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# Journal of Solution-Focused Brief Therapy

Volume 3, Number 1 – 2019

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**Journal of  
Solution-Focused  
Brief Therapy**  
Volume 3, Number 1— 2019

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#### EDITORIAL POLICY

The Journal of Solution Focused Brief Therapy is a scholarly journal that aims to support the Solution Focused community through the publication of high-quality research in outcome, effectiveness or process of the Solution focused approach and the publication of high quality theoretical and/or case-study related material in the area of Solution Focused practice.

The journal invites submissions as follows:

**Research reports** – We are committed to helping expand the evidence base for Solution Focused Brief Therapy and Solution Focused Practices. The journal seeks scholarly papers that report the process and results of quantitative and/or qualitative research that seeks to explore the effectiveness of Solution Focused Brief Therapy or seeks to explore the aspects of the Solution Focused process. We are also committed to research reports being “user-friendly” and so invite authors submitting research-based papers to address specifically the implications of relevance of their research findings to Solution Focused practitioners.

**Theoretical papers** – The Solution Focused approach raises many issues relating to psychotherapy theory, to our basic assumptions of working therapeutically and to the philosophical stance adopted by Solution Focused practitioners. The journal welcomes papers that explore these issues and which offer novel arguments or perspectives on these issues.

**Case study/Practice-related papers** – We are committed to the journal being related to Solution Focused PRACTICE. Therefore, we invite papers that explore the experience and perspective of practitioners. This might be a single case study, with significant analysis and reflection on the therapeutic process and which distills some principles or insights which might be replicable, or it might be a paper which explores a series of clinical/practical cases and which seeks to draw out overarching principles which might be used by others. Please discuss your ideas with the Editor (sarasmockjordan@gmail.com).

**Not just “therapy”** – The Journal recognizes that many useful and interesting manifestations

of the Solution Focused approach occur in settings that are not to do with therapy. Nonetheless, Solution Focused interventions are all concerned with helping to facilitate change. The journal is called the Journal of Solution Focused Brief Therapy, at least in part in homage to our heritage. Nonetheless, the journal welcomes submissions that explore the use of Solution Focused ideas in other settings.

#### SUBMISSION OF MANUSCRIPTS

##### Manuscripts

Manuscripts should be sent to the Editor as Microsoft Word or Apple Pages word processing documents. Please do not submit your manuscript elsewhere at the same time. Please send the manuscript double spaced with ample margins and a brief running head. The title of the paper should appear on the first page. **Since all manuscripts will be blind reviewed, please include names, affiliations, etc. of the author or authors on a SEPARATE first page. Please also include on this (or a next) page details of any grants that have supported the research, and conference presentations relating to the paper, any potential (or even perceived) conflicts of interest.**

Solution Focused Brief Therapy and Solution Focused may be abbreviated to SFBT and SF after the first mention.

References should follow the format of the American Psychological Associations (Publication Manual of the American Psychological Association, 6<sup>th</sup> ed.). Papers should include an abstract of no more than 150 words.

Any tables, figures or illustrations should be supplied on a separate pages (or in separate computer files) in black and white and their position indicated in the main document. For any images or photographs not created by the author, the submission must include written permission to reproduce the material signed by the copyright holder.

We would expect that papers will ordinarily me a maximum of 5,000 words; however, this limit is negotiable if the content of the paper warrants more.

##### Clinical/client material

This journal’s policy is that any actual clinical details in a paper (including but not limited to, therapy transcripts, client/patient history, descriptions of the therapy process) should have signed consent from the clients/patients for the material to be published. If a paper includes clinical material or descriptions, please include a declaration, signed by the first author, either that signed consent of clients/patients, specifically for the publication of their clinical information in this journal, has been obtained and is available for review OR that clinical material has been altered in such a way as to disguise the identity of any people. Fictional case examples can be used to illustrate techniques/ideas if consent from *real* clients in your practice can’t be obtained.

## Peer Review

Manuscripts will be reviewed by at least two members of the Editorial Board or ad hoc reviewers, who will be asked to recommend that the paper be accepted, revised, or rejected for publication; however, a final decision about publication rests with the Editor. Reviewers will also be asked to indicate what kinds of changes might be needed in order for the paper to be published. Where reviewers have indicated that the changes are required or recommended, we are happy to work with authors to address the reviewers' comments. When the reviewers recommend that the paper not be accepted, and the Editor accepts this/these recommendation, a final decision of reject is made by the Editor and no further consideration of the paper will be given. When the reviewers (and the Editor) suggest that your paper, while it may have merit, does not meet the requirements for this journal, we will endeavor to suggest other journals to which the author might submit the paper; however, we are under no obligation to help achieve publication in our journal or in other journals. Where one or more authors of a paper is a member of the Editorial Board, that person will take no part in the review process and the review process will still be anonymous to the author or authors.

Send manuscripts to: [sarasmockjordan@gmail.com](mailto:sarasmockjordan@gmail.com)

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## A New Chapter

Sara Smock Jordan

Editor-in-Chief, *Journal of Solution Focused Brief Therapy*

As a doctoral student, I had the opportunity to be an editorial assistant of a top-tier scholarly journal. Within a few weeks, I knew I wanted to be an editor someday. At that time, *JSFBT* didn't exist. I remember asking myself "What journal would be interested in an editor who focused on furthering the evidence-base of SFBT?" Time passed and I entered my first academic position as an assistant professor. More time passed and I finally obtained promotion and tenure. For the first time in a while, I revisited my interest in becoming an editor.

Several years ago, I was asked to join the editorial board for the new *Journal of Solution-Focused Brief Therapy*. I was very excited and honored to be part of *JSFBT*. As a member of the *JSFBT* editorial board, I was impressed with the quality of *JSFBT* over the years. I eagerly awaited the arrival of a new issue. After a lapse in publication, I became concerned. The value of this journal is so great I didn't want to see it dissolve.

This spring, I received an email from David Hains stating that AASFBT was looking for a new editor. I have to be honest, I thought "Could this be true? Could I be someone they might be interested in for the role?" I emailed David back, trying not to sound too eager, letting him know I was interested in the position. One day, David emailed me saying that he would like me to step into the *JSFBT* editorship. I agreed. We began to talk about possibilities for how *JSFBT* could be restructured. The excitement began to grow within me. I remember thinking to myself "Is this really happening? Am I really the new editor?"

My excitement about the *JSFBT* editorship was directly connected to the importance of the journal to the SF community. In academia, publishers ask "why do we need a new journal?" In the case of *JSFBT*, the question was "why should *JSFBT* continue?" *JSFBT* is important to the international community because it provides an outlet for scholars, clinicians, and practitioners from various disciplines to share their work with others. Steve and Insoo passed before *JSFBT* was launched, however there is no doubt in my mind that they would support and encourage the continuation of the journal. Both Steve and Insoo understood the need for SFBT to be recognized as an evidence-based practice, as well as the importance of maintaining the validity of SF. I honestly believe that *JSFBT* fulfills their vision

of disseminating quality SF work and widening the evidence-base of SFBT.

When asked to be the editor of *JSFBT*, I expressed my apprehension about *JSFBT*'s sustainability. Early in our discussions, David and I began to brainstorm ideas for increasing the support for the journal. One idea was to include co-sponsors. During a zoom call about the possibility of co-sponsors, I started to become emotional; I began to cry. I became so overwhelmed with the hope and opportunity to collaborate with various organizations on an international level. Across groups, cultures, practices, and schools of thought, differences exist. Could the re-birth of *JSFBT* be a common cross-cultural thread that would join and unite individuals and groups from around the world? The excitement began to grow even more. My vision of *JSFBT* was now more than generating quality materials but bridging a community of like-minded people.

First, we developed a plan to publish a crowdfunding issue of *JSFBT*. Our intent was to generate funds for *JSFBT*'s production. We also discussed platforms for *JSFBT*. We wanted a low cost, easily manageable option, and eventually decided on an open-access platform. We discussed how we would financially support the costs associated with the journal. The AASFBT had produced the journal on a shoestring budget, but the *JSFBT* could not be sustained or grow on such a tight budget. Through many conversations, we developed a plan to have co-sponsoring organizations fund the journal. We started by asking the larger SFBT organizations to be our main co-sponsors, and over the next few months we plan to open the invitation to other smaller organizations who wish to support *JSFBT*. Needless to say, it's been a busy summer.

As *JSFBT* continues to evolve, my best hopes are the following. First, that the journal becomes more widely accessible to individuals and groups around the world. Starting in 2020, the journal will be published using an online open-access platform. This will promote a world-wide readership. In addition, our hope is to translate abstracts into various languages. Second, my hope is to widen the scope of *JSFBT*'s articles, including SF manuscripts from a wide variety of topics, populations, and disciplines. This widened scope will foster further innovations for the SF approach. Third, my hope is that the journal will further promote SFBT's recognition as an evidence-based practice. Maintaining a SF journal will greatly increase the amount of SF research generated and published. Fourth, the journal plans to be more intentional about mentoring new scholars and non-native speakers. The hope is to develop a mentoring program that will encourage individuals and groups to submit their creative ideas and work.

So, what small steps need to happen to make these best hopes possible? You! It will take a community of SF individuals who are willing to writing up their new ideas, serve on the Editorial Board, and volunteer to be ad hoc reviewers. It will also require groups/associations to donate or co-sponsor financially.

I am so honored and excited to be the new editor of *JSFBT*. Over the next few months, the editorial board and I will unveil more small steps to accomplishing these best hopes. The future looks bright and I'm thrilled to be part of this international, collaborate effort to leave

a legacy of SF materials!

Sara Smock Jordan

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## The Day I Triumphed Over Hofstadter's Law (but not Impostor Syndrome)

David Hains

President, Australasian Association for Solution Focused Brief Therapy

Solution Focused Brief Therapy, Impostor Syndrome, and Hofstadter's Law. I can link all three things, but only inside my head. I can't find any previous writing or research how these 3 things may be linked.

While SFBT is my friend, the other two are my greatest enemies. If the JSFBT gets published in 2019 then I have finally gotten one-up on Hofstadter's Law. (I can't find anything previously written about the link between Hofstadter's Law and SFBT, but I note that Frank Thomas referenced Douglas Hofstadter back in 1996). Hofstadter's Law states that important or worthwhile tasks will always take longer than you expect, even when you take into account Hofstadter's Law. It doesn't really matter what I do, Hofstadter's Law slows me down...until now. From here on Hofstadter's Law will consume me no more.

I'm not sure what it is about SFBT that helped me conquer Hofstadter's Law. I never consciously thought about applying SF principles when trying to revive the *JSFBT*. Perhaps SF is just ingrained in me to the point that I can only focus on my preferred future? Maybe it is because talking about SFBT is so much more fun than the boring (non-SF) stuff I usually do? In retrospect, perhaps it was my other nemesis, Impostor Syndrome, that finally pushed me through? Whatever it was, I admit that the last 12 months have been pretty cool! Most mornings I wake up, check my inbox and find emails from all around the world – Sara, Mark, Harry, Chris, Evan, Alasdair, Frank, Peter, Gale, Kirsten, Rayya; I've seen your videos, I've read your books and your papers, but now you are emailing me? Ok, I admit that I am a solution focused nerd; your emails make me feel as excited as a kid in a candy shop.

Why are they contacting me? I am just a nurse from Adelaide with a long history of suffering from Impostor Syndrome. As it turns out, my international colleagues heard a rumour that the *Journal of Solution-Focused Brief Therapy* was coming back to life, and they wanted to make sure that it wasn't just a rumour. What have I learned over the past 12 months? There's an enormous amount of international support for a peer-reviewed solution-focused journal, and

a lot of people want to be a part of its success.

The story so far ...

The Australasian Association for Solution Focused Brief Therapy (AASFBT) was started in 2013. AASFBT's original aim was to publish an academic journal as a service to the worldwide Solution Focused community. Michael Durrant, the founding President of AASFBT and Editor of the *JSFBT*, was the driving force. Michael assembled an editorial board consisting of scholars and practitioners from 20 different countries. Over the course of four years, four issues were published. It is fair to say that Michael did most of this work on his own. The journal was his passion. He invested countless hours establishing the *JSFBT*. He solicited manuscripts, assembled papers, arranged peer reviews, completed copy edits, formatted content, printed and mailed hard copies of the journal, and all of this without payment. Amazingly he was able to produce a world-class publication for as little as AU\$3,000 per edition. The AASFBT, and the International Solution Focused community are indebted to Michael for the work he has done. Given the demands of maintaining an academic journal, the workload was too much for one person, or perhaps he too was defeated by Hofstadter's Law?

Back in July 2018 I took over as President of the AASFBT. One of my goals was to get the journal back into publication. It was clear to me that in order for *JSFBT* to succeed it would need more resources than what the AASFBT could provide, so we began to discuss ways to restructure the production of *JSFBT*. The first step was to find a new editor, someone who could build on the foundation set by Michael, someone who could expand and maintain the journal through the worldwide community.

I was VERY happy that Sara Smock Jordan applied for the role as editor of *JSFBT*. It only took a couple of emails before I knew we had the right person for the job. Sara first volunteered to serve as editor on May 1, and was unofficially appointed on May 23. Now, less than 5 months later, our new team has published volume 3, issue 1! In addition, we are establishing a permanent new platform for future issues of the journal in 2020. Our first issue with our new online platform is planned for July of 2020. Take that Douglas Hofstadter!

Sara really needs no introduction. She is one of the most well-respected people in the international solution-focused world. From her early days as a graduate student, Sara had the opportunity to learn the model from Steve, Insoo, and key members of the original Milwaukee team. Sara has studied, practiced, researched, and published extensively on SFBT. She brings an amazing amount of both clinical and academic expertise to her new role. Sara is a founding member of Solution Focused Brief Therapy Association, and past president of the association. Currently, she serves on SFBTA's board of directors and is a member of the research committee. We are excited to have Sara as our new Editor and have been working with her to rebuild the journal. This special edition is the culmination of 5 months' worth of work by Sara, her editorial assistant Kaitlin Andrewjeski, and the editorial board. I would like to personally thank everyone involved for their work, dedication, enthusiasm, and encouragement in getting the journal up and running again.

International collaboration: it takes a community to sustain a journal! From the very beginning, it was clear to me that the journal had to be supported by more than one association. While we are proud and grateful for what Michael and the AASFBT established, my desire was to have a fully international publication. Associations around the world are beginning to commit to the journal and we would like to invite other groups to join us as co-sponsors. In 2020 we will be establishing an open-access publication, providing free issues of the journal. While this platform will provide full international exposure of SFBT, costs of producing the journal still exist. Therefore, we call upon the solution-focused community - organisations, conferences, collectives, and individuals - to financially support the work.

So, welcome to this special edition of the *Journal of Solution-Focused Brief Therapy*. I hope you are as excited as I am to be reading this special edition (I haven't actually seen a copy yet!). Thank you for purchasing a copy. The money raised from this edition will be used to help fund the 2020 editions as we move to a full production schedule of two issues per year. From here, I will hand over the journal to Sara and wish her and her team every success in rebuilding the journal. As the President of AASFBT, I will stay involved in a managerial/oversight role along with our co-sponsors to build a truly international publication.

Please do not hesitate to contact me should you have any questions, suggestion, or submissions regarding the journal, SFBT in Australasia, or even just to say g'day, or to feed my impostor syndrome.

David Hains

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<https://www.solutionfocused.org.au/journal>

## Reference

Thomas, F. (1996). *Solution-focused supervision*. In Miller S., Hubble M., Duncan B. (eds) *Handbook of solution-focused brief therapy*. Wiley.

## Changing How We Think About Change

Evan George

BRIEF: The Centre for Solution Focused Practice

What happened to the word “change?”

I have recently completed four really enjoyable days of training in Liverpool and what the training has left me thinking about, amongst many other things, (including how much I like the city of Liverpool, of course), is the small word “change.” In fact, I have come to realize just how uncomfortable I feel with the word.

The realization came to me during a discussion. We were talking about what we can ask when someone is finding the ‘best hopes’ question hard to answer. One of the groups, very appropriately, suggested that we might reframe the question. What she might ask, I wondered, and her first thought was something on the lines of “so what do you want to change?” I immediately knew that this was not a question that I would ever want to ask. The first reason for my certainty was simple. If you ask, “so what do you want to change?” inevitably it invites the client into a problem-framed response, “well it is their behaviour that I want to change.” The question is not a million miles from “so, what brings you here today?”, again a question that will pretty well guarantee a problem-based answer. The second reason was trickier to articulate. I just don't use the word change! Now isn't that strange? A therapist (or counsellor or coach or consultant) who feels uncomfortable using the word change. So, what is going on I began to wonder.

It seems to me that the idea of change is fading into the background of the way that we conceptualise as Solution Focused practitioners. Obviously, the mechanics of the change process disappeared long ago; certainly in the BRIEF version of the approach. We do not ask prospective strategy questions, “How are you going to do that?” questions. We take the mechanics for granted linguistically jumping over them, focusing on the difference that the change makes. This is in some ways a development of the miracle question. The client wakes up and the change has happened. We are not interested in inviting the client to focus on how it is going to happen; what they must do to have it happen. We merely invite the client to describe their miracle day, how they will be able to know that the miracle has happened. I

notice that I tend to do something similar with the scale question. “Imagine that you move one point up on the scale and find yourself at 4” (for example). “How will you know that you are at 4?” People are invited to “find” themselves one point higher in my questions; the process of the change has disappeared. We do not invite the client to be interested in the prospective ‘how’.

Now, this disappearance of the prospective process of change, which in some ways we can date back to the early days of the approach (even though Steve de Shazer regularly [and rhetorically in my view] insisted on asking clients “so how are you going to do that?”), seems to have strengthened its hold on the way that many of us use the approach. Our friends and colleagues Elliott Connie and Adam Froerer are I think to be credited with the appearance of the word “version” in our conversations with clients. For example, we might ask, “imagine that you wake up tomorrow the confident and optimistic version of you – what is the very first thing that you will notice?” What interests me about the word ‘version’ is that any sense of change disappears. The “confident and optimistic version” is already there, latent in the client’s life. It is not an unrealized possibility that the client has to put in place or construct. It really is already there. Clients can wake up living the life of that version of themselves. If clients answer the question, they are implicitly accepting the premise.

