by

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Introduction

During the last few years, an unusually gifted Australian family therapist, Michael White (1984, 1986, 1987, 1988), has refined an innovative psychotherapy technique of "externalizing the problem." Ironically, this technique is both very simple and extremely complicated. It is simple in the sense that what is basically entailed is a linguistic separation of the distinction of the problem from the personal identity of the patient. This intervention opens "conceptual space" for patients to take more effective initiatives to escape the influence of the problem in their lives. What is complicated and difficult is the delicate means by which it can be achieved. White has recently referred to his work as "a therapy of literary merit". In other words, it is through the careful use of language in a therapeutic conversation that the patient's healing initiatives are mobilized. What makes the technique of interest to therapists is that it can be employed to contribute to an amelioration of a wide range of problems (including very serious conditions such as schizophrenia, depression, paranoia, violence, and suicide risk).

White cites two major sources of inspiration for his work. Both are from the humanities. The first is Gregory Bateson (1972, 1979), a British cum American anthropologist and philosopher, who applied cybernetics to the social sciences and elaborated a new view of "the mind". Key contributions from Bateson include the importance of epistemology in "how we know what we know", of the basic "differences that make a difference" in living systems and of the ecological "patterns that connect". The second source of inspiration is Michel Foucault (1965, 1973), a French historian and philosopher, who carried out a socio-political analysis of the emergence of modern medicine in Western culture. Foucault discloses how knowledge systems like medicine can be extremely oppressive by transforming persons into dehumanized "subjects" through scientific classification under "the gaze". In my own attempt to understand and clarify White's contribution, I have drawn from the work of Humberto Maturana (1972,1987), a Chilean biologist and neurophilosopher, who has proposed a comprehensive theory of cognition. Maturana offers an explanation for how the mind arises through human interaction and "languaging". The "mind is not in the brain", it lies in the linguistic interaction among human actors. Thus, consciousness is fundamentally social, not biochemical, physiological, or neurological. Unfortunately, time does not permit an adequate description of these theoretical contributions and their connections to White's method.

EXTERNALIZING THE PROBLEM

It was about 10 years ago when White made a simple but significant discovery. While working with children who had encopresis he observed that clinical progress was enhanced when he was able to talk about the problem as if it was distinct and separate from the child. He invented the label "Sneaky Poo" to refer to the encopresis (1984) and personified it as an entity external to the child (1986). For instance, with a particular child he might introduce this notion by asking: "What do you call the messy stuff that gets you into trouble? 'Poo'?".. "Have you ever had the experience of 'Poo' sneaking up on you and catching you unawares, say by 'popping' into your pants when you were busy playing?". If the child answers in the affirmative White goes on to ask about the sinister influences that the alien "Sneaky Poo" has had over the child in creating discomfort, unhappiness, frustration, family trouble, etc. He also asks other family members about the influence that "Sneaky Poo" has had in their lives: "When your son has been tricked by 'Sneaky Poo' into making a mess, what happens to you?" .. "When 'Poo' stirs up disgust and frustration, what does it make you do?". It gradually becomes apparent to the family (with a touch of humor) that they are all being oppressed by a common enemy, which is separate from the child's identity as a person.

White follows this first line of enquiry (about what influence "Sneaky Poo" has had over the family) with another set of questions about what influences the child and the family have over "Sneaky Poo." For instance, "Have there been times when

you beat 'Poo' and put it in its place rather than letting 'Sneaky Poo' beat you? ... Have there been times when 'Poo' got your son into making a mess and was inviting you to start yelling at him, but you were able to escape its invitations and offer support instead?" The child and family usually experience these new questions as strange. Indeed, they are, especially when everyone has been so preoccupied with the troublesome effects of the problem. This second set of "influencing questions" brings forth an awareness of the family's own resources in limiting the "power" of the problem over them. Family members are invited to notice that they have already taken some effective action against the problem. This enquiry not only validates the family's competence, it contributes further to externalizing the problem.

