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Deepening Understanding of Browning's Strategy: Emergence of an Integrative Strategic Model for Family Therapy

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ABSTRACT

Operationalization of strategic therapy remains something of a mystery. While numerous models utilize aspects of strategic therapy, or incorporate a few interventions that were articulated by the initial strategic thinkers, there is no single accepted version of strategic therapy.

Scott Browning was fortunate to be at the Kaiser Pleasanton Psychiatric Unit as an intern in 1985. Mental Research Institute (MRI) scholars, Dick Fisch and John Weakland, would come to the unit and participate in live supervision. This unit had the explicit mission of incorporating MRI treatment (possibly the purest strategic model) to the entire caseload of a large psychiatric practice.

Prior to working as an intern at Kaiser Pleasanton, Browning was a research therapist at the Redwood Center, where he was part of a Milan Systemic Therapy team. So, by the time Browning arrived at Philadelphia Child Guidance Clinic for his post-doctoral fellowship, he was already steeped in two strategic models. While he enjoyed learning Structural Family Therapy at the clinic where it was created by Minuchin, he realized that he had already formed a very clear strategic approach to treatment.

This article is Hull's[1] extension of her article that began the process of elucidating Browning's clinical approach with an emphasis on what makes his interventions strategic. At times in history, strategic therapy ventured too close to active manipulation with the use of directional paradox (see Browning et al.[2]), but that is not in the nature of the treatment itself. When therapists recognize that people are stuck and need a new perspective to move forward, strategic thinking is often at play.

Introduction

The present article further elucidates the clinical legacy of expert family therapist and psychologist, Dr. Scott Browning. Readers should refer to Hull et al.[1] for the precursor to this work. Kazdin[3] called for a rapprochement between researchers and clinicians in the field of psychology, and Scott Browning has worked toward such a reconciliation in his own career over a lifetime. He has authored three books which required active collaboration between researchers, scholars, and clinicians[4-6] and promoted further collaboration between research and practice in the field of psychology. This article continues the previous work by Hull et al.[1] to preserve and teach the bespoke techniques of Scott Browning as a master psychotherapist. Kazdin [3] lamented the field's tendency to promote and hail the quantitative methods; in such a pursuit, the field continually loses the valuable work of individual master psychotherapists when they reach the end of their careers. Evidence-based practice is comprised of individual evidence-supported treatments, common factors, basic research, and outcomes monitoring, and each clinician invariably practices an integrative approach, even those who claim to practice a strict manualized approach. It is the hope of the authors that this work and the work of Hull et al.[1] may provide clinicians with necessary tools to integrate Browning's work into their own.

The present article will begin with a case to illustrate some of Browning's techniques in an integrated whole. In understanding any approach to treatment, the use of a case, and the goal of therapy with that case, is greatly helpful. Hull et al.[1] proposed that strategic therapy has, as a central feature, the focus of offering a perspective that is different than the one currently held. The perspective of the presenting patient is often unhelpful or unproductive, but it is also understandable in many cases and may be entrenched in their mindset; therefore, trying to directly challenge it therapeutically will likely fail. Following a summary case illustrating the aforementioned strategic goal of offering a fresh perspective, three additional proprietary Browningian techniques will be outlined with the intention that readers begin not only to integrate them into their work, but also consider one's own legacy that one wishes to leave behind. In addition to the new techniques, the reader will also find an expanded description of non-blaming precision to supplement the previous work. Finally, the process of operationalizing an expert clinician's proprietary work will be outlined in terms of the coding process.

Browning's Implementation of Strategic Therapy

Strategic therapy encompasses a number of models (MRI[7]; Milan[8]; Problem-Solving [9]; Solution-Focused[10]; MSFT[11]) that had a foundational commonality. Rather than emphasize a pathology-based idea of dysfunctional human behavior, the strategic thinkers believed that people got stuck in interactional mistakes, often with the best intentions. Browning et al.[12] argued that all strategic models utilize the ideas put forth by Gregory Bateson[13] and Milton Erickson[14]. Thus, therapy that flowed from these models was systemic, but in addition, took the position that the client needed to view the situation from a different perspective in order to create change.