This small, but in my view significant, tweak to the way that we think and the way that we construct our questions builds on the clarity that BRIEF’s Chris Iveson brought to our thinking some years ago. Chris challenged whether we are in the business of change. We are, he counter-proposed, in the business of perspectives. We invite clients to look into the shadows of their lives, the hidden corners, and to notice the elements of the preferred future that are already in place, just not noticed, invisible and perhaps unseeable while the light is shining so strongly on the problems and difficulties that have come to occupy the fore-ground, the front-stage, of our clients’ lives. The brighter the light that shines on the problems the deeper the shade that obscures the instances and exceptions. As we look into a bright light our eyes, quite literally, find it harder to see in the gloom, the behind, the beyond. And in our lives our perception seems to operate rather like our eyes. So, people are not having to make changes, we are merely inviting them to shift their gaze. This really is quite a step from the early days of our approach when Steve de Shazer emphasized that one of the characteristics of “well-formed” or “workable” goals is that they should be perceived by the clients as involving their “hard work” (de Shazer, 1991, p.112). Even the word ‘goal’ has disappeared! We have come a long way in our thinking.

## Reference

de Shazer, S. (1991). *Putting difference to work*. New York: Norton.

Evan George

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## A Brief, Informal History of SFBT as Told by Steve de Shazer and Insoo Kim Berg

Peter De Jong

International Microanalysis Associates

This account of the origins and development of SFBT is not based on a rigorous historical analysis of key events, recovered unpublished documents, or the formal writings of de Shazer, Berg, and their colleagues at the Brief Family Therapy Center (BFTC). Rather, it is taken from the author’s records of two experiences he had with de Shazer and Berg: 1) notes from a lecture de Shazer gave about the history of SFBT just one month before his death, and 2) a recorded interview with Berg in 1998 about the origins of BFTC and SF techniques. The article concludes with a few reflections by the author.

In the latter part of the summer of 2005, I (Peter De Jong) came to Milwaukee, Wisconsin from Michigan for a couple of weeks as I had done every summer since 1990. I came mainly to work with Insoo Kim Berg on our joint projects and related writings. I would, however, also sit in on the workshops Insoo and Steve conducted each summer, and stay at their home, so we could discuss the workshop content and the participants’ responses to the material. These discussions helped inform Insoo’s and my writing about how to make SFBT more accessible to learners. The workshops were always run by Insoo. I would sit next to Steve, both of us drinking coffee, until Insoo asked one of us to do something; such as a demo of a miracle question conversation or address a particular topic. Insoo began that 2005 summer workshop as she always did, asking the participants what they would like to have heard, seen, or done by the end of the workshop. Predictably, among the requests was the wish to hear about how Steve, Insoo, and their colleagues at BFTC developed their innovative SF techniques. So, part way through the workshop Insoo asked Steve to talk about the history of the approach, and I took notes on what he said. The version of BFTC’s history contained in this article is reconstructed from those notes. It is supplemented with quoted comments from Insoo taken from a recorded interview I did with her in 1998 about the origins and development of SFBT. I conclude the article with my reflections from Steve’s lecture and Insoo’s comments.

### Steve & Insoo’s Telling of the History

The story begins in the 1970’s at the Mental Research Institute (MRI) in Palo Alto,

California. There, the likes of Don Jackson, Jay Haley, and John Weakland had been developing a form of brief therapy since the inception of MRI in 1958. Steve and Insoo, both from Milwaukee but unknown to each other at the time, came to Palo Alto wanting to learn more about the ideas and practices of MRI. They learned, among other things, that MRI's practice was, in part, inspired by the work of the psychiatrist Milton Erickson. Some of MRI's therapists including Haley, would visit Erickson in Arizona and talk to him about his cases. Haley, especially, has written about Erickson's work describing many of his cases (Haley, 1986). Erickson's practice with clients was short term, sometimes included hypnosis, and always involved Erickson doing something to bring about change.

Steve became fascinated by Erickson's work. While Erickson did not develop and write about a detailed model of doing therapy, he did describe many cases and what he did with them. For example, there was the case of a twenty-one-year-old woman who came to Erickson saying she was thinking of ending her life. She said she wanted a husband and children but had never had a boyfriend and felt she was too unattractive to attract a man. She said she worked as a secretary at a construction firm and kept to herself. There was a young man at work who she found attractive, who showed up at the drinking fountain when she did, and who seemed interested in her; however, she never spoke to him. She had no friends and believed she was "too inferior to live." She decided to see a psychiatrist before ending her life, telling Erickson she would work with him for three months before carrying out her plan.

Erickson thought the woman was pretty but dressed very unattractively and her hair was stringy and unevenly cut. The woman told him her main physical defect was a gap between her two front teeth which she self-consciously covered with her hand when she talked. Erickson responded to the woman by assigning two main tasks. First, he told her that since she was going downhill anyway, she might as well have one "last fling." She was to go to an assigned store and get help selecting an attractive outfit and then to an assigned beauty shop to have her hair styled. Erickson said she accepted the task because she did not interpret doing the task as improving herself but only having a "last fling." Second, she was to go home and, in her bathroom, practice filling her mouth with water and then squirting the water through the gap in her front teeth. She was to practice until she could squirt the water up to six feet and do so with accuracy. Erickson said she thought this was a silly task, but its silliness apparently prompted her to go home and practice it conscientiously.

When the woman returned and was attractively dressed, her hair newly styled, and skillful at squirting water through the gap in her front teeth, Erickson proposed another task. This time she was to play a practical joke at the office. The next time the young man appeared at the fountain, she was to fill her mouth with water, turn, squirt it at him, run toward him a bit, and then immediately turn away and "run like hell down the corridor." At first, the woman rejected this proposal as ridiculous, but later decided it could be part of having one "last fling." So, the next day she went to the office dressed in her new outfit and looking very attractive. When she approached the water fountain the young man predictably appeared. She filled her

mouth with water and squirted it at him. He yelled an expletive at her which made her laugh; she then turned and ran down the hallway. The young man chased her, caught her, and to her astonishment, kissed her. The next day, the young woman nervously approached the water fountain. The young man was hiding nearby and jumped out squirting her with a water pistol.

Steve studied scores upon scores of Erickson's cases trying to figure out his way of working with clients. Insoo had this to say about Steve's study of Erickson's work:

He (Steve) is the type that when he's interested in something he just reads and reads and reads .... That's what he did with Erickson's work; he just immersed himself. And he's always looking for patterns that connect. So, he looked a lot really into Ericksonian patterns – what is it about his way, how can he describe the patterns – that seem so out of nowhere.

Steve came to see at least two patterns that connected in Erickson's way of treating cases. First, Erickson heard and tied his tasks and proposals for the client to the client's goal. In the case of the young woman, he heard that she wanted a husband, a family, and friendships. Second, he creatively drew on qualities and skills that the client possessed and could be put to use in reaching the client's goal(s) (the principle of utilization). In the case of the young woman, she had a space between her two front teeth and she mastered squirting water through that space.

Steve also noticed that Erickson's brief way of doing therapy -- often in just a few sessions -- was radical because it came at a time when therapy was indefinite. Many therapists believed clients regularly needed one-hundred or more sessions. When research studies at the time showed the average number of sessions for clients was about four sessions, therapists would bemoan this and say things like: "the client's progress is only a temporary flight into health," or "the client's quick progress did not address the real or underlying problems," or "leaving therapy so soon is a defense mechanism; it is a sign of client resistance to getting better."

In thinking about these common therapist explanations in the 1970's for the average few number of sessions, Steve and his colleagues saw a "big disconnect" between these explanations and what their clients were telling them. As Insoo described it:

In that time (early to mid-1970's), families kept dropping out and dropping out of treatment. Families don't tend to stay in treatment very long. Couples don't tend to stay in treatment very long. And I didn't know that at the time. So, I kept getting this uncomfortable feeling that this isn't right, this isn't right. The clinical phenomenon and what the theory says didn't go together. So, I was in search for something – there must be an answer for this .... And I think that another thing that was interesting was that these 'failure cases' because by their (most therapists') criteria – anything less than people who stay in treatment for less than a year – was a failure case -- because they are dropouts. Yeah, (but) dropout cases were sending their best friends, their family members ... I only saw them three times and they must have thought that I helped ... because they are

sending their sister, their mother – so I thought something isn't right, something isn't right, but I didn't know what.

As a consequence of this “disconnect,” Steve and Insoo began looking more carefully at the existing data about number of sessions. They saw that mental health facilities at the time were taking as many as six sessions to do extensive assessments before they began treating the assessed problems. Clients often “dropped out” before the assessments were completed. Nevertheless, clients said coming to the sessions had been helpful. Other data indicated 80 to 90 percent of therapy was less than 20 sessions; yet, most clients said therapy was useful. Steve then realized that clients were using therapy differently than most therapists thought they should. With Erickson's work and the data about client number of sessions as background, Steve thought: Let's build a brief therapy around the client goals; they obviously are using therapy that way anyway. So, he decided to listen more intentionally to and believe what clients say they want and say is useful for them. Meanwhile, by this time which was in the later 1970's, Steve had returned to Milwaukee and joined the large family service agency where Insoo worked. Insoo had put a one-way mirror into her large office so she and colleagues could observe practitioners working with clients. They and their colleagues soon discovered that they could not simply ask the client: “What is your goal?” When they did that, the client would respond “to stop drinking,” or “to stop fighting with my teenage son,” or “to be less depressed.” These client responses were more like problem statements rather than goals. Accepting these responses as goal statements was not useful because practitioners know the hardest way to change is to try to stop something. Soon, Steve and Insoo observed and recognized that the clients who were making progress had discovered something else to do instead of the problem behaviors. So they began experimenting with questions like: “What are you going to do instead of the drinking?” “When you are not drinking, what will be there instead?” “What will be happening when you are not drinking anymore?” “What will others notice you doing when you are not drinking anymore?”

These questions, too, were difficult for clients to answer. Clients would often first respond, “I don't know.” So, Steve, Insoo, and their colleagues (who by now had formed BFTC in 1978) kept working at ways to ask questions about client goals in order to give clients maximum opportunity to construct useful goals for themselves. And then, in the early 1980's, Insoo had the case of a woman who came to her saying she was depressed and was contemplating killing herself. She had several children with many problems themselves and a husband who drank too much alcohol and was out of work. Insoo began goal work with the woman asking questions like: “so what needs to happen here for you to say our meeting was useful?” And, “what do you want different by the end of our work together?” To these and several similar questions, the client responded “I don't know” and she continued to give more details about the problems of her family and herself. Then, at one point the woman added the words “unless a miracle happens” to her “I don't know's.” Insoo, by this time intentionally attendant to client words, picked up the phrase and asked: “Okay, so suppose a miracle happens and all these

problems are over, what would be happening instead?” The woman then began to answer, “my husband would stop drinking and have a job,” and “I would have more energy.” Insoo continued with “what else would be different?” The woman responded with “my kids would be doing better in school.” As Insoo continued following up on each client answer and getting more details, she and the team noticed the woman became more animated and seemed less depressed and more hopeful. The differences in the woman from the beginning of the session to the end impressed the observing team so much that they decided, as they had been doing with each promising new technique, to ask the “miracle question” of all clients for the next several months and see what difference that made in the rates of client progress. The “miracle question” turned out to be so useful that BFTC made asking it a standard practice of their developing new form of brief therapy. Insoo has commented that the observing team at BFTC did not invent the miracle question; instead, it came from listening carefully to what clients say and then using that:

You know, I think clients say that stuff all the time: “do you have a magic pill?” Or, “do you have an answer to this?” “I need an answer from you.” “I need a miracle from you.” “Or a magic wand from you.” I think clients say that all the time... But sometimes when the event, the case, and the circumstances come together, *you hear them!* (italics added) And I think that out of desperation (laughing), when the case seems so hopeless; out of desperation you hear them. That's what happens a lot; and you get new ideas. It comes from that, not that we are so brilliant or so smart. But I think that, “oh my gosh, what do we do now?” creates that kind of crossroad, and then something opens up I think.

Steve says the same sort of careful listening to the client and then building on what he heard led to the use of scaling questions in SFBT. Steve had a case shortly after the release of the American film “10” starring Bo Derek as a beautiful young woman and Dudley Moore as a middle-aged composer. Moore's character, experiencing a mid-life crisis, becomes infatuated with the young woman whom he rates as “11” on a scale that only goes up to 10. The film was very popular and the practice of rating things on a 10 point scale was finding its way into popular culture. Steve's case was a man who was returning for a later session and Steve asked him how he was doing. The man said: “I'm doing better.” Steve asked: “How much better?” The man replied, “Well, I'm not a perfect 10; but I'm about an 8.5.” Then Steve asked: “So what tells you it's ‘about an 8.5’?” The client went on to describe the progress he had been making. After that case, and through discussion and reflection with Insoo and his colleagues, Steve came to realize scaling was so useful because the client had to be scaling himself relative to his own goal(s), not some professional, supposedly objective, criterion of success. And, in asking the client to provide the details for the number he gave, the client and Steve became clearer about what it is the client wanted different in his life which, in turn, made deciding what to do next easier.

Once it dawned on Steve that the client's goal was implicit in the scaling numbers for

progress, he also began to notice that many clients who were making progress came into later sessions already describing what was better. Implicit in these descriptions was what clients wanted different in their lives, i.e. their developing goals. So, Steve and his colleagues began asking “what’s better?” at the beginning of follow-up sessions and then lots of follow-up questions to get the details of what was better. This began in the early 1980’s and was a new direction because in the late 1970’s and into the early 1980’s, BFTC practitioners were still influenced by practice at MRI and would give clients tasks intended to bring change. As the tasks were intended to change clients and/or their situations, it was natural to begin later sessions by asking clients whether they had done the tasks and what the results were. In shifting toward conversations about what was better and away from asking whether clients completed their tasks, Steve and his colleagues discovered most clients, if asked, could identify something better. As BFTC practitioners pursued this new line of questioning, figuring out more and more ways to keep the conversation about what was better going, even when some clients would start out by saying “nothing,” they found over 90 percent could identify something better. The more they stayed with the “what’s better” opening in their follow-up sessions, the less they focused on asking about tasks and designing intricate tasks based on family systems thinking as they had been doing earlier. Steve says a bonus to shifting toward asking “what’s better” was the discovery that what clients described as “better” often had nothing to do with the original problem(s) that brought them to therapy. The bottom line here, Steve says, is that clients define success differently than most practitioners who try to help clients by assessing and solving their problems. He came to realize that in listening ever more intentionally to what clients want and inventing with them more and more ways to invite them to describe in detail what they want and the progress they are making, clients were teaching the practitioners at BFTC to move away from problem solving in favor of building solutions in partnership with them.

### Reflections

I (the author) am struck by three things in Steve’s brief telling of the history of BFTC and SFBT. The first is his focus on just a few years of that history; namely, from the mid-1970s to the mid-1980s. I wonder if this was the period, in his mind, when the key discoveries were made at BFTC. It was the period when BFTC began abandoning the theories and practices of the field of psychotherapy in general and differentiated itself in practice and thinking from MRI. It is also the brief period during which the unique solution-focused questions and practices were invented at BFTC that have endured to the present as heart of SFBT.

Second, I am struck by Steve’s emphasis throughout that the team at BFTC learned to listen to clients in a different way. While the rest of the field was using professionally constructed categories to assess client problems and then move to helping clients with related interventions, BFTC practitioners were learning to listen to clients on their terms versus the lens of the field. Steve and Insoo first noticed the “big disconnect” between the field’s view

about how much therapy clients needed and how clients were using just a few therapy sessions and finding that useful. BFTC believed the clients about the usefulness of just a few sessions and began listening more intentionally to what clients said they wanted and what progress they were making. In a sense, BFTC closed the textbooks about how to do therapy in favor of listening to their clients. And, as Insoo said, “...sometimes when the event, the case, and the circumstances come together, *you hear them* (the clients)!” The increasing BFTC capacity to hear clients on their terms rather than through professional categories, led to the signature SF questions and practices.

Third, I am impressed by the approach to investigation and knowing that BFTC adopted. While early on Steve and Insoo experimented with practices drawn from family systems theory, they soon set that approach aside in favor of direct observation of therapy sessions. Insoo put a one-way mirror in her office at the family service agency in the 1970’s. One-way mirrors and direct observation and review of recorded sessions remained a central feature of practice, research, and learning at BFTC until Steve and Insoo’s passing. The colleagues at BFTC consistently observed for which clients were making progress and what those clients and their practitioners were doing together that might be contributing to that progress. When they noticed a client and practitioner collaborating in a new and potentially useful way (such as Insoo picking up on her client saying “unless a miracle happens”), they incorporated the innovation into their practice and formed a research study to measure its usefulness. Employing rigorous observation of real time and recorded sessions is what contributed most to listening to clients in a new way and the invention of SF techniques. Steve, in a book published in the 1990’s reaffirms the importance of such observation:

Therapists are interested in the doing of therapy and, at least in a certain sense, only the observation of sessions or watching videotapes of therapy sessions can give them the ‘data’ they need [to learn SF and improve their practice skills] (de Shazer, 1994, p. 65).

Reviewing these notes from Steve’s 2005 lecture and the 1998 interview with Insoo has gotten me thinking that we may have more to learn from this version of the history of SFBT than I first realized. Many of us who teach workshops and write about SF practices, tell our learners that SF is “simple but not easy.” That is to say, it is simpler to describe, understand, and teach the SF approach in concept than it is to actually conduct a SF conversation. On reflecting once again on Steve and Insoo’s history described in this article I wonder if we have ignored some of their genius in our teaching. I know that for the nearly thirty years that I have been teaching and practicing the SF approach, I have focused mainly on teaching the SF questions invented at BFTC together with the outlook about clients and practice embedded in those questions. This question-based approach largely ignores how SF questions were invented. In contrast, Steve, Insoo, and their colleagues themselves first “learned” the SF approach through direct observation of therapy sessions and listening to and learning to hear clients on their own terms. Having recorded sessions allowed them to revisit the words of what clients said and stay close to those words so as to reduce the natural tendency (often

unintentional and below the level of awareness) to transform what clients say into the practitioner's preferred or professional categories. Perhaps, I am thinking more and more, SF learning would be enhanced by consistently having our learners record their SF interactions from the outset of their learning. That is easier than ever to do with smart phones, laptop computers, and role playing. The teaching can then be organized around inviting learners to observe for what their "clients" are saying and what they and their clients are doing together that contributes to clients constructing detailed visions of what they want and measuring progress toward these goals as the clients define progress. In organizing SF learning around learners becoming keen observers of their own SF conversations, they will be reinventing the SF model for themselves. Doing it this way originally worked well for the BFTC team; perhaps shifting our teaching in that direction will produce similar results for today's SF learners.

