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Journal of Solution Focused Practices

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EDITORIAL POLICY

The *Journal of Solution Focused Practices* 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 Practices*, 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, 6th 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.

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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.

ARTICLE**The Validation of Solution Building Inventory in the Turkish Population**

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Abstract

This study aims to adapt Solution Building Inventory (SBI) to Turkish and examine its psychometric properties. The study group consisted of 278 individuals (195 females and 83 males), whose age range was between 18 and 23 years old. Solution Building Inventory, Dispositional Hope Scale, and Positive and Negative Affect Scale were used as measurements. The results of the exploratory factor analysis showed the suitability of the data for factor analysis and revealed a two-factor structure explaining 49.38% of the total variance. Confirmatory factor analysis findings showed that the model had a good fit in the 11-item and two-dimensional structure of the scale. Besides, the correlation coefficients of the relationship between the SBI and other scales were expectedly provided equivalent and convergent validity. In reliability analyzes, the Cronbach alpha internal consistency coefficient of the scale was found to be .85 for the scale in general, while it was calculated as .78 for the supporting solutions sub-dimension and .85 for the creating solutions sub-dimension. As a result, SBI is a measurement tool with proven validity and reliability in Turkish.

Keywords: solution focused brief therapy, solution building inventory, validity, reliability, Turkish adaption

Introduction

Solution Focused Brief Therapy (SFBT; de Shazer et al., 1986), developed by Steve de Shazer, Insoo Kim Berg, et al. in the early 1980s, is an approach that is used effectively in many areas today. SFBT differs from other approaches by emphasizing the strengths, positive life exceptions, and the solution they build rather than focusing on individuals' problems (Arslan & Ulus, 2020; De Jong & Berg, 2013; De Shazer & Berg, 1997). This approach aims to help individuals discover and use their resources for positive changes (Grant et al., 2012). In SFBT, the relationship established between the client and the counselor is essential. The focus is on meeting positive feelings such as hope and well-being while seeking solutions to the client's problem (Kim & Franklin, 2015). Solution-focused thinking constitutes theoretical basis of SFBT, and the literature shows that SFBT makes it easier for individuals to experience positive emotions (Gingerich & Peterson, 2012).

In the problem-focused approach, the problem should be discovered to solve the problem (Grant, 2011). In other words, the essence of problem-solving is to analyze the problem and focus on the past. This approach seemed to be the only way until the postmodernist thought became effective (Haley, 1976). A postmodernist perspective suggests that excessive focus on the individual's problem may lead to overlooking solutions (Ergüner-Tekinalp & Terzi-Işık, 2013). It also suggests that solution-focused thinking can contribute to the individual in the counseling process. The idea that the solution may not be directly related to the problem lies in the logic of solution-focus thinking (De Shazer & Berg, 1997). In other words, the problem grows as it is put on the focus; on the other hand, the solution grows as the solution is

focused. This therapy adopted the approach of talking about the solution instead of the individual's problem (Arslan & Gümüşçağlayan, 2018; Murphy, 2008).

Problem-focused thinking involves the causes of the problem, whereas solution-focused thinking focuses on how the problem will end and how the change will be achieved (De Shazer & Berg, 1997; Grant et al., 2012). A solution-focused approach is a goal-oriented approach emphasizing that individuals should cope with difficulties, be resilient and experience positive change (Iveson et al., 2012). Being solution-focused in this approach addresses individuals' coping with stress and being psychologically resilient to survive (Seligman, 2002; Weiner-Davis & O'Hanlan, 2003). It can be said that a solution-oriented approach should be adopted in order to achieve the change faster and easier. Iveson (2002) states that the past is not important in solution-focused thinking; only the present and the future count. According to Murphy (2008), the assumptions of SFBF form the basis of solution-focused thinking. These assumptions are outlined in De Shazer and Berg's theory as follows (Murphy, 2008):

1. If it works, do more of it. If it does not work, do something different.
2. Every client is unique, resourceful, and capable of improving.
3. Cooperative relationships enhance solutions.
4. No problem is eternal, and change is inevitable.
5. Big problems do not always require big solutions (p. 43).