It is hoped that the reader will gain a perspective on clinical work that is both highly effective, and contrary to standard therapeutic language. The use of clinical examples, with articulated interventions is intended to provide a lived experience of clinical work that accepts the client's reality yet nudges them toward seeing alternative perspectives that are fully acceptable.

The previous work by Hull et al.[1] also introduces the reader to the Browning et al.[2] concept of directional vs. nondirectional paradoxical intervention, acceptance, and reframing. In order to effectively implement these interventions, one must also employ the corollaries to Browning's work: empathy, non-blaming precision, and use of language (e.g. semantic thoroughness).

Both directional paradox and nondirectional paradox are evidence-based[15-16] and, although directional paradox has been characterized by some in the history of psychotherapy as "manipulative,"[17-18] both directional and nondirectional paradox can be implemented in a highly empathic and humane manner. While the general concepts of paradoxical intervention, acceptance, and reframing are not novel concepts, the packaging of them with Browning's three corollaries is indeed novel; hence, the importance of documenting the work in a qualitative manner for training purposes.

SUMMARY CASE

A case on which we wish to examine to explore the usefulness of strategic therapy is one in which a mother has submerged her own needs to an extraordinary extent. Initial examination into this behavioral pattern leads to a couple of "truths" held by the mother. First, she believes that since she was abused by an adoptive parent, she is not worthy of good things. She adheres to the logic that both being given up for adoption, and ending up in a family that abused her, leaves her uncomfortable with taking care of herself. For her, taking care of others is easier, and she rationalizes that it allows her to switch the pattern so that her daughter will never feel unsupported.

As a therapist, hearing this message is arresting. On one hand, the obvious need for treatment to address the historical abuse is clear; yet, mother has taken the position in different treatments for her daughter, who is failing in school and acting out, that treatment for herself is not necessary since she (mother) needs to continue to care for the daughter, not lavish treatment on herself. The direct and logical approach to educating mother as to the flaw in this position, referring to placing the oxygen mask on oneself first (as stated in every airplane safety talk) does not convince her. Mother is holding on to her strength, and sees great benefit in keeping this approach going. In a sense, mother is saying, "yes, this approach has not really worked, maybe I need to spoil my daughter more to increase her security."

The dilemma posed in this case is a perfect example of where a change in perspective offers the chance for behavioral change. By not attacking the logic held by mother directly, the clinical interventions cause her to reconsider if her theory about caring for her daughter might be altered. By using quotations for the case (created for this article, based on the accumulation of multiple cases and not identified with one family), it is possible to see the nature of strategic therapy in action.

At one point, mother is stating that her daughter's shopping is getting costly. Mother is not pushing her daughter, Sally, to not purchase what she wants, but wishes to hear Sally state that she does use what is purchased. Sally challenges mother and says, "why don't you ever buy anything for yourself?" Hearing this question, the therapist responded, "…and if you were to say to Sally at that point...can you pick one thing that you don't really need, I promise that I'll treat myself." Sally said, "yes, I would totally put something back if you were to get something for you."

At this point mother started on her standard path of saying that she does not really need things. The therapist followed with, "in terms of spoiling yourself…right…but it sounds like Sally wants her mother to occasionally spoil herself. There's something there and I'm not quite sure what it is, but there's something about seeing you never treating yourself that agitates her."

Mother returned to her standard refrain that she gives to others, since she feels funny about caring for herself since she is not sure that she deserves it. To this, the therapist replies, "I understand that, but there must be some aspect of that…that while it sounds so charitable and giving, and obviously it sounds like you are a good person to do it, there must be something about it that must make Sally feel like, 'I need to know that my mother feels good enough about herself that she can accept some good.' It is hard to see someone you love who keeps on saying, 'I don't deserve this.'