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## Leaving No Footprints

Chris Iveson

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BRIEF: The Centre for Solution Focused Practice

### Abstract

In this paper, clients' experiences of therapy are used to examine two essential paradoxes: neutrality and influence, in the minimalist version of Solution Focused Brief Therapy developed by the author and his colleagues at BRIEF. Both concepts are linked to trust, a radical trust in each client to know what is best for their future, and a trust that decisions about this future are solely the business of the client. Maintaining this trust in the face of our own ideas and good wishes towards our clients requires a discipline which may not suit all Solution Focused practitioners.

### Dressed to Kill

Angela stepped in from the pages of *Vogue*; cool, assured and with an air of authority. She had been planning to kill herself when she read about Solution Focused Brief Therapy in *The Times* and decided to give it a go before carrying on with her plan. She had been drawn by the future focus and the apparent lack of need to talk about the past. She said she knew perfectly well the source of her problems but had no intention of talking about it.

Angela's adult life had been one of extremes. Having performed well at school she went so far off the rails that in her late teens she became a homeless heroin addict. A suicide attempt brought her to the attention of the mental health services and a successful rehabilitation programme. Picking up the threads of her life, Angela continued her education and became an accountant. Unfortunately, the past, as she put it, crept up on her and after a disastrous spell in a psychiatric hospital she once again became a homeless heroin-addict. It was barely possible to equate the ultra-fashionable, expensively dressed woman before me with the "bag lady" she had been through her late twenties. It was an attempted rape that "woke her up" a second time. She fought off her attacker and in doing so was reminded of her determination to survive.

This time she went cold turkey' alone, came off the heroin, cleaned herself up and began the long climb back into a more liveable life. Over the next few years, she built a successful career in the burgeoning financial services industry eventually securing a senior position in a small private investment company. With an expensive apartment, successful career and looks that had survived the ravages of homelessness and heroin she seemed to have her life in control until, once again, the past caught her out.

Hearing music from her neighbor's radio Angela found herself at his front door screaming abuse in his face. The next morning, on a crowded underground she punched a commuter for accidentally pushing her. She knew the signs: this was the road back to paranoia, drugs, homelessness, and death. This time rather than try to cope once again with the horrors of post-traumatic stress, Angela decided to go straight to death. She could not face the whole awful process yet another time. It was only the newspaper article that held her back.

All this she explained in the first few minutes of our meeting before expressing a hope that she might just get on with her life without the past dragging her back.

Once we have desired outcome, especially one that can begin immediately, we are likely to dispense with the miracle and begin with the less dramatic, less memorable, "Let's imagine you wake up tomorrow. . .?" However, Angela seemed to be asking for something she was doubtful could happen and like many clients who have suffered childhood abuse she believed only the eradication of the past would give her back a future. In these cases, the deployment of a "small miracle" can sometimes open a very large door: Let's imagine that tonight, while you are asleep, a miracle happens; it's only a small miracle, it doesn't get rid of the past, but what it does is stop the past messing with your future. What's the first thing you'll notice as you wake up that tells you are free to get on with your life without the past dragging you back?

This was the opening into a rich and detailed description of Angela's everyday life as she hoped to live it. Angela made good progress and according to brief therapy principles the time between sessions was stretched to accommodate this movement. The third session had been scheduled with a gap of two months, but after four weeks Angela asked for an emergency session.

She arrived thinking that she might need to be admitted to hospital. While this was not good news, it was a step up from suicide. I asked her what was it about this crisis and the way she was dealing with it that was keeping her on the side of life, no longer thinking of suicide. She said that the advances she had made in the course of our work together had been a huge and pleasant surprise. Stopping her self-harming behaviour (something she had never mentioned until this moment!) and managing to hang on to her job had been big factors, but much more importantly, her friends had noticed big changes. She was more engaged with life, easier to be with, more outgoing and, as her closest friend put it, "softer." Angela had always *appeared* super-confident but for the first time she was beginning to *feel* it. Until the previous day when she had lost her cool once again. Thinking that her boss was being patronising, she had shouted at him in front of the whole office. She was afraid the paranoia was coming back,

but after a little reflection, she decided that he actually was patronizing, and this had been troubling her for some time. On further reflection, she was even pleased that she had called him out, even though she might lose her job. We are always on the look-out for new behavior, even behaviors which at first sight might seem problematic. Any standing up to abuse, real or imagined is worth investigating. I asked Angela what had made the difference, what had decided her to stand up to her boss she said she had no idea but then told the following story.

I went to visit some old friends at the weekend. They live out in the country and had been trying to get me to stay with them for years. For some reason I decided to go, and it turned out to be a lovely experience. The woman was an old school friend and reminded me what a popular girl I had been. We had long walks and long chats and I slept better than I can ever remember. It was just lovely. I was planning to leave on Monday morning, but they begged me to do them a favour by looking after their baby while they did the week's shop. So, there I was with a baby plonked in my arms!

Angela was sitting with her arms held stiffly out, mimicking her discomfort at having a child in them.

I didn't know what to do so I just sat there, then, I saw him looking at me. He just kept looking with his big round eyes and I couldn't help looking back. It seemed to go on for ages, and gradually, I started to realize that this was a little human being, as perfect as anyone could be.

As Angela continued her story her arms lost their rigidity and began to fold around the baby.

I had such a strong feeling, like I've never had before. He was so beautiful, so perfect and I wondered 'How could anyone harm an innocent child like you'. It was such a strange experience I wanted to cry.

It was a moving story and perhaps a turning point since Angela then went on to say that she felt a new confidence in herself and did not think we would need to meet again! Then just before leaving Angela, looking uncomfortable, blurted out, "Before I go there's something I've got to say to you!"

I thought I was going to be told off and began running the past hour through my mind to find the cause! In fact, it was the reverse. She went on, "I know that if I had not come here I would now be dead, but I want you to be clear that you have not touched my life at all!"

Rather than be offended as Angela expected I felt I had been afforded the most wonderful of compliments and responded, "And I have to say that no one has ever paid me such a compliment, and you haven't touched my life either. But I'll always remember you!" "And I'll always remember you!" She said and stepped back into the pages of *Vogue*.

These had been three very straightforward, description-focused sessions. The "small



miracle” opened the door to a detailed description of Angela’s everyday life. As routine and hum-drum as the “behind-the-scenes” of most lives: making coffee, washing up, waiting for trains, sitting at computer screens, chatting to colleagues, meeting a friend and so on. Then a few minutes to begin looking at how much of this small miracle might already be happening. No summary, compliments, or tasks just a disciplined neutrality about whatever she decides to do tomorrow. Subsequent sessions were forensic examinations of progress. “What’s better?” with the emphasis on “How?” and following the ripples and counter-ripples of each achievement.

Angela’s final words were not the only comment on the value of detail. At one point during the last session, she remarked on the fact that she could never remember any of my questions. My half-joking response was that maybe it was because her answers were more interesting, which, of course, they are. A question such as “What might you notice as you are making the coffee?” places the client in a most inconsequential moment. If, as we hope sometimes happens, the client’s answer opens a new door to possibility, it is the door, not the question, that will be remembered. If the answer is as inconsequential as the question, both are likely to be forgotten. In this way, the client’s own words take centre-stage adding to the experience of it being all their own work.

Angela’s experience was not that our conversations had had no impact, she knew that they had saved her life. Nonetheless, like many clients she could not see the direct connection because everything she had done to turn her life around had come from her. The therapist had no part except that of a catalyst, an instigator of change. I might have walked with Angela, ahead, beside or behind, but every step she took was her own and only her own.

### From Goals to Hopes

Several significant steps in the development of BRIEF’s work led towards this “hands-off, footprint-free” approach. One of the early, language-created short-comings of Solution Focused Brief Therapy was its use of the word “goal”. It is a word that carries with it the notion of something specific to be achieved and can easily divert the therapist’s attention towards overly specific outcomes and problem-solving. This has led to a confusion in de Shazer’s writing where sometimes he refers to “well-formed” and “achievable” goals (de Shazer, 1991, p. 112) and describes simple “problem-solving”, or complaint-focused, strategies by which they might be achieved (de Shazer, 1988, p. 93-96; 1991, p. 115-118). However, at other times, especially when describing 10 on a scale he defines the outcome as “the day after the miracle” (de Shazer, 1994, p. 231). This latter definition encompasses not just the specific goal, or problem resolution, but the whole way of life with which it is associated. It was the “way of life” outcome that most attracted the interest of my colleagues, Harvey Ratner and Evan George, and myself to BRIEF. We began to see the “miracle” not as the resolution of the problem, nor the achievement of a specific outcome; but more as the context or “way of living” within which the problem will resolve itself or the specific outcome will appear. This led naturally to an

outcome-led start to the process, and from this, the word “hope” began to appear in our work. Not as a deliberate intervention, but as a sign of trust in our clients that they must be sitting with us for some good reason (Ratner et al., 2011).

A typical example of the process in which we move from a specific “goal” to a contextual or “way of living” outcome would be:

**Therapist** What are your best hopes from our talking?

**Client** I want my daughter to come home on time

This is a specific outcome which could be tackled in many ways within a broad Solution Focused framework. For example, by looking for and amplifying exceptions or by describing a “miracle” in which the daughter does come home and extrapolating from this a plan of action aimed at encouraging “miracle” behavior. This would represent a “goal-directed” or “problem-solving” approach rather than the “way of life” approach the therapist in this case uses. The question most often used to begin the expansion from a specific outcome, being home on time, to a ‘way of life’ outcome, having a good relationship, is a “What difference?” question (Shennan & Iveson, 2008). For example:

**Therapist** What difference would that make?

**Client** I wouldn’t be fighting with her all the time

**Therapist** What would you be doing instead?

**Client** Not screaming at each other!

**Therapist** What difference do you think that would make?

**Client** We just wouldn’t always be arguing.

**Therapist** So what difference would that make, if you weren’t fighting, screaming and arguing?

**Client** Then maybe we could get along like we used to. We were always very close, well, we still are – occasionally!

**Therapist** If somehow, our meeting led you and your daughter to get along more like you used to, and bring more of that closeness, would that mean it had been useful?

**Client** Definitely!

We now have the hoped-for outcome within which the client can find her own way to the initial, more specific goal, and can move on to a description of one way this outcome might

unfold. The client's preferred future.

**Therapist** So let's imagine that you wake up tomorrow and somehow you and your daughter are getting along in just the right way, with more of the closeness you still sometimes have, what might you notice is different as you began waking up into a new day?

**Client** I wouldn't be dreading having to wake her up for school.

**Therapist** What might you be feeling instead?

**Client** Maybe that it would be nice to see her – she always used to be very sweet in the morning.

### A Preferred Future

As the session above continues a very detailed description of the morning unfolds and is followed by some further description of the client's day. Then more description of the mother-daughter relationship after school but stopping short of the potentially troublesome evening. Finally, a few minutes to sketch out a scale: "How much of this miracle is already happening?" There is no attempt to address the specific issue of the coming home time. The assumption, borne out by client follow-up, is that the description will lead to an improved relationship between mother and daughter. They will do what every family must do – come to an agreement about mutual behaviours and boundaries. There was a similar description in the last session with Angela when she expressed worry about losing her job and wondered how she might approach her boss. Instead of focusing on the way she might approach him we focused on the likely consequence of a successful approach. As Angela began to answer, "He'd ring me about –" she suddenly broke off with a gasp "He already has! He rang me while I was on my way here to check if I was still up for a meeting we'd planned for tomorrow!" However, frequently it happens that clients bump into the fact that something they are hoping for has already happened without them noticing!

*Clues* (de Shazer, 1988) became BRIEF's bible when it was first published in 1988 and, like *the Bible*, it is full of contradictions. The "specific" rather than "vague" goals that he argues for (p. 93) are confused with detailed descriptions or "pictures in words" (p. 187) to describe "life without the problem" which might consist of tens, or even hundreds, of differences far too many to be realistically thought of as goals. They can be more aptly described as "ways of living." It was this realisation that led us at BRIEF to talk of the client's "preferred future" (Ratner et al., 2011), rather than the client's goals, and paved the way to move from "What brings you here?" (a request for problem information which is redundant to the therapeutic endeavour) to "What are your best hopes from our work together?" (a question designed to discover the client's hoped-for outcome).

From this perspective, as illustrated in the case examples above, what de Shazer would

have criticized as "vague goals" have become the preferred starting point for our work. Thus, a client who wants to give up drugs might wish to "have a normal life." The therapist could ask "Let's imagine you wake up tomorrow beginning to move towards the normal life that you are seeking." A client who is isolated and depressed might want a future in which he is more self-confident. A suicidal client might want to wake up with the sense of a future, or, as in Angela's case, "free to get on with her life." All vague, even global outcomes, but ones that give the opportunity for the client to describe a way of living which might lead to problems being resolved "organically" without the therapist needing to know what they are.

### Small changes are big changes

De Shazer was quite right when he said, "Goals need to be achievable but perhaps not so right when he said they also need to be hard to attain" (1988, p. 93; 1991, p. 112). The purpose of a very detailed preferred-future description is to make sure every aspect is well within the client's range of possibilities. The more the hoped for future (or the miracle) can be located in the everyday routine of the client's life, the more possible it would seem to be. Asking Angela, "What might you notice as you are making your coffee?" will elicit an answer very close to what has been happening for months, or years, yet, it will also describe part of a more desirable way of living.

Looked at from this perspective, the essentially linear idea that a small change can lead to a big change might be replaced by the idea that each small change is, in fact, part of the big change already happening. In the case of the mother wanting a better relationship with her daughter, the imagined "good morning" is not a small thing that might lead to a larger thing, but a small thing which is a consequence of the large thing (e.g. the miracle) already having happened.

For instance, a young mother struggling with serious and chronic eating difficulties described her experience of a single session and clearly demonstrates that the "small" is also the "large":

I have been through every sort of therapy since I was 14, and though this sounded different, I wasn't really hopeful. When I was asked about a miracle my heart sank because I knew a miracle wasn't going to happen, but when I started answering the questions, I felt a glimmer of real hope because my answers were things I could easily do. So, I set a sort of test. Every time I answered a question, I asked myself "Can you do that?". If the answer was "yes" I'd carry on but once I said 'no' I would know it wasn't going to work for me. Because all my answers were "yes" I knew for the first time that it was possible to overcome anorexia; I'm not sure that I'll manage that, but now I know it's possible I'm going to give it my best shot!

### Therapist Neutrality

This detailing of preferred futures has been described many times elsewhere (Connie, 2013;

Ratner et al., 2011), but what has not been emphasized so much is the value of the therapist's neutrality towards these descriptions. This is not a new idea. The Milan Group (Palazzoli et al., 1982) were heavily criticized for appearing to place neutrality above responsibility. At BRIEF, neutrality refers to a therapeutic stance which is overridden if there is a serious concern for the safety of the client, or others, or if any likely actions of the client are potentially harmful in other ways. When these concerns become paramount, the therapy ceases and the therapist becomes an "agent of society" exercising (depending on their role) their legal, professional or citizen responsibilities. It is never our right to dictate how others should behave. But we do have the right and responsibility to guard the outer boundaries of what is permissible in our society. We may not tell a parent how to raise a child, but we have a duty to do what we can to prevent harm to that child.

Being neutral is not easy. And what we write and what we do, as we at BRIEF are constantly reminded, are not always aligned. Our writing tends to reflect our ambitions more than our practice. And, the same was true of de Shazer who also aspired to a form of neutrality:

Frequently, by the end of a session clients are beginning to know their way about or at least are starting to have some confidence that they can find their way about. Thus, there is no need to overwhelm clients by making lots of suggestions or inventing [tasks]; rather, the therapist simply needs to support clients' going in their own chosen direction with the confidence that once they get where they want to be they will then know their way about (de Shazer, 1994).

But whatever de Shazer's aspirations to neutrality it is lacking in the cases described throughout all his books (de Shazer, 1985, 1988, 1991, & 1994). Time and again, client's descriptions are turned into goals and action plans and hence become, in some way, the property of the therapist. At BRIEF, we have come to see these descriptions as just one set of possibilities which we have no right to expropriate or recommend as future actions. Instead, we see them as creating a realisation that more preferred ways of living are within the client's range even if, by the time tomorrow arrives, these preferred ways of living turn out to be different from those imagined today.

Put very simply, what each of our clients does tomorrow is none of our business. Each client is responsible for the decisions they make. If we believe our own soft-spoken words, that each client is in the best-placed position to make their own decisions, we cannot attribute expertise to the client only on the condition that it fits with our view of the best way forward.

This neutrality is a discipline and one which may not sit comfortably with many Solution Focused practitioners. Nor, given de Shazer's practice as cited above, is it essential. However, it is one which fits well with the underlying philosophy of de Shazer's writings, and clearly demonstrates the therapist's trust in the client as well as guarding us against our 'better knowing'. But as a behavioral discipline it requires hard work and constant attention. There can be nothing robotic or unconcerned about the discipline of neutrality. Instead, it must sit

side by side kindness and wishes for the well-being of others; as well as side by side with our need to be successful as therapists. Ultimately, neutrality is a pragmatic decision. Does it work? Does it fit with brevity? Our experience is that it does.

It is the same with "footprints." Every time we sit down with a client, we must fervently wish that it will be a life-changing event, that the client will begin a new course towards a better future. We back up this wish by using techniques that we hope, a hope based on evidence, will create transformation. We also have to know that whatever the client does tomorrow has a history going back through generations and that tomorrow has always been possible. All we have done is ask the questions that bring that possible tomorrow, and its history, into focus. This raises the question of just how "co-constructed" is the future our clients aspire to and how much of our own lives are similarly "co-constructed" during our conversation with them. Hopefully, we are not too changed by every encounter so, at the end of a busy day, we can return to our families and friends not too different from how we set off in the morning. Whereas, we hope rather the opposite for our clients.

To return to Angela, her words suggest that she experienced whatever happened as entirely her own work. With every idea and action coming only from herself. How could it be otherwise, and what could be better than this realisation? What we hope Angela also experienced, as we do for every client, was a complete trust in her ability to make her own choices without pressure, however subtle, however well-meant, from the therapist to make those choices that best fit the hoped-for outcome.

Solution Focused Brief Therapy, as with every other talking therapy, provides a set of guidelines for managing the therapeutic conversation. To follow these guidelines requires discipline and discipline can only be maintained with constant practice. One of the obvious disciplines of Solution Focused Brief Therapy is to avoid questions which seek an explanation of the problem. Information from these questions does not further the Solution Focused process. This does not mean that the answers to these questions are uninteresting, especially within a culture that privileges explanations, just that they are not useful within the Solution Focused model. Therefore, we must guard against our natural (culturally determined) curiosity and wish to understand.