When the problem is clearly distinguished as being "Sneaky Poo" rather than the child, the complications of criticism, blame, and guilt are significantly reduced. The child has less reason to criticize and blame itself, after all, Sneaky Poo is the culprit, not the self. The parents have less reason to criticize the child or to blame themselves. And professionals have less reason to blame the parents (e.g. for being too severe in their discipline, or for being "too overprotective"). Because blame tends to restrain and guilt tends to constrain, reducing their prevalence is liberating. It opens space to explore new efforts in problem solving. Since everyone is under the influence of the same "troublemaker" and family members are no longer pitted against each other, it is easier for the child and the parents to "join forces in beating Sneaky Poo". As a result the therapeutic process proceeds more smoothly and quickly.

Although this treatment method was first elaborated in work with children with encopresis, it has since been generalized for use with a wide range of problems and has been applied successfully in work with individual adults, couples, and families (White, 1986). For instance, in a recent paper on schizophrenia, White (1987) describes how it is possible to externalize Schizophrenia as an illness, then externalize aspects of the "in-the-corner lifestyle" (i.e. the cluster of negative symptoms) that are coached by schizophrenia, then externalize the specific habits that support the lifestyle, and finally externalizing the pathologizing assumptions and presuppositions upon which these habits depend. In other words, the process of externalizing the problem is progressive. It is not a static reframe of the problem; it is a continuous process of co-constructing "a new reality" in the ongoing therapeutic dissection of the problem, "cutting it away" from the patient's sense of self as a person. That is, there is a systematic separation of problematic attributes, ideas, assumptions, beliefs, habits, attitudes, and lifestyles from the patient's dominant identity.

The reason this process is so healing is that it is an effective antidote to an inadvertent but ubiquitous pathologizing process in human interaction, ie. negative labeling. For instance, in the course of ordinary conversations about the problem with family members, friends, and relatives the problem tends to be "collapsed" onto the identity or personhood of the patient. This occurs because of the "common sense" assumption that "the person that has the problem is the problem". The medical model and DSM III also support this assumption. "The mental disorder is in the person." Professional and lay conversations that are based on this presupposition are inadvertently pathologizing in that they contribute to the elaboration of a problematic identity through labeling. As the problem becomes incorporated into the personal identity of the patient it becomes increasingly difficult to escape. This is simply because it is not possible for a person to escape himself or herself. "I am a schizophrenic, that's why I do weird things". Thus, externalizing the problem is a very useful therapeutic technique that opens space to "undo" some of the negative effects of social labeling.

INTERNALIZING PERSONAL AGENCY

Much more than de-labeling is possible, however. Once the overall problem and specific components of it have been externalized, patients are invited to notice opportunities to take action against the externalized problem(s). They are invited to escape the oppression of the labeling and to set their lives in the direction that they prefer (White, 1987). "If it was possible to do so, would you like to limit the influence that schizophrenia has on your life? ... Can you see how schizophrenia has been coaching you into withdrawing and avoiding people? .. How did you manage to defy schizophrenia's instructions to avoid people and come to this meeting today? What do you imagine this might tell you about your ability that you might not otherwise

have noticed? In what other ways have you stood up for yourself and not let schizophrenia push you around? H o w ready are you to take a further step against the withdrawal habit that has such a grip on you? Would you prefer to be a weak person with a strong habit or a strong person with a weak habit? ... When you submit to schizophrenia's efforts to push you into an unreasonable position how does this invite your parents to do all the reasoning for you?" These are reflexive questions that enable self-healing. They can be instrumental in achieving a variety of things in the course of an interview (Tomm, 1987). The main thing I would like to draw your attention to here is that these questions embed the notion that the patient does have choices, and that the patient is an active agent in the course of their own lives. If the explicit or implied meaning of the question fits the experiences of the patient, it is "taken to heart" and is internalized as part of the patient's evolving identity. Consequently a greater sense of personal agency may be achieved and the therapeutic conversation becomes a process of personal empowerment for the patient. I would like to emphasize that the technique of externalizing the problem does not remove personal responsibility. It focuses and refines it. Patients are invited to recognize that they have the option of continuing to submit to the influence of the externalized problem or the option of rejecting the invitation to submit to the dictates of the problem. As they begin to see these alternatives more clearly and experience them as genuine options they almost invariably select the latter. They are, of course, then supported in their protest and rebellion against the oppression of the problem.