Mother reacted emotionally at this point and teared up, responding that growing up never feeling special has left her uncomfortable with treating herself. To this, the therapist responds, "I'm not denying that there's a history behind there that makes complete sense. I'm not challenging you on that, I'm just saying that I think that you could accept a little bit of it, like I know that you'll never be someone who says, 'hey pour it on me.' I realize that you've been hurt too much. But I think it does have that unusual effect on people who love you and feel like, gosh it's hard to see someone who doesn't want us to show our love to her, who sort of says, I don't really deserve it."

Mother asked at that point, "how would I even change that, I am so good at taking care of others." The therapist responded, "…perhaps if you, Jane, could say to yourself, 'maybe I could start to let in some limited love.' Because I think that you've become very good at saying, 'I'm self-sufficient, I'm an island here.' But I think that if you understood that at some level it's not totally fair to the others….and not fair to you, frankly. And I know it would be unfair to expect you totake the whole jump, but I wonder if there's a little jump that you can make that says, 'you know what, I understand that part of this means I am lovable. That these people love me. And that's ok, that's good.' Or do you feel like, 'oh I almost don't want to think about the fact that they love me?'"

Analysis

In a strategic manner, these interventions accomplished several helpful therapeutic goals. This exchange allowed the therapist to bring up a topic that previously the mother, Jane, would simply dismiss since her identity is that of a "giver," and she took comfort in that definition of herself. However, the downside of this attitude, particularly in relation to her daughter, was difficult for Jane to comprehend. This intervention also put Sally (daughter) in the position of expressing that she is wanting to do for others. Her life as one smothered in gifts and attention had left her feeling empty. She could now reidentify herself as one who can care for others, and that her mother is worthwhile. And finally, it allowed the topic of Jane's abusive childhood to be discussed in such a way that she became more open to considering treatment for herself.

ADDITIONAL TECHNIQUES

Teaching Honesty and Healthy Interaction

Honesty is a value that may be taught to others through explicit instruction and through modeling. Indeed, hosts of children's literature exists to positively model honesty for children in their formative years. Family therapists themselves differ to the extent to which they allow for "secrets," in the family therapy office, with some family therapists permitting "keeping secrets" and others taking a harsh stance against any and all secrets. Browning's stance has always been a nondogmatic stance, but one that rests on honesty as the fundamental backbone of the approach. With this in mind, while a therapist may unwittingly find themselves on the receiving end of a secret, one may choose to use this as a teaching moment for the family to teach honesty and healthy interaction.

Browning's approach to honesty is based on openness and non-directive discourse among the family. One may follow his lead and teach in the following manner following the revelation of a "secret." 1. Validate the natural desire to not discuss difficult topics; 2. Make reasons known why honesty is a better choice (give explicit applied examples of how outcome is often improved with honesty); 3. Do not order patient to disclose a secret outright; rather, extend the conversation and let their thought process play out while considering possible negative and positive consequences of honesty; 4. Express understanding and empathy while silently taking the temperature of the individual or family's desire to disclose (see Hull et al.[1] for in-depth review of Browning's application of empathy); 5. Reward small steps in honesty; 6. Teach language to express oneself

when sharing a secret. Through both teaching honesty and modeling an open and honest viewpoint, the therapist can form honesty into a norm in the family system. As mentioned in the previous paper, use of language and semantic thoroughness is another technique that one may draw from the compiled works of Browning. One could also apply Wile's use of "scriptwriting" here to help family members talk to one another[19]. The following is Browning's description of his process (S. Browning, personal communication, July 23, 2024):

> I think what I do is drop the 'detective mindset.' I no longer actively want the secret revealed, all I want is for the client to reach a place of deeper understanding of how the secret is affecting them, hurting them. As that starts to happens, they sometimes just divulge, or they start to construct what they need to feel safer.