Devising questions that are content-free is also a discipline which is hard, perhaps impossible, to maintain. We do this by seeking only descriptions of future possibilities. Though we might be less neutral about past achievements, the history of the preferred future, we do our best to follow the client with regard to what constitutes success. Using the client's words, guarding against introducing our own words, interpretations, and ideas, and looking at the world through our client's eyes, rather than our own, are all part of this discipline.

Similarly, the "sister" discipline of neutrality requires constant practice. Our good wishes for our clients provide an all too easy excuse for trying to influence the decisions they make, even just by summarizing what we think are the important parts of what they have said. Such good intentions are one of the most used excuses for the abuse of power. Whether it be by

therapist to client, or state to citizen. If we were to ask our clients, “Would you prefer your therapist to guide you or to trust you?” What might they answer? And how might their answer influence our practice? Let us give the last words to another client who puts it all in a ten-word nutshell!

**Client** (At the end of a single session) It’s the questions, isn’t it? It’s the questions!

**Therapist** Well, maybe it’s not so much the questions as the answers.

**Client** I know, but I would never have had those answers without the questions!  
(Iveson et al., 2014)

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## It Will Never Be the Same Again

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### Abstract

This paper describes the Conversations Led by Clients (CoLeC) model as practiced at several Bulgarian and Russian helping institutions as a development of Solution-Focused Brief Therapy (SFBT). The model emphasizes therapeutic conversations as something that has to follow step by step from the clients’ enquiries. The questions include the mind-activating Question (MAQ): What do you think is the most useful question you can hear from me now? (or at our next session?); the time-oriented question: What do you think is most useful to talk about now: past, present or future?; the multiple-choice question: Which of these questions do you think is best for you right now? (from a list provided by the therapist); and the delayed-answers question: If client has no current answer, ask them to think about the question until the next session and propose self-questioning activities. CoLeC, being a step beyond some therapeutic models, is an initial effort to assist helping professionals find answers to this quite different question, “How should this client’s conversation with me be?” This makes it the beginning of a qualitatively new attitude to what we, as professionals, do. We hope that many, young and new to the profession, will not only join in, but also help further this way of thinking and doing as we see these types of conversations with clients, useful.

**Keywords:** client, conversations, help, questions, usefulness, therapy

### Introduction

This paper is about what we believe could be the future of helping professionals’ conversations with clients – which are conversations organized by professionals and led by clients. It is a step beyond traditional SFBT, and shares its basic belief in clients, their abilities to be their own best helpers, their good will and resources for change. Our approach is a step

beyond SFBT because it emphasizes the client's feelings and personal knowledge pertaining the best time for therapeutic-interventions. The client chooses the appropriate time to discuss any issue, the most useful questions to be asked by the therapist, and the answers they need when creating future change. However, our approach still shares the basic SFBT beliefs about clients' abilities to be their own best helpers through their good will and resources for change.

### Once Upon a Time...

If we take a closer look at therapeutic conversations, we shall notice that therapy can be understood as a specific kind of socially constructed Language game (Wittgenstein, 1953), which is very similar to somatic medicine. Going to a doctor, patients expect many and seemingly different activities from him, all aimed at discovering the nature of their problem, which is intended to create a pathway for effective interventions. Most of these activities, however, are in fact improvisations of the same game: asking questions. The conversation usually includes a discussion about the patient's medical history and reason for visit. This kind of conversation is usual for directive and/or problem-focused health care approaches. Even when we ask clients about their best hopes from therapy in a solution-focused way we start to play our roles as professionals in asking questions, thus reflecting the traditional Language game of asking.

If we look at the ancient roots of this approach, we find Socratic debate as a method for finding the hidden knowledge leading the opponent to an insight when he finally contradicts himself, through a series of questions. Started as a medical activity by a neurologist, Sigmund Freud, psychotherapy has been traditionally perceived and practiced in the cause-and-effect medical frame of thinking. Since rational and cognitive therapies started to develop, the problem in therapy was often seen as a clients' enmeshment in illogical beliefs. So the therapist takes a stance of a curious questioner and leads the client out. Though this Socratic method model is widely known and accepted in many modern therapy approaches, it sometimes leads to possible ignorance of clients' intentions, nuances, causing resistance and "non-participative" style of therapy where clients feel themselves as not understood.

Even within this framework, however, Dr. Albert Schweitzer noted (in Norman Cousins' *Anatomy of an Illness as Perceived by the Patient*, 2005, p. 78), "Each patient carries his own doctor inside him. They come to us not knowing that truth. We are at our best when we give the doctor who resides within each patient a chance to go to work."

### Now...

The therapeutic tradition is maintained today by many professionals who believe that 'therapy' should be the therapist's job just like a violinist's job is to play the violin. In SFBT, for example, there is a metaphor that compares a therapist to a taxi-driver. This is because a taxi-driver asks his passenger "Where to?" when inquiring about the final destination (Bannink & McCarthy, 2014), implicitly admitting that the person behind the wheel is the real worker, the

professional.

Sometimes we just forget the fact that a majority of therapy is initiated by clients (or others important persons in their lives – relatives, neighbors etc.), and less often by caring professionals. We should clearly realize that every professional encounter is a result of a series of steps previously taken by clients: they have asked themselves "Do I need to talk to someone about my situation?", then obviously replied "Yes" to it; then they asked themselves "Who should I talk to?", and in response to this have made a preliminary study, asking other people, preferably ex-clients in their families, among friends, at their workplace, at the hairdresser's, on the Internet, in diverse media... in this way they find the professional they would like to discuss their situation with. And then they ask the next question (appearing to the professional as if being the first one), quite often containing its answer: "Can I come to see you on Wednesday at 10:30, as this is the most convenient time for me? A wish to speak within a session is a client's personal initiative.

### Some Tools in Brief

In CoLeC, the professional is engaged in what we call now the Questioning for Most Useful Questions (QUQu). It is a set of techniques that try to keep, maintain, and support the clients' lead by helping them develop their own abilities in the art of asking useful questions. This has not been overlooked by solution-focused therapists, so we are supposed to make some additional accent to these points.

We also suggest the use of clients' self-questioning. We often invite the client to think specially about those questions that involve most clients' interest, and about possible answers. We can use these self-questioning techniques in different ways, in direct or paradoxical manner (changing and reformulating them in a creative way). The process of asking oneself brand new and unexpected questions and trying to find answers is a process that develops dialectically balanced views (Mikhalsky, 2014).

Table 1. *CoLeC Questioning Techniques*

<b>Eliciting clients' own questions</b>	What questions did you want to ask me in this session? Answering what questions would be most useful for you today? What questions did you ask to yourself often but not finding the answers?
<b>Mind-activating question</b>	What do you think is the most useful question you can hear from me now (or at our next session)?
<b>Time-oriented question</b>	What do you think is most useful for you to talk about: your past, present or future?
<b>Multiple-choice question</b>	Which of one of these questions, if any, do you think is best for you to discuss right now? (From a list provided by ConCon)
<b>Best therapist question</b>	When the dialogue gets stuck, it could be very useful to ask in this way: 'What question would the best therapist ask now?'
<b>Delayed-questions question</b>	If the client doesn't have questions or hesitates which will be useful, we can ask him to think about the Most Useful Question for the next session.
<b>Delayed-answers question</b>	If clients have no current answer, ask them to think about the question until the next session, or until they find a high quality and useful answer. As Dr. Alasdair Macdonald (2019) states: "The Delayed Answers question above draws on the original MRI model which often mentioned 'going slow'. A useful variation mentioned by Steve de Shazer was 'Think about possibilities but don't do anything until we next meet.' Telling clients to do nothing often leads to some action.
<b>If clients ask 'Why does this happen?'</b>	Then ask them 'What do you think is the simplest possible and most useful explanation of this situation?'
<b>If they have no answer</b>	Suggest they choose from this list: it happens first and then becomes a habit; because you love each other (in cases of conflict); because you are a living person; it is your energy; because you say so.

**Discussion**

Encouraging clients to ask questions and to develop new ones considerably changes both the usual narrative form these situations are described, as well as clients' perceptions of them. The ongoing tough life situation becomes *under question*, in other words, manageable, and clients become much more creative trying to state whatever they want to say in a question form. As Steve de Shazer (1994, personal communication) said, "If a client has already stated her situation for seventeen times in the same way, try not to be the eighteenth person hearing the same story, but do everything possible to be the first one who hears at least a little bit different story!" Stating one's situation (no matter if past, present, or desired) as a narrative is dramatically different from questioning it. This move from narration to dialogic co-construction *based on self-questioning* changes its framing and its perception by clients and professionals.

Conversation Led by Clients (CoLeC) tries to challenge expert-centered, medical and Socratic habits of structuring human conversations, thus tending to be perceived as strange and unusual within the existing 'normal' psychotherapy setting. These changes, however, require non-automatic use of their language from clients, helping them to develop their own new style of communication and thinking. As a client recently noted at the end of her single-session consultation, "I never expected that we shall talk in my algorithms and not in yours."

Practicing the Questioning for Useful Questions (QUQu) also touches upon George Herbert Mead's (1913) concept of the internalized conversation. G. H. Mead argues that we regularly engage in unspoken internalized conversations as we reflect upon practical issues in our everyday lives. The questioning practices described here, promises to expand clients' skills and options in conducting their internal conversations, far beyond their encounters with a therapist or a counselor.

**What do we need second-order changes for?**

Each and every client's question has at least *three advantages* over any therapist's question:

1. It is stated in the client's own language, so it is understandable to her. Any client can misunderstand every therapist's question, while we all (clients included) seem to understand our own utterances.

Miller (June 7, 2016) in personal communication, however, proposes another important aspect of focusing on clients' own questions:

I would say that clients' own language appears to be understandable to them (this is a good reason for asking them to form their own questions) but that upon further reflection clients might discover that they misunderstood what they were asking. I think the key word here is *discovery*. When the client asks a seemingly understandable question that turns out to have really been a misunderstanding on the client's own part, it is a discovery and potential

source of insights into one's self that immediately expands clients' sense of personal agency, knowledge, skills, and perhaps strengths (Miller, personal communication, June 7, 2016).

2. It is always on time! A therapist's question may happen to be on time, and may happen to be out of time (since therapists cannot know what time it is now for the client), while a client's own question is obviously fitting her timeline.

3. The more clients practice asking useful questions, the better they become in this. The ability to do it effectively helps clients not only find solutions to their present problems, but also to deal effectively with tough situations in their future. As Einstein is supposed to have said (as cited in Quote Investigator, 2014):

If I had an hour to solve a problem and my life depended on the solution, I would spend the first 55 minutes determining the proper question to ask, for once I know the proper question, I could solve the problem in less than five minutes (Quote Investigator, 2014).

To summarize, the benefits are: empowering of clients, appropriate timing of therapeutic interventions, solving the problem with misunderstanding, helping clients not only find solutions to their current dilemmas, but also preparing them for handling future difficulties. Since effective help is based on the asking of useful questions, the more capable clients become in this, the less help they will need in the future.

### Conclusion

Therapeutic conversations cannot evade the times of radical shifts in meaning. CoLeC is just one of the many possible and coming changes in therapeutic conversations. These changes do not come too fast. People often have their own pace for making changes. They can usually tell you what pace they prefer, which can inform expectations about progress in your work together.

The above-described sequence of clients' activities clearly defines them as the initiators, owners, and main change-agents in therapeutic conversations to follow. In the Conversations Led by Clients (CoLeC) approach, we use the metaphor of the professional who acts as the Conversations Conductor (ConCon). He is not supposed to sound, but to organize the best possible sounding of the conducted musicians. The professional tries not only to keep the clients' ownership and leadership, but also helps the client develop her language skills. The ConCon therapist does not focus on algorithms, and instead of asking himself "How should *my* conversations with clients look like?" tries to ask "How should *this client's* conversation with me look like?", "How can I *help* the client to formulate *his* questions and answers?"

If we define our approach to helping activity as a kind of assisted self-help therapy, the professional's role drifts towards following, encouraging, and assisting the already started process of clients asking themselves useful questions, finding answers to these, and helping to develop on this basis their next steps. The steps can lead towards their desired situations

(Switek, 2014) or thoughts and emotions, or states of mind and body, whatever. In our opinion, the final goal of this assisted self-help Conversations Led by Clients (CoLeC) is not only in helping clients in co-constructing solutions to their current hardships, but also in preparing and equipping them with specific language tools they can use in the future for managing other tough situations. Practicing the art of asking useful questions within their sessions with us, clients learn how to handle other difficulties they will further encounter. That sounds similar to the original intention of Solution Focused Brief Therapy to focus on clients as able to create their own solutions and to live the lives they truly want to live (de Shazer, 1994).

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## Solution Focused Work as an Aesthetic

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The Centre for Solutions Focus at Work

### Abstract

The current paper looks at Solution Focused (SF) work in a novel way – as an aesthetic (what makes it beautiful?) as opposed to a method (how do you do it?). This term comes from the art world, where different schools of painting can be described as having different aesthetics. Starting with a definition of the term, I propose five elements of an SF aesthetic: brevity, client autonomy, radical acceptance, staying at the surface and valuing small differences. While these are not present in every piece of SF work, they are things that we strive for, qualities that bring me (at least) satisfaction, cheer and reasons to continue to support, promote and develop SF.

*Keywords:* Solution-Focused, beauty, aesthetic, satisfaction, qualities

### Introduction

This paper brings a different way to look at Solution Focus (SF) – what do we as SF practitioners think is “beautiful” in our work? This look might be extended to other forms in the brief therapy tradition, but I want to focus on SF in particular here. This examination might go some way to shedding light on the long-term resistance and ignorance of SF from those in other schools. If we are working to a different aesthetic, then they won't be valuing the same things and will be confused, angry and baffled by what we do (and possibly vice versa, of course).

I was immediately and passionately engaged with SF work when I first discovered it in 1993, for reasons that were not completely clear to me at the time. Over the past three decades or so, I have continued in this commitment, and have come to realise that these aesthetic aspects are very important to me. I am now wondering if these (not often discussed and often assumed) aspects are shared, and to what extent. This paper seeks to present these aspects explicitly. It is an overview of why I personally love SF practice. What about you?

### What is an ‘aesthetic’?



Looking at the dictionary (Aesthetic, n.d.), we find definitions of ‘aesthetic’ in the following terms:

**Adjective:** *Concerned with beauty or the appreciation of beauty.*

**Example usage:** *‘the pictures give great aesthetic pleasure’*

**Noun:** *A set of principles underlying the work of a particular artist or artistic movement.*

**Example usage:** *‘the Cubist aesthetic’*

The term originates from the Greek word *aisthētikos*, meaning “perception connected with the senses”. Although sensory perception is clearly important, the idea of aesthetics means more than this. David Hume, 18<sup>th</sup> century philosopher and a good cook as well, wrote that delicacy of taste is not merely “the ability to detect all the ingredients in a composition”, but also our sensitivity “to pains as well as pleasures, which escape the rest of mankind.” (Hume, 1987, p. 5). This is about considered affective and emotional responses as well as sensory distinctions.

One way into this topic is to look at the world of art and in particular painting. For centuries, artists strove to produce renditions of (say) landscapes which were detailed, clear and representational. Look at Canaletto’s famous paintings of Venice for a fine example, or the British artist Thomas Gainsborough. In these cases, the artists made extensive preparatory sketches and then worked up a final highly detailed artwork in their studios, constructing the composition to be pleasing (aesthetically) rather than a snapshot of a particular moment. Even today, the results are sensational.

In the second half of the 19<sup>th</sup> century however, painters started to explore with greater vigour what happened when they ventured outside the studio and worked “en plein air”, in the open air at the location. Painters such as John Constable and JMW Turner had begun to explore this in the early 19<sup>th</sup> century, but it was taken to new extremes by painters such as Claude Monet, Pierre-August Renoir, Alfred Sisley and others in the early 1860s. Their work focused on light and the immediacy of the moment, and was being routinely rejected from the Salon de Paris, the accepted leading curated art show which favoured painters of the classical style. Emperor Napoleon III saw the rejected works and decreed that the public should be allowed to judge for themselves. As a result, a “Salon de Refusés”, an exhibition of the refused, was organised. While many came to laugh, this exhibition was a key rallying point for those keen on the new “impressionist” aesthetic which took its name from Monet’s *Impression, Sunrise*. As has often been the case through history, the name came as an insult from critic Louis Leroy who in his article *The Exhibition Of The Impressionists* referred to Monet’s work as at best a sketch, nothing like a finished work. (For more details on the development of impressionism the reader is referred to the Metropolitan Museum, New York’s excellent website; Samu, 2004).

The impressionist aesthetic is much more about capturing an “impression” of a moment in

time; the brushwork is bigger and bolder, the effect more spontaneous. If we look at an impressionist painting with a classical aesthetic, we see what Leroy and others saw – unfinished, incomplete daubs of little lasting consequence. If we look at Caravaggio and Gainsborough with an impressionist aesthetic, we see stylised, overworked “perfection” which says little about the artist’s (or the viewer’s) response. (It is interesting that impressionism emerged around the same time as photography, and can be seen as a conscious alternative to it).

Both of these aesthetics are, of course, interesting and valuable. What I am seeking to point to here is the way that an alternative paradigm, a new way of looking at things, can be seen through the aesthetic lens; what makes something beautiful? What is valued, prized, admired, noticed, applauded? It’s something to do with what makes you go “Yes!!” and what makes you go “Blurghhh!” In this article I will seek to explore what makes me cry “Yes!” in SF work, and thereby shed a little more light on what it means to work in an SF aesthetic.

What follows is my list of the things that I love and value about SF practice. The list is not complete, of course, and it’s a personal one. I hope that many SF practitioners may find a recognition and a resonance in at least some of these items.

### Brevity

SF was originally called Solution-Focused Brief Therapy (SFBT) for a reason – it’s brief! The original version of interactional brief therapy emerged from the Brief Therapy Centre of the Mental Research Institute, Palo Alto, led by John Weakland, Paul Watzlawick and Dick Fisch. This version of practice, called MRI model or Problem Solving Brief Therapy, is still around, and uses a 10 session framework as its basis (Segal, 1991). At the time (in the 1970s) this was startlingly brief, compared to the years of weekly treatment considered normal by practitioners working in the psychodynamic tradition.

When Steve de Shazer and Insoo Kim Berg moved from hanging around MRI to setting up their own centre in Milwaukee in the late 1970s and early 1980s, they wanted to build on this work and developed the idea that brief therapy should be ‘as brief as possible, and not one session more’ (de Shazer, in his Foreword to Dolan, 1991). This is quite a step onwards from even a 10 session basis – every session could be the last, and is carried out with this possibility in mind. The choice of continuing is at least partly with the client; we will return to this aspect of power sharing later.

