly articulated strategies based on observed patterns of previous problem solving and problem logic. Those strategies are then creatively repeatable as relevant and also researchable in terms of the results they achieve for our clients. Those who come to seek our help as therapists are often in great states of fear, anger, controlled by extreme pleasure based problems (eating, drinking and so on), sadness, pain, stress or self-harm. Advising an opposite or controlling stance to the problem is unlikely to work as we can imagine that clients have already tried these strategies previously. That is why it is essential to understand what has been tried, what has been useful and what has not worked. Therefore, much time and space is allotted at this point. The author has referred to this as giving the client 'pulpit time' where they can speak if that is what they want to do, without correction, without instruction and just be listened to.

'The Pragmatics of Human Communication' which was first published in 1967 is given its due regard as a harbinger of understanding ourselves as communicating beings and knowing that we cannot not communicate. (Watzlawick et al 2011). If we accept this we are then faced with a choice in the face of human suffering, do we persuade, convince or manipulate? None of these are necessarily unethical in and of themselves. It is how they are used as strategies that is the issue. A knife can cause harm or cut bread to feed us. Bringing us through the axioms of communications the author builds up a rationale for why we need to acknowledge the different levels on which we communicate so that we can be ethically in service to our clients and not side-line, non-verbal, paradoxial or power aspects of communication in our relationships with them. Don Jackson was known for saying that there are no impossible clients just incompetent therapists. The paradox inherent in all requests for help is accepted. We know ourselves that if we have an ache somewhere in our bodies

we want it removed it but are often reluctant to let anyone touch us because we feel so tender. So the 'change me, don't change me' request is an ordinary, common human experience and not just of those who seek psychotherapeutic help. Ordinary logic would dictate that there would be a simple univocal message, 'please help me'. However, we know from our own lives that in situations of difficulty there is a greater chance that a non-ordinary logic will prevail, 'change me without me having to change. We live in a dualistic world where ambivalence is contiguous. So a major task of therapy is an ability to hold a space for ambivalence or non-ordinary logic and find the 'wisdom' in it. Our task is not to rush headlong into ordinary logic or non-practitioner research modes of action. If we do we invite the possibility of resistances emerging to our lack of timing and understanding. This book outlines common resistance possibilities and how we can move with and alongside them. In this way we can stay in relationship with our clients as they experiment with ways forward that fit with their logic and not the logic of an 'expert'. None of us can proceed straight from the amygdala to the neocortex as it were. If we are sensually overloaded, the cool head needs to be gently introduced by providing the islands of experiential safety outlined in this text first. When senses and emotions are calmer there is more room for perceptual understanding and transformations to emerge.

Rigorous but not Rigid

This is where the approach all comes together through the practice of *strategic dialogue*. Information is collected about the problem in its daily manifestation, attempted solutions, how the client experience their lives with this problem. Right from the get go the invitation is to a broader observation for both therapist and client together. There is no assumption of a particular way forward but the ground is being built, the overloaded sensory system is being relaxed in this looking together. *Why* the problem might exist from a professional viewpoint is not given primary attention but rather *how* the problem is functioning in the everyday world of relationships is intently focused on so that *why* the problem is manifesting can emerge from the client's point of view. As the attempted solutions of the client or their families are explored therapists are given a view of how these attempts have either been useful or more likely have compounded the existing problem thus setting up a vicious cycle of problem – attempted solution – bigger problem and so on. By asking clients to then perform the problem so that more understanding can be had inserts a be spontaneous paradox and co-creates opportunities for the client to move more into an observer/participant positioning in terms of their problem. This creates a subtle distance from, a meta viewing of the problem and attempted solution. In this small space co-created around the performance of the problem major steps forward often emerge. The client has the possibility to no longer feeling so controlled by their problem and there is literally more breathing space for manoeuvre. This small or sometimes large experience of change from the outset, creates a different kind of knowing. We are shown how a change in perceptions follows experience. However, it also avoids the call to a self-protective resistance in a journey which the author states is like a strategic journey of "joint discovery" through three different phases, initial, secondary and finally tertiary and prescription. Systemic therapists will find the old familiars, careful problem/solution excavations, circular questioning, 'illusion of alternatives' questioning, scaling questions, reframing, paraphrasing, the use of metaphor, anecdotes and recapping, appearing in the construction of this transformative therapy. These provide a useful scaffold for model application and the flow that therapy might take and how we might assess our progress as we go. The power of metaphor is extolled as a way of holding a space for ambivalence and ambiguity and allows the client to "take their own meaning" as one client said to me. In this way 'trojan horses' carry an aspect of change that is less likely to

be impeded by the self-protective strategies of resistances. The good wine as it were is left until last as this is where the 'prescription' comes in - to perform and observe the problem in its usual context but also not to change anything even though they may be tempted to do so. The work outlined in this book is familiar and also new but this time with a decade good research in different contexts backing it up. Our field has been waiting for this juncture where clinical practice and research are conjoined activities. The clinician becomes researcher and vice versa. (Gibson, 2013, 2014, 2019; Castlenuovo et al., 2014,2016,2019; Nardone 1993 Watzlawick Nardone-1997-Nardone Verbitz-Milanese, 1999; Simon, 2017).

Make haste slowly

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