Use of Nonverbal Empathy

The use of extensive nonverbal empathy was demonstrated by Browning in his clinical work over the years. One may conceptualize the nonverbal component of empathy as an extension of the empathy described in Hull et al.[1], combined with the use of nonverbal communication. Nonverbal communication is a critical component of communication between humans and animals. Indeed, nonverbal communication accounts for a greater proportion of interpersonal communication than verbal communication (approximately 60-65%), despite emphasis on verbal communication in clinical settings[20]. Due to the presence of ongoing nonverbal communication in a clinical encounter, it makes sense to dedicate training in techniques and interventions that explicitly include nonverbal behavioral training and practice.

In a family therapy case with a strained father-daughter relationship, Browning used nonverbal empathy to convey his experience of empathy for the father. Describing their relationship, the father began to share with, "I'm sorry, but….," to which Browning interrupted strategically with, "I'm sorry for you! That's a hard position to be in." He goes beyond the verbal message conveyed and threw up his hands, shaking them emphatically in the air. This technique of attending to one's empathy expansion in the verbal and nonverbal domain was highly effective in this case, as it strengthened respect of the clinician as someone who literally gives more than "lip service" to the situation.

"Almost watch it like theatre"

In another case example, the intervention of "almost watch it like theatre" was used to assist a couple in recognizing the reality of a partner being disliked by the other couple member's children. Whenever a dilemma can be identified that leaves the client's in a situation that is understandable, but not necessarily changeable, that state of affairs is discussed.

In this case example, the couple are dealing with the frustration of two small children, from Daniel's marriage (now divorced) who are openly defiant toward his new partner (who happens to be a man, Wilson). There is nothing in the children's comments that suggest overt anger about their father realizing he is gay; rather, typical issues that arise in most early step-couples is present. Rather than simply accepting that the anger expressed by the children is quite typical when the children realize that Dad has a new partner, these two men are looking at all the things they are doing (and what their partner, is or is not, doing) that might result in this situation. In this situation, helping each member of the couple see the children's reaction as expected is a useful intervention.

> Therapist: Both of you are in an unfair position...I don't think either of you are doing anything wrong here… (the therapist needs to be able to state why the actions of both people, given the context, makes sense).

The session continues with the intervention filling in information that clarifies that both men were doing exactly what would be expected, as were the children. Wilson felt hurt by the open disdain

toward him by Daniel's children, Daniel felt frustrated since he saw his children so rarely and he just wants to enjoy them, and the children simply had no bandwidth to get to know Wilson yet. This therapist did not meet with the children, but their reaction matches closely with numerous cases in this general systemic situation[21]. The intervention is strengthened when one goes on to the next step and discusses a few possible actions that can be taken by Wilson. In a conversational tone, Wilson was advised that two possibilities are that he could, 1) leave the house when the kids are there, to not feel more aggravated, or 2) observe how the children show the developmentally typical response of not warming up to him.

> Therapist: Almost watch it like theatre…watch it with fascinations about how did they show their dislike….you simply are not responding to the rejection…if you keep on throwing something into an empty place, it just doesn't become interesting enough …you never see the ripples …they're doing it for the reaction.

At this, Wilson smiled and said, "they are eight and ten, why am I so upset?"

It is here that the therapist recognizes that it is still painful, and Daniel will need, at some point, make it clear how important Wilson is, but not yet, not in the beginning of the divorce.

A Closer Look at Non-Blaming Precision

A therapist utilizing Browning's technique does not recognize or consider the application of blame for action in a clinical setting. As a rule, Browning's work does not employ "blaming" of parties. That being said, if an action on the part of one person directly influenced a catastrophic outcome, recognition of the role that individual played in the cascade of events may be clinically useful. But "blame" is only useful to the degree that it helps to highlight systemic issues rather than exploring and digging into individual blame.

The following outlines eleven steps that one can move through to successfully implement non-blaming precision in practice:

1. *Find the impasse*.

2. *Explore the impasse*. Once the impasse is detected, the clinician promptly examines if there is a perspective in which neither party is inherently right or wrong.