The very idea that therapy can be effective at all in one or two sessions is still considered outlandish by some. Indeed, workers in the psychoanalytic tradition have developed the concept of the “flight into health,” where the client’s claims that they are suddenly and completely cured is seen as a defensive reaction to the treatment, and therefore a sign of the need for even more therapy. This can be seen as a kind of Catch-22 bind; if the client says they are better, they need more treatment. And if they say they aren’t better, then of course they need more treatment!

Why is brevity an important end in itself? Of course, effectiveness – the results of the treatment – is important. There are influential findings (Wampold, 2001) saying that all forms of therapy, at least those based on the five “common factors”, are as effective as each other. Wampold doesn’t look at efficiency, the amount of time it takes to reach an effective outcome, nor does he take account the disturbance to the client of participating in the treatment. If all therapies are equally effective, then surely it’s better to choose one that takes less time? It helps the client get on with their life sooner, and it frees up the practitioner to help new clients.

The advantages of this are particularly clear when resources are limited, as in the UK National Health Service (NHS). The efficiency of a service is directly proportional to both the number of practitioners and their average length of treatment, assuming that each practitioner has the same number of sessions every week. According to the 2013 report *We Still Need To Talk* (MIND, 2013), over one in ten people had been waiting over a year to see a therapist, and approximately 50% had waited more than three months. Brevity, via effective treatments, is clearly valuable to a statutory service. It remains something of a mystery why the popular view of longer equals better still seems to hold so much sway.

Another benefit of brevity is that a short treatment will mean that the client is back living their own life sooner. There is a clear distinction between those practitioners who see the act of seeing a client as valuable in itself, and those who seek to get out of the client’s life as soon as they can. The goal of SF is, as Steve de Shazer (quoted by his long-term collaborators at BRIEF, 2019), used to say, echoing an old aphorism sometimes attributed to Edna St. Vincent Millay, to return the client to a life of “one damn thing after another”. This is everyday life as we know it – not a flawless and effortless glide but a series of ups and downs, handled by the client without professional help. In contrast, those who seek treatment usually do so because their lives have become “the same damn thing over and over” – something keeps happening that they don’t want, or doesn’t happen when they seek it. The former case isn’t seen in the SF aesthetic as grounds for treatment: the latter is. The same holds true for MRI Problem Solving Brief Therapy - when the same damn thing isn’t happening any more, that’s enough for now.

Brevity is not a simple matter of a small number of sessions or a limited time. It’s about the work being as brief as possible - subject to a satisfactory conclusion, or onward referral. This is not to say that every person only has one problem in their lives. As an SF coach to business leaders, I sometimes get contracted for a series of sessions (ten, for example). However, I don’t consider this to be outside the brief aesthetic, as we are not using the ten sessions to tackle a single issue. Each conversation is usually about a new issue, something that’s fresh on the client’s mind, or perhaps reflects a developing situation that we’ve discussed before. And the client can decide that they’ve had enough of a topic, or indeed of me – which leads us onto the next aspect of an SF aesthetic, the valuing of client autonomy.

### Client autonomy

In the normal everyday world, people get to make decisions about their own lives; what to

do, who to be with, where to go. These decisions are never the only factor in determining what happens. There are always other context and forces at work. One of my favourite quotes is from biologist Steven Rose (1997) who, paraphrasing Karl Marx, observed that “we create our own futures, but not in circumstances of our own choosing” (Rose, 1997, p. 309) It is worth considering, then, that in therapeutic work it has been normal for practitioners to take decisions for, and sometimes in opposition to, their clients.

This comes from an old version of the basic doctor/patient relationship, where in decades gone by the doctor’s word was law, with the patient’s role being to play a grateful and willing recipient of the doctor’s expertise. Of course, if about to undergo brain surgery, then we would want someone with expertise in charge of it, and we would listen seriously to their advice. The risk is that this relationship can become unbalanced, one-sided and potentially abusive. If the doctor becomes an unchallengeable authority figure, and perhaps even one who is getting paid by making the relationship continue, then the risks of over-long treatments and disempowered clients are clear.

The SF position has been that, broadly, it is the client who makes many of the decisions. What are their hopes from therapy? What are they going to do about it? When are things good enough to stop coming? In everyday life these questions are clearly for us as individuals. In the therapy world, however, it can be seen as a paradigm-busting revolution. While the conventional doctor/patient relationship can be characterised as parent/child (in the Transactional Analysis tradition, see for example Berne, 1958), the SF worker/client relationship is much more adult/adult. Both have responsibilities, both have parts to play, both have priorities, and these are to be kept as balanced as feasible. In the 1990s, I attended a workshop with Bill O’Hanlon in which he urged us to find the healthy adult within - in a pointed repost to the fashionable and non-SF urge to see our clients as wounded children or whatever.

Of course, client autonomy is not automatic and over-riding in all circumstances. If the client seems to be putting themselves, or others, at risk then clearly the practitioner has some choices to make. Should they inform others? Should they instigate safeguarding processes? These are matters of professional judgement for the practitioner and are not to be underestimated. There are other situations where outside constraints – for example court orders, probation agreements or other matters of law, impinge on the client’s freedom of action. These can be taken into account in various ways with the client’s autonomy bounded rather than removed. In all these situations, the limits on client autonomy are seen as topics for discussion and ideally agreement with the client in terms of the next steps to be taken.

There is an interface here with brevity as discussed above. The client’s autonomy includes their choice to decide when the treatment is over, or that they wish to see someone else. SF has found a healthy home in the world of coaching over the past couple of decades. One reason for this may be that SF therapy looks more like coaching than many other forms of practice, and so the fit is clear and natural from the start. Coaching clients are not usually seen as

vulnerable people needing protection – rather, they are informed individuals who are making their own decisions about seeking support. The International Coach Federation (2019) defines coaching as “partnering with clients in a thought-provoking and creative process that inspires them to maximize their personal and professional potential”. The focus on partnering with clients seems to me to be a clear fit with the aesthetics of SF.

### Radical acceptance

If we are viewing the client as making their own decisions, then we should also think very carefully about trying to argue with them. This skill of not arguing is sometimes called “radical acceptance” (de Shazer, 1997). He argued in the same article that:

The client's answer needs to be accepted fully and literally” which is an art rather than a science and “difficult for many people. It requires a lot of self-discipline and a good deal of close listening. It is not easy to give up making judgments about how high the [scaling] number should be or how unreasonable and unrealistic the initial response to the miracle might be (de Shazer, 1997, p. 378).

A key word here is the “initial” response to a question. One of the concerns I come across from people learning SF is that their clients may seek something impossible from the miracle; the amputee seeking the return of their lost limb, or the bereaved child wanting their parent to come back. And yes, it can be unsettling in some way when this happens. It is also a very obvious and heartfelt wish, and can therefore be accepted quite easily. Who wouldn't want these things? The key point is that accepting doesn't mean blindly agreeing and moving on. It can look like nodding gently, exhaling and waiting; waiting is often a good strategy, to allow the client to continue their thinking. It can look like quietly saying “Yes, of course...” and pausing to see what comes next. What comes next - sometimes after a very considerable silence - might be something like “I'd be visiting my friends more” or “I'd be happier going to school”. These are more tractable and can be picked up and expanded in the conversation.

It turns out that in any actual client response to a question there will be multiple elements, and it is impossible to respond to all these elements equally or indeed at all. In a particular favourite example of this, Swedish psychiatrist and veteran SF practitioner Harry Korman (personal communication, 2009) mentioned (in a workshop some years ago) the woman who told him, “I want to be a better mother, but I'm such a worthless, worthless person.”

There are clearly two parts to this statement. A problem focused practitioner might want to ask about being worthless. An SF practitioner will clearly see the first part, about being a better mother, as more obviously connected to what she wants. Harry Korman (2009), being the highly experienced SF practitioner that he is, found a way to accept both and yet promote the solution-focused element:

So you think you're a worthless person... but you want to be a better mother? (rising inflection at the end, making it a question and an invitation to carry on with this thread).

Radical acceptance comes down to not arguing with the client, even when to do so would be quite normal and acceptable. In his book *Preventing Suicide: The Solution-Focused Approach* (Henden, 2008), John Henden covers ten ways to accept an apparent wish for suicide, up to and including:

If you decided to go ahead with the last resort option: (a) What method would you use? (i.e. pills, rope, razor blades, vacuum cleaner tube, firearms, etc.) (b) How prepared are you should you decide? (Henden, p. 129).

In the context of an ordinary conversation, this sounds appalling – we might be seen to be urging the person on. But an SF conversation is not an ordinary one. There has been conversation before this, beginning to explore the client's situation and build trust and connection within the first 10 minutes of the session. And indeed, Henden himself says that if he uses this question it is to get a better idea of how serious the person is – many people will back off at great speed when asked this question. With those who don't, the practitioner can at least be more aware of what is happening, while continuing to take the client seriously and radically accept what they say.

De Shazer shared this outlook with his long-term mentor and friend John Weakland. In a joint interview from 1994 (Hoyt, 2001) de Shazer speaks about taking the client seriously, whatever they say about their situation.

A client tells you they've got a problem, then they've got a problem and you'd better take it seriously. You'd also better take it seriously if they tell you they ain't got a problem... someone sent him because he drinks too much. He says he doesn't drink too much and it's not a problem. Leave it alone. Take it seriously (p. 21).

Of course, there are other ways to take this kind of conversation forward without arguing with the client, such as asking about how come the referrer sent them along. And as the conversation develops, the client's view of what they want may well develop and change. But if we don't take them seriously to start with, an argument immediately ensues, enabling the practitioner to label the client as “resistant” or “in denial” which contributes little to progress and much to continuing stuckness. “Reading between the lines” is a distraction; listening very carefully to the lines and formulating appropriate responses is the name of the game. Radically accepting, not arguing with our clients and not reading between the lines leads to another key element of the SF aesthetic; staying at the surface.

### Staying At The Surface

In more traditional methods of therapy, counselling and allied practices, it is quite normal to see the client's behaviour as the outward manifestation of some kind of hidden internal causal mechanism. There are various forms of these hidden mechanisms, ranging from emotional to neuroscientific to ancient experience. The therapist's task is to go deep to discover

these causes and assist the client to deal with them. Indeed, the practitioner may claim to be the first to notice these causes and their importance, which the client must then address in order to satisfy their practitioner.

In SF work, as I have written before (McKergow & Korman, 2009), we step around these potential questions by looking at the “in-between” – the interaction of the client with their environments, including other people. Sometimes newcomers don’t notice initially that SF questions are always framed with a person (often the client, but sometimes others in the client’s world) and their interactions, rather than any “internal” drivers. “What would be the first tiny signs you noticed that things were getting slightly better?” is a typical example. It is addressed to a person, about their interactions. It is not inviting them to introspect, to speculate over their feelings or other causal matters. Rather, we seek to focus our clients’ attention towards the outside, towards the world and towards what’s better in the past, present and future (Jackson & McKergow, 2002; 2007).

This focus can be traced back to the Interactional view of the Mental Research Institute, Palo Alto (Watzlawick & Weakland, 1977) where Steve de Shazer and Insoo Kim Berg met and were first enthused about the brief therapy tradition. The MRI method of problem solving brief therapy seeks to get out of the mental box by looking for specific, concrete, descriptive information - who does what to whom and when? Their purpose in asking these questions was to seek patterns of behaviour that were holding the problem in place and then get the client to break or disrupt them. In SF, which followed on in the same tradition, the same questioning techniques were used to look for specific exceptions to the problem, so that these patterns could be amplified, and later to describe days after the miracle when the problem had mysteriously vanished overnight. These descriptions have become even more important as SF work has developed in recent years (Iveson & McKergow, 2016).

Both the MRI team and later SF workers were striving to take mental health out of the clients’ heads and into their interactions with others. There has long been a conceptual muddle generated by those who want mental illness to ape physical illness. In the latter, something is amiss within the patient’s body, which must be diagnosed and cured. It’s an easy assumption to think of mental illness in the same way – something, perhaps depression or schizophrenia, is lurking within the client’s body or brain, and therefore diagnosis accompanied by either internal reflection or drugs are required to cure it. I am not anti-drugs by any means, but I am not in favour of putting people on drugs when they can be helped by a few sessions of conversation.

Note that staying at the surface, like radical acceptance, does not mean that one client utterance is the end of the story. Different things will emerge as the therapeutic conversation goes on, and indeed the task of the SF practitioner is to frame questions to help this process. However, I don’t think this is about matters coming to the surface, as if they were there all the time, lurking in the depths and waiting the right moment to pop up. Rather, meaning and awareness shift during the conversation, new and overlooked things become more or less

relevant, and fresh ideas emerge from the interaction.

It’s interesting to notice how client autonomy and radical acceptance sit happily alongside staying at the surface. These are all important parts which add up to a dramatic new take on what it means to be human.

### Value of small differences

This final, for now, part of the SF aesthetic is slightly different to the others – the value we place on small differences, detailed descriptions and tiny as opposed to huge signs. It is normal and logical to assume that large changes to the client’s life and circumstances will require big plans, big efforts, total commitment, and utter transformation. One part of this is why it is assumed that long treatments must always be superior to short ones, despite evidence to the contrary. Small signs of progress are seen as very valuable, the potential forerunners of more change, and signs that the client is on the way to a good enough life, where they feel able to tackle things under their own steam.

From my very first SF training workshop (with Jane Lethem of the then Brief Therapy Practice in 1994), the idea has been present that small changes in one area of the client’s life can expand both through natural processes, but also as a ripple effect into other areas of life. The client notices changes and becomes more aware of how they are contributing to these changes, which then spread into other domains. It’s not hard to see how - slightly better relations at home can spill over into more confidence at work, more openness to relations with children and parents, less stress, more time to enjoy life and so on.

This kind of connectedness fits well with both Buddhist philosophy, in which Steve de Shazer was interested (see for example de Shazer 1994, p. 9), and also with the science of complexity (see for example Waldrop, 1993), which emerged in the early 1990s. (I discovered both SF and complexity at the same time, and made some initial connections of my own.) Complexity shows how novel and unpredictable outcomes can emerge from small differences in unplanned and unexpected ways. The 1980s Chaos Theory offers a more sophisticated version of the butterfly effect - how the tiniest change to a weather system, such as the flapping of a butterfly’s wings in Brazil can lead to a tornado in Kansas or a storm in the Philippines. It doesn’t *always* lead to these outcomes – but small changes with amplification can lead to more impact than large plans, which stall and lead nowhere.

SF questioning has led more and more to discussions of small, indeed tiny, details and differences which are part of better for the client. Follow-up questions like “what’s the first sign someone else would notice?”, and “what else?” help us to build more and more detail. Similarly, in follow-up sessions we ask about “what’s better?” and invite our clients to expand on whatever has emerged – whatever that might be. Of course, many of them start by saying “nothing is better...” which can be radically accepted and built on by a skilful practitioner.

Sometimes when I have worked with people from other traditions, I have noticed that while

they may be happy to discuss better in big picture, abstract noun, \$5,000 words terms, they can become very nervous when I start asking about tiny details. One very experienced facilitator complained that they thought I was forcing people into action by doing this. Well, as long as that's what they are paying me for, I make no apology! It is certainly interesting and under-discussed how talk about tiny details seems to lead smoothly and quickly to new possibilities for action. My book chapter from the SF World Conference (McKergow, 2019) will start to address this question.

**Conclusion**

If we look at these five aspects of an SF aesthetic, we can see a very telling contrast from the classical psychotherapeutic norm.

Table 1. Comparing the classical therapeutic and SF aesthetics.

Classical aesthetic	SF aesthetic
Long treatments are necessary	Brevity – as brief as possible – is desirable
Power is with the practitioner	Client autonomy is to be respected wherever possible
Read between the lines	Radical acceptance
Go deep	Stay at the surface
Valuing large and dramatic transformations	Valuing small differences

Note that none of these are about miracle questions, contracts, scaling, compliments and so on as such. These techniques seem to me to be more like corollaries of the aesthetic, natural ways of working which follow from these basics.

There may well be a clue here about how come SF gets such short shrift from those accustomed to a more classical/traditional way of working. In the same way that Monet and Matisse were laughed at by the Parisian art audience, so SF is seen as a bit of a joke by those used to valuing length and depth. It may well be this total shift to a new paradigm that got me

interested back in 1993 and has kept me at it for all the years since. For a new way of things to be more elegant is precious enough. For the new way to be more efficient as well is truly extraordinary. If SF delivers brief, respectful, humane treatment and progress at work, at school, in the hospital and the therapy room, then that's worth nearly 30 years of my life.

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## Solution Focused Therapy for Trauma Survivors: A Review of the Outcome Literature

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### Abstract

Directly confronting and processing past trauma can be distressing for clients and may contribute to the high dropout rates among leading trauma treatments. Solution-focused therapy (SFT) primarily focuses on the present and future and has been proposed as a strengths-based alternative for treating trauma survivors. This review systematically evaluated the existing outcome literature for the effectiveness of SFT for trauma survivors. Multiple databases were searched using search terms to identify results for solution-focused therapy as a treatment for trauma survivors. Eligible studies included experimental, quasi-experimental, or pre-post designs that reported outcome measures following SFT-based treatment. A total of five studies met inclusion criteria and were evaluated and summarized. Four out of the five studies included data on within-subjects changes in the SFT treatment group, reporting statistically significant improvements on trauma symptoms, recovery, self-esteem, and parenting, with moderate to large effect sizes. Three studies compared SFT with treatment-as-usual (TAU) or no treatment and found mixed results. Compared to control groups, SFT showed statistically significant improvements with large effect sizes on post-traumatic growth and sleep issues, but effect sizes for trauma symptoms were small and not statistically significant or varied greatly between different reporters. The existing literature provides initial evidence of overall improvement for trauma survivors who received SFT, but the effectiveness of SFT at addressing trauma symptoms requires further investigation. More high quality, controlled studies are needed to evaluate SFT as a trauma treatment.