It is also important to emphasize that the responsibility for submission is usually only implied, rather than explicitly stated. This is done in order to minimize any reactivation of blame and guilt (along with their immobilizing effects). Nor is any pressure brought to bear on patients to take a particular course of action. What is emphasized and brought forth in the therapeutic conversation are the alternatives that might be available to them. In so doing, patients experience more space and freedom to explore new patterns of perception, thought, and action. When patients do not enter into and explore the new space, it is assumed that additional aspects of the problem are restraining them and further, more differentiated, externalization is required. For instance, they may be under the influence of an associated "fear of failure."

Another important feature of the method is that the problem is externalized from the person and not projected onto someone else. Thus, the liberating protest and rebellion is not against other persons. Consequently, significant others in the patient's social network are less likely to be triggered into defending themselves and are less likely to respond by blaming, re-labeling, and re-pathologizing the patient.

It is, of course, extremely important for therapists to remain mindful of the problematic effects of high expectations for constructive change. This is especially true when working with patients struggling with chronic problems. Indeed, it is often necessary to externalize "unrealistic expectations" as a component of the problem (sometimes for the therapist as well as for the patient and family!) in order to escape the pathologizing effects of experiences of failure, discouragement and hopelessness. Very small steps may be all that is realistic. It is often useful to suggest that a pattern of "three steps forward and two steps back" is what is most probable, especially when the patient's desire to escape a chronic problem is strong. Anyone who has tried to alter a well established personal habit will know that "old habits die hard'. What is most important is the direction of the patient's evolution as a person, that is, a direction towards greater health, not the size or frequency of the steps.

Finally, when constructive steps are taken, they need to be recognized and responded to, in order to become part of a healing identity. This is necessary if the constructive changes are to persist "What did you do that made it possible for (the constructive event) to take place? ... How did you manage to take this step forward?" The new constructive behaviors are acknowledged, validated, and then given significance to enhance their incorporation as part of the new emerging self. "Do you realize that by doing so, you have cast a vote for yourself and against the problem? Can you see how significant your initiative has been?" If not, then try: "Can you see how I can see that by taking such action you have made a choice for yourself and have taught the old habit a lesson by refusing to be dominated by it?". Adding a broader time frame and contrasting differences

contributes further to the process of internalization. "How does this contribute to a new direction in your life, to a new lifestyle? … If you continued in this new direction of taking action against the problem, how would your new future differ from your old future (which included submission to the problem)?". Broadening the conversation to include the patient's social network to become an audience for the constructive changes also contributes to endurance. "What would your family (or friends) think or feel if they were aware of these new steps you have taken? … How will you let them know what has happened?". Through these questions patients are invited to become selective observers of themselves, to invite significant others to participate in noticing their constructive actions, and to recognize their own personal agency in making healing choices for their lives.

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DISCUSSION

White's process of externalizing the problem is not entirely new. In some respects it captures some of the ancient religious wisdom of demon possession and exorcism. But it demystifies

the process and utilizes it in a rigorous and precise manner. Likewise, much of the technique of internalizing personal agency is consistent with aspects of behavior therapy and conventional psychotherapeutic practice. But the focus on rebuilding a patient's identity or personhood through specific questions offers greater refinement.

At present, evidence of the effectiveness of this new method is mainly experiential and anecdotal. Nevertheless, in the last few years White's approach has had a major impact on patterns of clinical practice in Australia and New Zealand. It is now beginning to be introduced to North America and Europe and has already been taken up by a few centers. In my own clinical practice and in that of my colleagues in the Family Therapy Program at the University of Calgary, it has been possible to apply this method to help a surprising variety of patients. Empirical studies on this approach have barely begun. As of this writing, I am aware of only one formal study: a retrospective analysis of White's application of his own method with 35 chronic psychiatric patients who had been repeatedly admitted to the Glenside Hospital in Adelaide. It was an independent investigation carried out by Hafner, Mackenzie and Costain (1988) and revealed that there was a highly significant reduction of the mean number of days spent in hospital in the year following White's therapy; reduces to 14 days compared to 36 days for a matched control group who had received the usual kinds of psychiatric care.

White's work offers a useful new technique for day-to-day psychotherapeutic practice. It is respectful and humane, and in my opinion, is among the most exciting new developments in psychiatry in the past decade. For those of you who are interested in exploring it further, additional information may be found in White's own publications cited below.

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