3. *Multiple viewpoints*. The clinician explores and considers all perspectives on the issue. Clients are encouraged to express and explore their viewpoints.

4. *Eliminating judgment*. The clinician intentionally withholds judgment and does not support either position, including judging clients' behaviors as good/evil or right/wrong.

5. *Consider possibilities*. The therapist actively encourages and promotes the idea that any results from behaviors as part of the impasse are appropriate. Again, clinicians have no preference for outcome in keeping with systemic thinking.

6. *Worldview modification*. Non-blaming precision encourages clients to change their worldview (through their consideration of the matter with increased openness), mainly through hearing and considering others' views. Clinicians drive this openness by offering the possibility that either partner could alter their opinion without one being stronger, better, or preferred.

7. *Disregarding blame*. The clinician makes a focused effort to disregard placing blame on any partner. This may involve strategic use of language, which is another Browningian technique from Hull et al.[1]. By changing language, and, in some cases, reframing, one may steer towards systemic issues instead of finding fault in one person.

8. *Team approach*. The clinician must maintain an open-minded perspective and not contradict the clients. They are a team working through an impasse together, not on opposing sides of an argument. The clinician is reflecting on their ideas,

perceptions, and beliefs so that they might better understand them.

9. *Belief in systemic viewpoint*. The clinician believes fully and truly in the systemic frame of reference, that the issue at hand is a systemic issue not an individual problem. This is communicated clearly and authentically to the clients.

10. *Power to the people*. Through new perspectives and reflection, the client is given autonomy and empowered to shift their own view voluntarily. The clinician does not direct change but allows the clients to come to it on their own with modeling if needed.

11. *See the systemic issues*. The clinician identifies the systemic issues from the impasse and encourages the clients to understand it that way as well. By providing this knowledge, the components of the system can better regulate. Understanding drives improvement.

Coding Process

The authors encourage other expert clinicians to consider methods to qualitatively capture the essence of their therapeutic work. Outcome research overwhelmingly supports the person of the therapist and the therapeutic relationship as powerful common factors responsible for a significant proportion of psychotherapy outcome[22]. While one can only aspire to objectify the subjectivity inherent in individual selves and the individual self-in-relationship, attempting to do so may be useful in memorializing the meaningful work of individual lifetimes.

These authors completed this task by viewing psychotherapy video recordings of Browning's work over his lifespan, and demarcating underlying themes that characterized interventions. As this practice serves to contribute to the qualitative research base of psychotherapy techniques, it may be useful to clinicians in the future. Clinicians and researchers desiring to replicate this process may use the following protocol:

1. Compile a minimum of five training psychotherapy videos conducted by an expert clinician.
2. Watch each video through once without a note-taking process.
3. Begin watching each video again with the goal of documenting each intervention used. At this point, the researcher may wish to hypothesize or make notes regarding the nature of the thematic content; however, at this stage it is only necessary to document the exact point of intervention.
4. Once the researcher has completed this for each video, he/she/they may begin to classify the interventions into different themes until a point of saturation is reached.
5. Review the most salient themes that emerged.

Conclusion

One of the major tasks in becoming comfortable in practicing strategic therapy is to shift one's perspective. Most psychotherapy models look at some aspect of the individual, couple or family and determine the fundamental defects that affect the client's capacity to live a healthy, functional life. Strategic therapy is looking at individuals as stuck, not sick. The seminal book, *Tactics of Change* by Fisch, Weakland and Segal[7] expressed this idea beautifully by writing, "We believe that people persist in actions that maintain problems inadvertently, and often with the best intentions" (p. 16.). In other words, people truly believe that continuing to do the seemingly correct thing, even though no change or improvement occurs, is the best course of action. Strategic thinkers use some of the ideas expressed in this article to both accept the client fully, and present a perspective that is unexpected. It is often in the respectful, unexpected action and perspective that opens the system to change. This article continues Kazdin's[3] call for more liberal application of qualitative methods to operationalize the life's work of established experts in the field of psychotherapy.

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