### Solution Focused Therapy for Trauma Survivors: A Review of the Outcome Literature

Trauma is a significant public health issue with wide-ranging consequences for individuals and communities (Magruder, McLaughlin, & Elmore Borbon, 2017). Up to 70% of people

experience some form of trauma in their lifetime, with an average of up to three traumas per person (Kessler et al., 2017). The risk of trauma exposure varies widely across different countries due to variations in experiences related to war, crime, and disasters (Burri & Maercker, 2014), but many traumatic experiences are more common to everyday life—such as interpersonal violence, sexual assault, and sudden loss of loved ones (Kessler et al., 2017). Traumatic experiences that cause symptoms such as hyperarousal, flashbacks, and intense psychological distress may lead to a diagnosis of post-traumatic stress disorder (PTSD) (American Psychiatric Association [APA], 2013), but only if the traumatic event meets narrow and controversial criteria related to threat of death, severe injury, or sexual violence (Pai, Suris, & North, 2017). Qualitative research drawing on the lived experiences of participants indicates that PTSD criteria encompass only a small portion of problematic symptoms secondary to trauma, and instead suggests a complex relationship among relational distress, individual distress, and resilience (Coulter & Mooney, 2018). In response to the limitations of the PTSD diagnosis, there has been increased attention in the research literature to complex trauma and developmental trauma, which include repeated traumatic exposures and trauma beginning in early developmental stages (Denton, Frogley, Jackson, John, & Querstret, 2017; Wamser-Nanney & Vandenberg, 2013).

### Effects of Trauma

Traumatic experiences are associated with a variety of co-occurring disorders and disproportionately affect vulnerable populations (Mørkved et al., 2018; Slack, Font, & Jones, 2017). The effects of childhood trauma continue to reverberate through later life. Adverse childhood experiences (ACE) are associated with problematic changes in brain structure, mental and physical health problems in adulthood, and even early death (Brown et al., 2009; Herzog & Schmahl, 2018). The experience of childhood trauma is also associated with mental illness and substance use disorders, and increased exposure to repeated childhood trauma is related to increased rates of psychosis (Mørkved et al., 2018). There is also a relationship between child abuse and more severe psychosis; trauma from psychological abuse is associated with increased hospital admissions, and sexual abuse doubles the likelihood of attempting suicide (Álvarez et al., 2011). Trauma and PTSD are both found at high rates among youth in foster care, with males more likely to experience interpersonal violence and females more likely to experience sexualized violence (Salazar, Keller, Gowen, & Courtney, 2013).

### Trauma Treatment

Considering the high prevalence and lasting impacts of trauma, effective interventions are needed to address symptoms and promote healing following the experience of trauma. There has been significant focus on evaluating effective treatments for PTSD among adults, children, and people with serious mental illnesses (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Gillies, Taylor, Gray, O'Brien, & D'Abrew, 2012; Sin, Spain, Furuta, Murrells, & Norman, 2017).

In general, research supports the effectiveness of psychotherapy for improving symptoms related to trauma among adults and children (Bisson et al.; Gillies et al., 2012). However, the evidence is weaker for the treatment of PTSD symptoms in persons who also have diagnoses of serious mental illnesses (Sin et al., 2017). The most tested interventions for PTSD symptoms are trauma-focused cognitive behavioural therapy (TF-CBT), exposure therapy, eye movement desensitization and reprocessing (EMDR), and non-trauma focused cognitive behavioural therapy (CBT; Bisson et al.). While the overall evidence supports the effectiveness of psychotherapeutic approaches, there is weaker evidence that these treatments are significantly more effective than other psychotherapies (Bisson et al., 2013). The most commonly tested trauma treatments—TF-CBT, EMDR, and exposure therapy (Bisson et al.)—reflect a linear perspective that trauma treatment must directly address the traumatic event to be effective. However, there is growing interest and evidence for present-centered therapy (PCT) as an effective alternative to “active” treatments focused specifically on trauma (Belsher et al.).

### Drawbacks of a Trauma-focused Approach

Trauma can be a difficult subject for clients to discuss. By the nature of PTSD's diagnostic criteria, clients with PTSD likely already experience flashbacks, hypervigilance, and psychological distress (APA, 2013), even without the added stress of having to recall traumatic memories during therapy. Incompetence or lack of empathy among helping professionals can result in a client's re-traumatization rather than healing (Newgent, Fender-Scarr, & Bromley, 2002). The potential drawbacks of a trauma-focused approach are evident in the high dropout rates for PTSD treatments, which include reported dropout and non-response rates as high as 50% (Schottenbauer, Glass, Arnkoff, Tendick, & Hafter Gray, 2008). One meta-analysis found that various trauma treatments showed similar dropout rates when compared with each other, with the exception that PCT showed notably lower dropout rates than trauma-focused therapies (22% for PCT compared to 36% for trauma-focused; Imel, Laska, Jakupcak, & Simpson, 2013). This has contributed to increased interest in PCT as a frontline treatment for trauma, but the authors of a Cochrane Review Protocol point out that PCT was originally designed only as a comparator condition for TF-CBT, and thus its design can likely be improved upon (Belsher et al., 2017).

### Solution-Focused Therapy

Solution-focused therapy (SFT) originated at the Brief Family Therapy Center in Milwaukee, Wisconsin, with an emphasis on the construction of solutions rather than assessment of problems (de Shazer et al., 1986). Like PCT, SFT does not focus on the past, except to elicit past successes and exceptions to problems (De Jong & Berg, 2013). Unlike PCT, SFT has an intentional design based in constructivist philosophy, systems theory, and observations from real-world practice with clients and families (de Shazer et al., 1986). The fundamental shift from a problem-solving approach to a solution-building approach eschews

the need for detailed discussion of past events, and instead necessitates a present- and future-focused orientation to generate change that is meaningful from the client's point of view (De Jong & Berg). SFT techniques such as praise, exploring past successes, and looking for exceptions to problems reflect a strengths-based orientation that may help with problems such as client "resistance" or treatment drop out (De Jong & Berg).

### **Solution-Focused Therapy for Trauma**

SFT has been applied to clients managing a variety of different forms of trauma (Froerer, von Ciffra-Bergs, Kim, & Connie, 2018), with an emphasis on post-traumatic success rather than PTSD symptoms or the trauma itself (Bannink, 2008). Trauma can produce overwhelming feelings of helplessness and hopelessness (Sklarew & Blum, 2006), but SFT offers a number of strategies for empowering clients and building hope (De Jong & Berg, 2013). First, the exploration of exceptions can help clients identify the times when they are already able to manage the symptoms or effects of their trauma and could generate hope that these moments of exception can increase in the future. Second, the emphasis on small changes—which will reverberate through client systems to become larger change (De Jong & Berg)—may seem more realistic and manageable for trauma survivors than attempting to directly confront their worst trauma. The miracle question may not be appropriate for clients who have experienced severe trauma, as this does involve picturing the trauma completely gone and may be too much for some clients to imagine (Coulter, 2014).

SFT has demonstrated effectiveness across a variety of populations and problem areas (Gingerich & Peterson, 2013; Kim, 2008). Research has also supported the utility of resource-based and future-oriented processes in SFT techniques (Franklin, Zhang, Froerer, & Johnson, 2017), which are key to the conceptual case for SFT as a trauma treatment. SFT has been applied to work with populations with a high prevalence of trauma history, such as child welfare (Sabalauskas, Ortolani, & McCall, 2014). Growing evidence supports the effectiveness of SFT among foster care youth; SFT has demonstrated improved results in placement stability (Koob & Love, 2010), self-efficacy (Cepukiene, Pakrosnis, & Ulinskaite, 2018), and behaviour problems (Cepukiene & Pakrosnis, 2011). Systemic group therapy—with a similar orientation to SFT—outperformed a psychoanalytic group for adult survivors of childhood sexual abuse (Lau & Kristensen, 2007), though the treatment effects diminished over time (Elkjaer, Kristensen, Mortensen, Poulsen, & Lau, 2014). With a strong conceptual argument for SFT's applicability to trauma (Bannink, 2008; Coulter, 2014), current application of SFT for trauma treatment (Froerer et al., 2018), and evidence of effectiveness in populations where trauma is likely (Cepukiene & Pakrosnis, 2011; Cepukiene et al.; Koob & Love), a review of the evidence for SFT for trauma survivors is warranted.

### **Method**

The present study aimed to conduct the first systematic review of the outcome literature

for the effectiveness of SFT for trauma survivors, and to evaluate the methodological rigor and fidelity of existing studies. For the purposes of the review, studies needed to clearly identify the presence of trauma history among the entire treatment group or employ a direct measure of trauma symptoms. Due to the systemic nature of SFT—where change in one area is expected to cause change throughout the system—additional outcome measures unrelated to trauma were assessed as part of the effectiveness of SFT so long as the entire sample consisted of trauma survivors. As a result of the variety of outcome measures included, the authors decided not to employ meta-analytic techniques as part of the review.

### **Selection Criteria**

The study aimed to obtain as much useful information as possible regarding a topic that has never previously been the subject of a systematic review. For this reason, the study sought all available outcome literature on the effectiveness of SFT for treatment with trauma survivors. For the purposes of the review, we included any research study—published or unpublished—that 1) utilized identifiable SFT techniques with a treatment group, 2) identified the entire sample as trauma survivors or directly measured the effect of SFT on trauma symptoms, and 3) reported quantitative outcome measures. Unpublished dissertations met inclusion criteria but masters theses found in database searching were excluded. Study designs could include randomized controlled trials (RCTs), quasi-experimental designs, or one group pre-post designs; single subject designs and case studies were excluded. Though randomized controlled studies are considered the most rigorous evidence (Engel & Schutt, 2017), we decided to include a broader range of methodologies to allow for the most comprehensive review possible of the literature regarding SFT for trauma survivors.

### **Search Process**

The search process began with database searches to identify studies related to the treatment of trauma survivors or trauma symptoms that used a solution-focused approach. Since there has been no prior review on the topic area, we searched the time period up to and including June 2019. The search included the following databases: EBSCOHost (Criminal Justice Abstracts with Full Text, MEDLINE, PsycINFO, Social Work Abstracts, SocINDEX with Full Text), PubMed, Web of Science, ProQuest Dissertations and Theses, Campbell Collaboration, and Cochrane Library. In each database, we searched for SFT studies by searching titles, abstracts, and keywords for "Solution focused" OR "SFBT" OR "SFT," and narrowed results to trauma survivors by adding an additional title, abstract, and keyword search for "trauma\*" OR "PTSD" OR "post-traumatic" OR "abuse" OR "victim" OR "violence" or "survivor." In addition to database searching, the grey literature was assessed by looking for studies on ClinicalTrials.gov, as well as by contacting SFT researchers. We also reviewed the reference lists of included studies and identified one potential study from the reference list of a systematic review evaluated during the full-text review process. Studies written in languages



other than English were included in the review and were assessed based on their English abstract; no studies in other languages proceeded to full-text review. The search process identified 676 total records for screening and review.

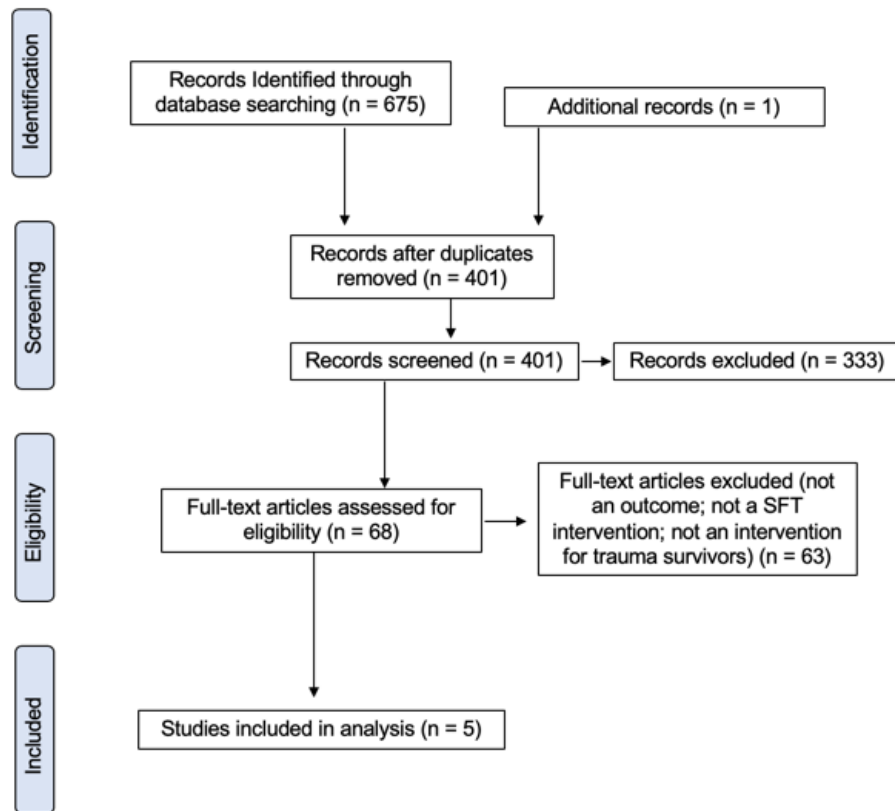


Figure 1. Systematic Review Process

## Screening and Eligibility Review

From the initial pool of 676 records, we eliminated 275 duplicate results so that 401 records progressed to the screening process (see Figure 1). We then conducted title and abstract reviews and excluded a further 333 records that did not meet study selection criteria. The remaining 68 articles and dissertations warranted full-text review to determine if they met all inclusion criteria. During full-text review, we determined that 37 results did not meet criteria for being an outcome study, and a further 5 studies did not meet the criteria for using an SFT-based intervention. The final phase of eligibility screening involved determining whether the study used SFT as a treatment for trauma survivors. Twelve studies in the full-text review did not relate sufficiently to trauma and were excluded. Another 3 articles used solution-focused approaches as part of macro interventions for trauma-informed agencies, and 6 studies used SFT with offenders or couples in domestic violence situations; these studies were excluded as they were not interventions targeting the survivors of trauma. In total, 63 studies were excluded during full-text review, and 5 studies met all inclusion criteria and were included in the analysis.

## Data Analysis Strategy

For the five studies meeting all inclusion criteria, data were abstracted from the articles regarding the study design, intervention, sample size, population, and outcome measures. We then assessed each article for its methodological quality and SFT fidelity, adapting a format used in a prior SFT review by Gingerich and Peterson (2013). The present study used an adapted version of the SFBT Model Adherence Checklist (Smock et al., 2008) to assess for seven SFT components and techniques: scaling questions, miracle question, exceptions, goal-setting, focus on solutions, break for consultation, and compliments/praise. For methodological quality, seven common components of high-quality studies were assessed for each study: use of a control group, randomization to treatment conditions, clear treatment fidelity procedures, large sample size for the treatment group ( $n > 20$ ), active treatment comparison condition, and peer-reviewed publication process (Engel & Schutt, 2017; Gingerich & Peterson, 2013). Finally, the present study compiled and summarized the findings of each study regarding the effectiveness of SFT for trauma symptoms and/or trauma survivors, and the comparative effectiveness of SFT against control groups. When possible, we included effect sizes in terms of Cohen's  $d$  that were published by the included studies' authors, that we converted from other published effect sizes into Cohen's  $d$ , or that we calculated ourselves from information provided in the included studies' results sections.

Table 1. *Study Outcomes and Effect Sizes*

**Results**

Study	Design (Control condition)	Sample Size	Sample Population	Outcome Measures	Effect Size	
					Within Group Treatment / Control	Between Group
Kim, Brook, & Akin (2018)	Experimental (vs. TAU)	64	Child welfare parents	Trauma Symptom Checklist-40 <sup>1</sup> (TSC-40)	TSC-40: .76* / .62*	TSC-40: .29
Liu (2017) [dissertation]	Experimental (vs. TAU)	41	Children with sleep problems and trauma history	Child Reaction to Traumatic Events Scale-Revised (CRTES-R) Connecticut Trauma Screen (CTS) Sleep Self Report (SSR)	CRTES-R: .82** / -.09 CTS: IDR SSR: IDR	CRTES-R: 1.00* CTS: .06 SSR: 1.05*
Zhang, Yan, Du, & Liu (2014)	Quasi-experimental (vs. No treatment)	43	Mothers of ASD children	Post-traumatic Growth Inventory (PTGI) [Chinese version]	PTGI: IDR	PTGI: Post-test: 1.26** 6-month follow up: .92**
Hiebert-Murphy & Richert (2000)	One Group Pretest-Posttest (N/A)	29	Mothers with CSA history	Rosenberg Self-Esteem Scale Parenting Sense of Competence Scale Kansas Parental Satisfaction Scale Index of Parental Attitudes	Self-esteem: .68** Parenting efficacy: .47* Parenting self-esteem: .81** Attitude toward children: .53*	N/A
Kruczek & Vitanza (1999)	One Group Pretest-Posttest (N/A)	41	Teen girls with CSA history	The Solution Focused Recovery Scale for Survivors of Sexual Abuse The Skill Mastery Test (SMT)	Recovery: 2.62** SMT = IDR	N/A

Note. TAU = Treatment as usual; N/A = Not Applicable; ASD = Autism Spectrum Disorder; CSA = Childhood Sexual Abuse; Effect Size = Cohen's d  
 IDR = Insufficient data reported to calculate effect size  
<sup>1</sup>For Kim et al., the entire sample did not have established trauma history, so only the trauma symptom measure was assessed  
 \*statistically significant at  $p < .05$ ; \*\*statistically significant at  $p < .01$   
 Positive effect size indicates desired direction (improvement or favoring treatment), negative effect size indicates change in undesired direction

Five studies met all criteria for inclusion in the review. The studies consisted of two RCTs (including one dissertation), one quasi-experimental design, and two single group pretest-posttest designs. Total sample sizes ranged from 29 to 64, and SFT treatment conditions ranged from 18 to 41 participants each. The studies were all assessed to be adequately powered, which was supported by the later observation that each study produced at least one statistically significant effect size. Four of the five studies had samples comprised entirely of trauma survivors, which included mothers and adolescent girls with history of childhood sexual abuse, mothers whose children had received an autism spectrum disorder (ASD) diagnosis, and children with sleep problems and assessed trauma history. Kim, Brook, and Akin (2018) did not specify trauma history for their sample of child welfare parents with substance use problems—though a high prevalence of trauma is expected for this population—so only the outcome measure directly assessing trauma symptoms was included in the review. In addition to the trauma histories among studies' participants, four out of the five studies also included outcome measures related to trauma symptoms, post-traumatic growth, or recovery following sexual abuse. Table 1 shows the study designs and samples, as well as outcome measures and effect sizes.

**Intervention Outcomes**

As shown in Table 1, the included studies employed a variety of outcome measures capturing symptoms and recovery directly related to trauma, as well as additional benefits of SFT treatment on the lives of trauma survivors. The inclusion of indirect as well as direct effects of SFT on trauma reflects the systemic perspective underlying SFT. Among the direct measures related to trauma, two studies used outcome measures specifically assessing trauma symptoms, which included: Trauma Symptom Checklist-40 (TSC-40); Child Reaction to Traumatic Events Scale-Revised (CRTES-R; child report); and Connecticut Trauma Screen (CTS; parent report).

Additionally, two studies directly measured growth or recovery following the experience of trauma, which included: Post-traumatic Growth Inventory (PTGI; Chinese version) and The Solution Focused Recovery Scale for Survivors of Sexual Abuse. In addition to the outcomes directly related to trauma, included studies also measured additional benefits of SFT for trauma survivors, including sleep problems (Sleep Self Report [SSR]), self-esteem (Rosenberg Self-Esteem Scale), parenting (Parenting Sense of Competence Scale [PSOC], Kansas Parental Satisfaction Scale [KPS], and Index of Parental Attitudes), and knowledge of positive coping strategies (The Skill Mastery Test [SMT]).

Since included studies measured outcomes in terms of within-subjects improvement over time, improvement compared to no treatment, and improvement compared to treatment-as-usual (TAU), it is important to analyze various categories before discussing the overall evidence of SFT effectiveness.

**Within-subjects findings.** All five included studies reported results of within-subjects changes over the course of treatment, though, for several measures

(CTS, SSR, PTGI, SMT) there was not sufficient data reported to calculate an effect size. On direct measures of trauma symptoms (TSC-40, CRTES-R), subjects in SFT treatment groups showed statistically significant improvements in their trauma symptoms with moderate to large effect sizes ( $d = .76 - .82$ ). On the TSC-40, the control group also showed statistically significant within-group improvements with moderate effect size ( $d = .62$ ), but on the CRTES-R the control group showed slight regression ( $d = -.09$ ). The reporting in Liu (2017) did not allow within-subjects effect sizes to be calculated on the CTS, but visual inspection of reported results showed notable improvements for both the SFT and control groups. As the CRTES-R (child report) and CTS (parent report) represent trauma symptom measures from two sources within the same study, it is unclear why the control group in Liu's study varied so significantly between child and parent reports; however, the SFT group showed improved PTSD symptoms on both child and parent reports. On direct measures of post-traumatic growth or recovery, the SFT group in Kruczek and Vitanza (1999) showed statistically significant improvements in symptom recovery with a very large effect size ( $d = 2.62$ ). Zhang, Yan, Du, and Liu (2014) did not report sufficient data to report within-subjects effect sizes on the PTGI, but visual inspection showed notable improvement in the SFT group and no significant change in the control group.

For the additional indirect benefits (not directly related to trauma) from SFT with trauma survivors, three studies reported data on additional benefits but only Hiebert-Murphy and Richert (2000) reported sufficient data to calculate effect sizes. The SFT treatment for mothers with history of childhood sexual abuse showed statistically significant improvements related to self-esteem ( $d = .68 - .81$ ) and parenting ( $d = .47 - .53$ ). The authors also published significant results on parental satisfaction from the PSOC but noted that the improvement in parental satisfaction on KPS was not significant ( $p = .11$ ) without reporting the data, so the effect size on parental satisfaction was excluded from this review. For sleep problems (SSR), visual inspection showed improvements for both the SFT and control groups, and for knowledge of coping strategies (SMT). Kruczek and Vitanza (1999) noted visual evidence of improvement that did not achieve statistical significance.

**Between-group findings.** Three of the included studies used control groups that allowed statistical testing between the treatment and control conditions. For post-traumatic growth, Zhang et al. (2014) tested SFT against a no-treatment control condition. The PTGI scores were significantly better for the SFT group at both post-intervention and 6-month follow-up, with a very large effect size in favor of SFT at post-intervention ( $d = 1.26, p < .01$ ) and a large effect size favoring SFT at 6-month follow-up ( $d = .92, p < .01$ ). Two other studies compared SFT to a TAU control group and tested direct measures of trauma symptoms. Liu (2017) compared solution-focused art therapy provided during a summer youth program to a control group receiving only the summer youth program. The findings on the effectiveness of SFT compared

to the youth program differed between child and parent report of PTSD symptoms. Based on CRTES-R (child report) scores, SFT significantly outperformed TAU in reducing PTSD symptoms with a very large effect size ( $d = 1.00, p < .05$ ). However, based on CTS (parent report) scores, there was no meaningful difference between SFT and TAU ( $d = .06$ ). Liu (2017) also tested SFT for sleep problems (SSR) among trauma survivors against TAU and found a large effect size ( $d = 1.05, p < .05$ ) favoring SFT. Finally, Kim et al. (2018) compared SFT to a TAU condition consisting of other research-supported treatments used by agency clinicians, which mostly consisted of CBT, TF-CBT, and motivational interviewing. The study found a small effect size in favor of SFT ( $d = .29$ ) for improved TSC-40 scores at post-treatment, but the effect was not statistically significant. Based on this finding, Kim et al. concluded that SFT showed comparable effectiveness with other evidence-based treatments. The overall evidence for SFT versus TAU for trauma symptoms varies widely, with effect sizes ranging from very small to large ( $d = .06 - 1.00$ ) in favor of SFT.

#### Harms from SFT treatment?

None of the five included studies indicated evidence of harm caused by SFT with trauma survivors. In fact, all within-subjects changes mentioned by study authors showed some improvement following SFT even if the trend was not statistically significant, and none of the control groups outperformed SFT when compared on outcome measures.

#### Treatment Fidelity and Study Quality

In addition to compiling the empirical evidence for SFT for trauma survivors, the present study sought to evaluate the quality and methodological rigor of included studies. The included studies provided SFT-based interventions through a number of modalities, including individual counselling, group treatment, and art therapy (see Table 2). This review assessed the SFT treatment fidelity of each included study, and also evaluated the quality of the study design.

**SFT fidelity.** To determine whether the treatments delivered in each study met criteria for being solution-focused, the author assessed each study for evidence of seven solution-focused techniques: scaling, miracle question, exceptions, goal-setting, focus on solutions, consultation break, and compliments/praise (Smock et al., 2008; SFBTA, 2013). All three of the controlled studies included six out of the seven SFT components, indicating a high level of fidelity to SFT principles and techniques. Both RCTs also included formal fidelity procedures and measures, while the quasi-experimental study employed expert content developers. The two older pre-post designs employed four and one SFT components respectively, with no formal fidelity process, indicating moderate to poor SFT treatment fidelity.

Table 2. *Intervention Fidelity and Study Quality*

Study	Intervention	SFBT Fidelity	SFBT Components <sup>a</sup>	Quality Components <sup>b</sup>
Kim, Brook, & Akin (2018)	SFBT individual counseling	40 hours SFBT training for clinicians, SFBT Fidelity Instrument, sessions reviewed at random by clinical directors	S, E, G, F, B, C	C, R, P, F, L, A, O
Liu (2017) [dissertation]	Solution-focused art therapy	Author developed Solution-Focused Art Therapy Manual and Fidelity measure	S, M, E, G, F, C	C, R, F, L, A, O
Zhang, Yan, Du, & Liu (2014)	SFBT group counseling	Intervention content developed by 10 experts on SFBT, group counseling or raising children with Autism Spectrum Disorders	S, M, E, G, F, C	C, P, O
Hiebert-Murphy & Richert (2000)	Solution-focused parenting group	Authors give an outline of a 12 session-group based on a solution-focused approach to intervention	E, G, F, C	P, L, O
Kruczek & Vitanza (1999)	Solution-focused / Ericksonian group therapy	Authors developed treatment protocol based on solution-focused and Ericksonian interventions	F	P, L, O

Note. SFBT = Solution-focused brief therapy

<sup>a</sup>S = scaling questions, M = miracle question, E = exceptions, G = goal-setting, F = focus on solutions, B = break for consultation, C = compliments

<sup>b</sup>C = control group, R = randomization, P = peer review, F = fidelity process, L = large sample (treatment group > 20), A = active treatment control

O = objective outcome measures

<sup>c</sup>Evaluation of components adapted from Gingerich and Peterson (2013)

**Study quality.** The present review also assessed the methodological quality of the included studies using seven components of design quality: control groups, randomization, peer-reviewed publication process, formalized treatment fidelity process, large treatment group sample size ( $n > 20$ ), active treatment control condition, and objective outcome measures (Engel & Schutt, 2017; Gingerich & Peterson, 2013). Only one study (Kim et al., 2018) included all seven quality components, representing a high level of methodological quality and rigor. The other RCT (Liu, 2017) included six out of seven quality components, but was an unpublished dissertation that did not go through a peer-review process. Also, the wide variation in the control group's post-test PTSD scores between child and parent reports raises concerns about the study's measurement validity. The remaining three studies each met three out of seven quality criteria, with only Zhang et al. (2014) including a control group, representing lower methodological quality susceptible to various threats to internal validity (Engel & Schutt). These three studies all lacked formal fidelity processes, which weakens the conclusions that can be drawn regarding the effectiveness of SFT for their reported outcome measures. In the case of Kruczek and Vitanza (1999) in particular, it is questionable whether the intervention tested truly represents SFT.

## Discussion

The present study conducted the first systematic review of the effectiveness of SFT for the treatment of trauma survivors. The evidence base for SFT for trauma is still in an emerging developmental state, with only five studies meeting inclusion criteria for SFT outcome studies for trauma survivors. Despite the small number of studies and dearth of high-quality studies, the review provides valuable insights into the potential benefits of SFT with trauma survivors.

## Effectiveness of SFT for Trauma Survivors

The existing outcome literature provides initial evidence of the overall effectiveness of SFT for treating survivors of trauma. In particular, within-subjects treatment effects showed moderate to large effect sizes on direct measures of both trauma symptoms and recovery, as well as indirect benefits on outcome measures including self-esteem and parenting. The within-subjects tests meet two criteria for causal validity—time order and association—but cannot rule out additional explanations for the change in scores, such as maturation (Engel & Schutt, 2017). In fact, two measures of direct trauma symptoms also showed notable improvements in the control group, and the unpublished dissertation reported large time effects in repeated measures ANOVA tests (Liu, 2017). However, the effectiveness of SFT for trauma survivors was also supported by between-group tests, particularly for post-traumatic growth and benefits for sleep problems. SFT showed large effect sizes for post-traumatic growth (compared to no treatment) and for sleep problems (compared to TAU). The use of control groups in both studies and randomization in the latter study lend greater confidence to the evidence of benefits from SFT for trauma survivors. Though the overall evidence is weakened by fidelity

and rigor concerns and the small number of studies, there is some evidence that SFT provides both general benefit to trauma survivors and specifically encourages post-traumatic growth and recovery.

### **SFT for Alleviating Trauma Symptoms**

A primary concern among many studies of trauma treatments is the reduction of PTSD symptoms (Bisson et al., 2013). In this area, the existing evidence regarding the effectiveness of SFT is mixed, particularly when compared with TAU. Though all trauma symptom measures showed significant improvements following SFT in within-subjects tests, this evidence is weakened by similar improvements in control groups. In the highest quality study, SFT outperformed TAU that included established trauma treatments, but the effect size was small ( $d = .29$ ) and not statistically significant. In the other RCT, the large effect size favoring SFT over TAU on child-reported PTSD symptoms vanished when comparing parent-reported PTSD symptoms, suggesting possible measurement issues. More well-controlled studies are needed to establish the effectiveness of SFT for alleviating trauma symptoms.

### **Appropriateness of SFT for Trauma Treatment**

The application of SFT to trauma survivors draws from compelling conceptual arguments that a solution-focused approach could be an effective means of treating trauma without subjecting clients to the stress of directly focusing on traumatic memories. Notably, the included studies in this review did not show evidence of harms from SFT, and no evidence suggested SFT was less effective than TAU. Furthermore, the benefits seen from SFT with trauma survivors on a variety of direct and indirect outcomes provide support for the systemic assumptions underlying the SFT treatment approach. The initial evidence supports the appropriateness of SFT for trauma survivors, and it is notable that SFT produced favorable treatment effects without a direct, past-focused approach to trauma treatment. Therefore, it is plausible that some of the clients who drop out of trauma-focused treatments could benefit from the SFT approach. The present study did not analyze retention or dropout rates, though the comparative dropout rates for SFT versus trauma-focused treatments would be a rich area for future research.

### **Limitations**

The small number of studies and lack of high-quality controlled studies significantly limits the conclusions that can be drawn regarding the effectiveness of SFT for treating survivors of trauma. Many of the conclusions noted in this review are based on within-subjects findings, which are especially susceptible to multiple sources of bias. The decision to include weaker methodological designs added to the scope of the review but lowers the quality of research evidence summarized in this review. Also, the search process did not include hand searching of trauma journals, so it is possible that some studies could have been missed; however, the

final list of studies was sent to leading SFT researchers who felt it was comprehensive. We also opted to exclude studies that used SFT as a treatment for perpetrators of trauma as well as macro-level responses to traumatized populations, which may have omitted valuable insights on the systemic applications of SFT in the field of trauma. This review did not analyze included studies' dropout rates, which would help bolster the case for SFT as an alternative to trauma-focused treatments with high dropout.

### **Implications**

This systematic review of the outcome literature for SFT for trauma survivors has important implications for future research and practice. First, policymakers, agencies, and clinicians should consider adding SFT to the evidence-supported treatments offered to clients who have experienced trauma. While the evidence for SFT for trauma is in an early developmental stage, there is no evidence of harm from SFT or lower effectiveness compared to other treatments. More importantly, SFT offers a distinctly different approach than the direct, trauma-focused approaches that may contribute to the high dropout rates seen for PTSD treatments (Imel et al., 2013). Some traumatized clients who would otherwise drop out of traditional treatment may find SFT a more acceptable alternative. Even as the evidence base continues to build for SFT as a trauma treatment, clients who prefer a present-focused or strengths-based approach should be given the option of receiving SFT as part of an approach that allows clients to discuss their traumatic experiences if they choose, but without pressuring them to do so.

### **Future Research**

The current review's findings indicate the need for additional research on the effectiveness of SFT for trauma survivors. The current evidence suffers from a small number of studies and low-quality research designs, so additional studies with randomized, experimental designs would add considerably to the quality of the evidence for SFT for trauma treatment. In particular, more research is needed regarding the effectiveness of SFT at alleviating trauma symptoms when compared with other treatments. Also, the conceptual basis for SFT for trauma treatment warrants additional research on the comparative retention rates between SFT and trauma-focused treatments. This review did not analyze dropout rates, but future research studies and systematic reviews should seek to determine whether SFT involves lower dropout than trauma-focused approaches. Finally, the search process uncovered a number of studies regarding SFT with perpetrators of trauma and couples experiencing domestic violence – this alternative approach to use SFT to prevent future trauma may warrant its own systematic review.

### **Conclusion**

This study conducted the first systematic review of the effectiveness of SFT for the treatment of trauma survivors. Though based on a small number of studies with limited quality,

the evidence provides initial support for the benefits of SFT for trauma survivors without needing to directly focus on past trauma. Additional research is needed in this area, especially regarding the effectiveness of SFT for alleviating trauma symptoms when compared with other treatments. The conceptual basis for SFT for trauma suggests that SFT may involve a lower dropout rate than trauma-focused treatments, but this was not a focus of the review. Future studies should seek to replicate the positive effects of SFT with trauma survivors, and also test retention rates for SFT versus trauma-focused treatment.

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## The 3.0 version of “Reflections on Mark’s Paper SFBT 2.0 - The new generation of SFBT has already arrived”

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When I read Mark’s paper the first time, I thought that Mark had done a pretty decent job at pointing out some of the key differences between what I call the BRIEF-model<sup>1</sup> and my more traditional way of doing and teaching SFBT. I felt a tiny bit of unease as I read the paper but couldn’t put my finger on why that was except for a couple of things where I did not agree with his descriptions of the BFTC<sup>2</sup>-model. I thought most of my unease was due to me just being and feeling old-fashioned.

Then the other day one of the people on our diploma training said, “Why do we need to learn SFBT 1.0 when SFBT 2.0 is already here?” I felt some more unease, so I re-read Marks paper again, and more carefully. Towards the end of the paper in the last paragraph Mark writes, “This is not to say that SFBT 1.0 is wrong, or bad, or outdated, or anything like that”(McKergow, 2016, p. 15). This phrase contradicts most of what came before it in the paper. Mark not only describes SFBT 2.0 in positive terms, it describes my way of doing Solution Focused Brief Therapy (the old way) in negatives.

Language is powerful. Some people even have the idea that meaning making happens in language. I think Mark is one of them. The way we describe our world is how we live and take part in it. So, I decided that in this comment on Mark’s paper I will not accept the names he proposes because the numbering system in itself denotes that one is better, more advanced, a major update, etc. Since I am not yet convinced, I will instead talk here about the BRIEF-model and the BFTC-model.

### A couple of examples

Some of the words qualifying the BRIEF model (quotes from Marks’s paper in italics; my emphasis in bold):

- *even simpler in form*
- **left behind** many elements

- **important evolution** of existing practice

A couple of comparisons:

- *losing hangovers* from family therapy
- *the end of the session has **lost many of the trappings***
- *even **more elegant** than the previous versions.*
- *an even **clearer commitment** to offering power to the client,*

A description of the BFTC-model around the utilization of the team and descriptions of the summary:

- The idea of others watching, hidden from view, seems not only costly but also rather **creepy**.
- compliments in a **sustained barrage**, as the prelude to **selling some kind of intervention** (McKergow, 2016).

I think my student’s question now makes sense. Who would want to do creepy things, sell interventions, use outdated elements, have hangovers<sup>3</sup>, be trapped by thinking about how to finish the session, be clumsy (instead of elegant) etc.<sup>4</sup>?

### A short look on what I don’t agree with

Mark then compares the BFTC-model with the BRIEF-model where one is not “...trying to deliberately prompt the client to action” (McKergow, 2016, p. 11). Maybe this is a misunderstanding. I think that our much esteemed friends at BRIEF are saying that if you stop thinking about what to do at the end of the session you get more time and space to develop the preferred future in the future; the present and the past and new things will start happening in the session that you haven’t conceptualized and seen before. If they are actually saying (or thinking) that they are not deliberately trying to prompt the client to action, they are falling into the trap described by Weakland:

Influence is inherent in all human interaction. We are bound to influence our clients, and they are bound to influence us. The only choice is between doing so without reflection, or even with attempted denial and doing so deliberately and responsibly (Weakland as cited in Gilligan & Price, 1993, p. 136-145).

My view on influence is that it happens in the negotiation of meaning that is continuously on-going in the therapeutic conversation. My contribution in the process lies in the choices I make when I echo, paraphrase, and build questions on only parts of what the client told me (De Jong, Bavelas, & Korman, 2013; Korman, Bavelas, & De Jong, 2013), and in the presuppositions of my questions (McGee, Del Vento, & Bavelas, 2005). Since most people don’t like to be told what to do, and since one of the reasons they have come to see me is that they don’t know what to do, it would be rather unproductive to ask them what they need to do.



Instead, I ask them how they will notice when things get better, how they feel, what they think, how they behave, and how other people will behave differently. People can only answer these questions when they have imagined themselves noticing that things are better, and what actions would follow or precede. Pretending that this is not deliberately prompting the client to action is ignoring the power of language and the whole post-structural revision of SFBT that Mark refers to in his paper (de Shazer, 1992 p. 92; McKergow, 2016).

This is the largest beef I have with Mark's paper. In more or less subtle ways, through his description of the BRIEF-model, he minimizes the effect of seemingly simple questions like: "So, after the miracle – what is the first thing you, or someone else, notices that you feel/do/think?" And pretends that this is not prompting the client into action.

Since the above is also a major part of Mark's description pointing to the BRIEF-model being a major upgrade from the BFTC-model, this is also questionable by inference. But let's suppose for the sake of the argument that the BRIEF-model represents a major shift.

### Is the BRIEF model one step forward?

When I first heard Chris, Harvey, and Evan present the BRIEF-model at a conference some 15 years ago or so - I was enthusiastic. Steve de Shazer was walking out just in front of me, so I caught up with him, and asked him what he thought of this great simplification of his work, particularly considering his own fondness of simplicity. He grunted in response, so I pressed on. "Don't you think it's great that they have reduced the number of questions to only 2"; The questions being "What do you want? And what of that is already happening?". He answered: "If it's only a question of reducing the number of questions there is only one that is important." That caught my attention. Being a fervent admirer of Steve's thinking I asked him what THE QUESTION was. He answered: "What's better?" He then added that one problem that BRIEF's description "makes it damned difficult to teach". So – a question I have been asking myself since I listened to BRIEF presenting their model is:

### Is it easier to learn the BRIEF model?

Mark didn't say in his paper that the BRIEF-model is easier to learn. I think my student thinks it as easier though. And Steve suspected that it might be more difficult to learn SFBT with the BRIEF-model than with the BFTC-model. So, I decided to talk about it here as well.

If Solution Focused Brief Therapy is only, and I mean only, about creating a preferred future, and describing instances of that future, the answer would undoubtedly be: Yes!

Obviously, the BFTC-model is more complex. If you use the model with the end of session message, including an experimental thing to do, something to observe, or just compliments requires that you create particular information in the session and it requires you to make a certain number of decisions. Is the miracle picture vague or concrete? If you were not able to construct a preferred future in the session, what is the form of the problem? The pieces of better something the client can do deliberately? problem? etc.? You need to categorize the

information created in the session and you need to make decisions on how to proceed in order to construct a useful therapeutic reality.

Sometimes it's more complicated and that's where the BFTC-model may have some advantages (and may have some disadvantages). There are more pathways described, there are more options available. Among them, there is for instance, the possibility of finishing a "bad" session in a useful way with a summary that you have taken some time to reflect on. More importantly than the summary though, the BFTC-model opens up a variety of pathways in the session. If Scott Miller is right in that the best therapists are the ones with a wider register of available behaviors, then de Shazer may be right that the BRIEF-model makes it more difficult to learn the variety that one needs to fit with all kinds of people in therapy.

So, I personally believe that Steve's comment about the BRIEF-model being more difficult to learn is that BRIEF-mapping makes it more difficult to learn the many different pathways of SBFT that I believe are useful to master.

### Is the BRIEF-model better?

There are some strong arguments for the BRIEF-model. For instance, the elegant simplicity of its description and the fit with many of the basic assumptions extracted from the work at BFTC. The strongest argument though are the claims that it has the same results in fewer sessions and that because of the simplicity it might be easier to learn. I'm not sure that this is what the guys at BRIEF think, but it's certainly what my student was thinking. And it also feels like the gist of Mark's paper – despite him negating this.

Thinking about this, I re-read the paper where Shennan and Iveson (2011) present the development of the BRIEF-model and the research they did. I read with a critical eye, deliberately avoiding being solution focused.

In the paper (Shennan & Iveson, 2011), they describe the 5 studies that the team at BRIEF was involved in. Talking about the fifth study they have a headline: Study 5: Briefer and Still Effective? The dip in outcomes (60% improved) of the fourth study compared to the previous studies spurred us on to put systems in place to enable more regular and systematic evaluations of our work. Because we wanted to check our practice as quickly as possible after the fourth study, the fifth was undertaken about a year later. On average, eighty-four percent of the clients reported that they had made progress towards their "best hopes" from the work, a year after its completion, with an average of 1.8 sessions per client. The questions asked in this study differed from those in the previous studies. The measure being about achievement of hopes rather than resolution of problems. This reflected the significant practice developments that had been set in motion by the earlier studies, and it is to these that we now turn.

It honors Shennan and Iveson (2011) that they put a question mark after the heading. Regardless of their motive for changing the measure it makes all comparisons between study 4 and study 5 nonsense and opens alternative interpretations. An unexpected finding of the fifth study was that the average number of sessions across the 25 clients was as low as 1.8.

This reminded me of a study on clients at BFTC on 168 clients made by Kiser (1988) and Kiser and Nunnaly (1990), referenced in de Shazer, Putting Difference to Work (1991; See Table 1). At follow-up, 80% of the clients reported either "Complete relief of the presenting problem" or "Clear and considerable improvement."

About half of these clients had 4 sessions or more, and about half had 3 sessions or less. The researchers looked at if there was a difference in outcome correlated with length of therapy. In the group that had 4 sessions or more, 91% of the clients were better. In the group who had three sessions or less 69% were better. That is a big difference. Trying to be a brief therapist, I did not like that more therapy correlated with better results. The clients were also asked if things had improved in other areas than the problem that they had talked about. Again, there is a difference. There with more clients from the 4 sessions or more group meeting secondary goals.

Table 1. Kiser (1988) and Kiser and Nunnaly (1990) cited in de Shazer (1991).

	BFTC 3 sessions or less (51,8 % of the clients)	BFTC 4 sessions or more (48,2% of the clients)
Total % improved	69%	91%
Met secondary goal	44%	61%

So, I took a look at De Jong and Hopwood (1996), and in their findings of the follow-up of 276 clients at BFTC from 1992-93 there is a tendency in the same direction: More sessions – better results.

Some years later, Scott Miller, who used to work at BFTC and who has been a strong advocate for practice-based evidence, told me that there are many studies that show that longer therapy is more effective than shorter. One of the key elements of his "Feedback Informed Treatment-model - FIT" is that we need to locate our unsuccessful cases early in therapy. Using the Session Rating Scale, we can find the cases at risk of dropping out in the first and second session. When we do, we can apologize for the bad fit we had with them and a lot of them will then return to a next session. Giving us the opportunity to perform better. Doing this improves outcome significantly.

Another thing that Scott talks about in his later, and now on-going work, is that the best therapists regardless of model seem to have a wider variety of behaviors at their disposal when things become difficult in a session.

Shennan and Iveson (2011) continue in their article:

Our best guess about the reason for the reduction in the number of sessions is that it is related to our attempt to become non instrumental in our conversations with clients.

Though overall our intention is to be successful therapists by helping clients move forward in their lives, client by client, the team endeavors to remain neutral about what the client

does. Our hunch is that if clients are confronted in any way by our ideas concerning possible actions to take, then they will need to take time to consider these ideas. Conversely, the more we are able to keep out of their way, by simply inviting clients to describe future possibilities and whatever aspects of these possibilities are already in place, the more quickly they will be able to get on with whatever they choose to do. (Shennan & Iveson, p. 295)

It makes sense to see the reduction of the number of sessions as the result of something good happening in sessions at BRIEF, but only if the outcomes of their therapies are not worse. Due to the fact that they changed their outcome measure between study number 4 and 5 this cannot be claimed.

So, using my critical posture, here is another alternative. The BRIEF-model does not, in a significant number of cases, lead to the same kind of fit as the wider, older model that has more options on how to conduct the session and end it. Thus, the BRIEF-model might have more early dropouts and worse results (as they were in study number 4).

**Conclusion**

I agree with BRIEF that in lots of cases even having the idea that the client needs to do something doesn't fit. If the therapist has the idea that the client needs to do something it will be visible in the presuppositions, in the selection process, and it will lead to a bad fit with that client. With other clients, for instance, someone who misheard what I asked with the best hopes/common project question; and to have heard me ask: "What can I do for you?" or "What needs to happen in this session for you to feel that it's been useful?" and answers with: "I need you to give me some tools". This answer will be taken into account in my BFTC-way of doing SFBT. It will be one of the threads of the conversation. And it might very well be a part in my summary, proposal of an experiment or what to pay attention to. I try to understand and work inside the client's worldview even knowing that we are co-constructing it in the session. And I hope that it helps me develop/maintain the fit that I believe is crucial in developing a useful therapeutic reality with my clients.

Maybe, the BRIEF-model is the next generation of Solution Focused Brief Therapy or maybe it has taken too many important and useful things away from the BFTC-model and is a step backwards. I don't know. I want to see more research on both process and effect to decide where I stand.

And maybe, maybe all of us brief therapist should do what Steve de Shazer did several times in his career. When the data doesn't fit the theory, change the theory. Maybe we should at least ask ourselves if our old adage "briefer is better" is a useful way to think.

1 What Mark calls SFBT 2.0, I call the BRIEF-model which is also in homage of the people who developed it.

2 What Mark calls SFBT 1.0 I call the BFTC-model.

3 I originally wrote: "If you want a hangover – use SFBT 1.0". This is a classical rhetoric move. You use the words the other person used but you use it with another sense. I think it irritated me that Mark chose the word "hangover" because I use lots of stuff coming from Erikson (and thus the MRI).

4 The numbering system is interesting by what it implies. This is my third version on the reflections on Mark's paper. Suppose I said: "This is not to say that versions 1 and 2 were wrong, or bad, or outdated, or anything like that." Would you believe me?

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## Response to Harry Korman's Reflections on SFBT 2.0 Paper

Mark McKergow

The Centre for Solutions Focus at Work

First of all, many thanks to Harry for giving such detailed attention to this paper. I am very honored that he thinks these developments are worth paying serious attention to. He raises some very interesting points.

At the outset, let me say that I don't accept that what I have termed "SFBT 2.0" solely as the creation of BRIEF, although their work is clearly very important to it. I see this as much wider trend in the way SFBT is going and has been going for a decade or more. For example, I myself proposed a greater focus on 'chunks' of conversation all the way back in 2002. I have attempted to assemble the various changes and shifts into a coherent picture – which itself then reveals even more about new directions for our work. This also includes theoretical developments which are not the topic of the current SFBT 2.0 paper but are somewhat presaged in the *Brief Therapy: Focused Description Development* paper by Chris Iveson and me.

Although I can see the temptation to refer to what I have termed "SFBT 1.0" as the BFTC model, I don't think that's a wise move either. As Harry knows, Steve and Insoo's work developed over their careers in ways that were not always well documented. Peter de Jong has said to me recently (and I am happy to agree with him) that Insoo's late work might have been seen as something like "SFBT 1.6". It's useful to set up an idea of "SFBT 1.0" as a counter point but that doesn't mean that most people are doing exactly that – in fact I think most SFBT practitioners I have seen are moving along this spectrum, albeit with different degrees of awareness and deliberation.

So, in this paper I am both attempting to point to shifts which are already happening, and also to show how a renewed and even more sharply honed set of practices might be emerging; which offers practitioners both clearer focus and a new connection to the question "how does it work". The question "how does it work" could reposition SFBT in a clearer space for newcomers and the wider world. (Again, I accept that this element is not yet present in the

paper under discussion.) Is that "better" as a clear conception of what we are seeking to do? Yes, I think so, hence the various comments about "leaving behind" elements of existing

### *Deliberately prompting the client to action*

Of course, I take the point of Harry's reference to John Weakland about the all-pervading influence of communication. I am not seeking to pretend that our questions such as "so, after the miracle, what is the first thing you notice..." are not in the bigger picture intended to promote some kind of action in the client. I am making a rather narrow point – that these questions are not explicitly couched in "action" terms ("what will you do") as in descriptive terms ("what will you notice").

In the initial work from BFTC (for example in Clues), the discussion about a hypothetical miracle future was only deployed if suitable exceptions had not been found. The advantage of these exceptions was seen, at the time, as being that as they had already happened, they could be deconstructed in detail to examine what the clients had *done* already that had helped. Then, as the practice developed, the miracle question took a more central part and the work seemed (to me) to take on a hybrid quality of being partly about descriptions of the future and examinations of past exceptions. And all of this was at the service of an intervention design, to be done in a group and delivered at the end of the session.

Over the past 10-15 years, we have seen a shift away from deconstructing exceptions and building detailed interventions (in real-life action terms), and moving towards a much more creative and expressive way of working with clients. We want clients to feel encouraged to speak about themselves in the here-and-now and explore events in the future and past. Our goal is not to see what "really" happened but to connect with them in different ways. And of course, this is, in the end, about helping clients live their lives differently, in ways which give them less pain and more satisfaction. So, my point about prompting the client to action is about moving away from the blunt explorations of doing and towards the even more interactional and latent power of noticing.

### **Is SFBT 2.0 one step forward?**

As I said above, I am seeing current practice as being at various points along an imaginary scale from SFBT 1.0 to SFBT 2.0. At the moment many people (including me) are doing something which allows for a mix of possibilities, and I get the sense from your document that you like the option to give tasks and get people to do things. I am reminded here, of the story Steve used to tell about the teenaged boy who came to therapy with his parents, watched what was going on for a while and then asked "So, are you asking these questions for you to get the answers, or for us to hear the answers?". I think Steve's response was a "hrmph" or something, because in the current practice it is ambiguous. It could well be both.

What I am proposing here is that with SFBT 2.0 the answer is basically "so the client can hear the answers". The practitioner hears them too – and their role is to construct more

questions to expand the description of the client. This is a different *kind* of endeavour from SFBT 1.0 where the practitioner is going to construct a task. I think / hope that in leaving that behind the practitioner is able to stay even better with the client in expanding their descriptions and their world, without having to worry about what to do with the information. That's the proposal anyway, it clearly needs exploring and testing.

By the way, I don't think that BRIEF has only two questions – in order to make sense of that, we need a whole raft of skills, sub-questions, and tactics. They are (as ever) being modest about their skills.

### Distinguishing sessions of SFBT 1.0 and SFBT 2.0

You say that you're not sure whether an observer could distinguish between sessions like this apart from the obvious lack of a break. It's a very good question. Peter De Jong asked the same thing, so at his suggestion, we compared an Insoo session, ("Over The Hump", chosen by him) and a Chris Iveson session, ("Mary and the cuddle", chosen by me) by both looking at them to draw distinctions etc and then comparing notes. Of course, there are plenty of similarities – both sessions are clearly SFBT and not something else. However, there were also some clear distinctions.

In what seemed as a complicated session due to the amount of children in the room, Insoo didn't get a "project" agreement with the clients but rather assumed it. She may have been justified in doing that because of the situation. Then Insoo asks the miracle question and has to do a lot of clarifying because the family misunderstood it (unfortunate, but not very significant in this discussion). She then gets some "headline" answers but doesn't expand much on them. Insoo tended to get a headline (in response to the miracle question, or a scale) and then repeat it, whereas Chris tended to dive into more detail from whatever starting point – he uses the question "what difference would that make?" six times (Insoo 0), and variations on "what might you notice?" over 20 times (Insoo 0). I will add my marked-up copy of the complete *Over The Hump* transcript with my comparison notes to this reply when I send it. (This includes the opening and closing, which were not examined for microanalysis purposes.)

Peter De Jong concluded that these sessions show "very clear variations which could be very profitable to explore." He also said that we were "reaffirming the spirit of SF" by looking directly at the work in action.

### Varieties of Pathways

Yes, there are more possible pathways and options in SFBT 1.0. It's not totally clear to me that it's a useful thing – perhaps it means making decisions which takes one's attention away from the client at hand. Perhaps there is enough variety within the options for SFBT 2.0 – we don't know yet. What I do know is that I spent years recording open consultation sessions waiting for the perfect "difficult" one where the usual things didn't work, resulting in doing something amazingly creative. And yes, I was frustrated that it never happened and the usual

stuff (put together in a way which seemed to fit the situation) produced some useful ways forward. I think there are plenty of options in SFBT 2.0 – assuming a platform/project can be agreed, one can go to past, present or (more usually) future in various ways. The art gallery metaphor shows how what we're after (a variety of different descriptions/pictures/scenes) can be approached in different ways.

Also, if there is not a fit between client and therapist, it may be better to move on more quickly to an alternative therapist or treatment.

### Is SFBT 2.0 better?

Research – yes of course more is needed. As I say in the article, if we can name and define this as something to investigate, then investigation becomes likely. The research you mention about more sessions being better... it is of course, interesting and thought provoking. We could usefully remember that most of the world is still not using a brief therapy mentality. I recently did a training for an agency here in Edinburgh where they give their clients 25 sessions routinely. (And guess what... the therapists report that there is a crisis around 20 sessions when the clients finally realize they have to do something!) In this context, the difference between 4 and 5 sessions is less fundamental.

Changing our emphasis in SFBT from "as many sessions as needed and not one more than necessary" would be a very big step. I guess we might, in situations (such as those here in the UK where therapist resources are limited in the NHS) discuss the relative benefit of one more session to an existing client who is well on the way to recovery, and giving a new client a first session.

Yes of course we need more research. However, this can also act as a paralysing. I don't think BFTC had a huge amount of weapons-grade research when they wrote *Clues* in 1988. They had some good ideas and some experience of them working, and look what that started. I also think there are some useful connections to come from SFBT 2.0 in terms of connection to things like enactive cognition, which is not included in the initial paper, but I hope to add soon from other work.

### "Give me some tools"

You ask about the kind of situation where the client, in answering questions about their hopes, say "I need you to give me some tools..." We can easily respond to this not by accepting it at totally face value but rather asking "and what difference would it make, if you had some tools?" We might get towards somewhere where the client knew what kind of tools to go look for, or they might realise that there are other ways to handle the situation – we just don't know. Of course, defining a common project or platform is key in all of this, in all manner of SFBT variants.

Thank you again Harry for taking all this trouble to respond to the paper. I am honoured and humbled that you felt it worth the time and energy. I hope this conversation will continue

Mark McKergow

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over many months and years to come – I value your experience, your knowledge, your commitment and your friendship.

Cheers,

Mark McKergow

Edinburgh, February 2018

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