Solution-focused thinking helps individuals understand that their problems have a solution and they have their strengths. Individuals focusing on solution-focused thinking should change their perspective and directly address the solutions (Sparrer, 2012). A small step towards solution-focused thinking can bring significant results and solve big problems. Oliver and Charles (2015) emphasize that looking at problems from a different perspective will positively change many things. According to the literature, the empathy level (Şanal-Karahan et al., 2017), social communication, social skills, social support (Siyez & Tan-Tuna, 2014), life satisfaction, self-efficacy (Sarı et al., 2019), and psychological well-being (Arslan & Asici, 2021) and hope (Şanal-Karahan, 2016) of the individuals adopted a higher level of solution-focused thinking, are significantly higher. Besides, other studies in the literature show that the well-being, positive emotions, and sense of hope of the individuals adopting solution-focused thinking have higher (Grant & Spence, 2010; Kashdan & Rottenberg, 2010; Kim & Franklin, 2015; Simon et al., 2005; Theeboom et al., 2015). Theoretically, González-Suitt et al. (2016) stated that solution-focused thinking improves coping with depression and stress and positively affects psychological well-being. Individuals who adopted solution-focused thinking have increased their levels of hope and psychological well-being by acting towards goals, being practical against the problem, and focusing on the solution by eliminating the causes of their problems.

De Jong and Berg (2013) outlined three aspects that form the basis of solution-focused thinking. The first aspect is identifying the solution and finding functional techniques such as miracle questions ("what if the problem is gone"). The second is raising awareness; for example, focusing on exceptional events in an individual's life. Finally, instilling hope and courage to shape the future. In this direction, Smock et al. (2010) have developed the Solution Building Inventory (SBI) that measures these three components' effectiveness, evaluates the effectiveness of solution-focused thinking, and can be used in counseling sessions effectively. Adapting SBI to Turkish was thought to be necessary because school and mental health counselors in Turkey widely use SFBT in counseling. Accordingly, the purpose of this study is to adapt SBI (Smock et al., 2010) to Turkish and examine its validity and reliability.

Methodology

Participants

The workgroup of the study consisted of university students older than 18-year-old. The data was collected from two different randomly selected samples. The first study involving the scale's linguistic equivalence consisted of 51 participants, 38 women (74.5%) and 13 men (25.5%). In the second study, data were collected from 278 participants, 195 women (70.1%) and 83 men (29.9%), to perform confirmatory factor analysis, equivalent scale validity, and calculate Cronbach's alpha internal consistency/reliability coefficient. The age of the individuals participating in the study varied between 18 and 23 years, and the average age was 20.3 (SD = 0.9).

Instruments

Solution Building Inventory

Solution Building Inventory (SBI) has been developed by Smock et al. (2010) to determine individuals' solution-focused thinking tendencies. SBI consists of items aiming to determine the extent of individuals' solution-focused thinking. The inventory, which has 14 items, is one-dimensional and scored on a 5-point Likert scale. Each item of the inventory is scored between 1-5, where 1 = Strongly disagree and 5 = Strongly agree. Higher scores indicate individuals with higher solution-focused thinking. Cronbach's alpha internal consistency coefficient of the original inventory was .84, and this value was found to be .85 in this study. The findings were parallel to the scores of the original inventory.

Dispositional Hope Scale

Dispositional Hope Scale (DHS), which had been developed by Snyder et al. (1991) to investigate individuals' dispositional hope levels, was adapted to Turkish by Tarhan and Bacanlı (2015). The scale is two-dimensional and has 12 items. Four of these items are filling items, and they do not play a role in the scoring. The scale's overall score is calculated by combining the total scores obtained from its sub-dimensions measured on an 8-point Likert scale. Confirmatory factor analysis of the scale showed that fit indices are adequate; reliability analysis indicated that both the sub-dimensions and the whole scale are reliable. Cronbach's alpha internal consistency coefficient of the original scale had been calculated as .84, and it was .85 in the study of Demirtaş and Baytemir (2019). In this study, this value was found to be .80, which shows that the reliability value is consistent with the literature.

Positive and Negative Affect Scale (PANAS)

The positive and Negative Affect Scale (PANAS), aiming to measure individuals' positive and negative emotions, had been developed by Watson et al. (1988) and adapted to Turkish by Gençöz (2000). There are 20 items, involving ten positive and ten negative emotions. These two sub-dimensions are independent of each other, and they can also be used as separate scales. The scale is scored on a 7-point Likert scale. Cronbach's alpha internal consistency value was found to be acceptable in the fit indices and reliability analysis of the scale. Watson et al. (1988) calculated the positive and negative affects' internal consistency of the scale as .83 and .86, respectively. In this study, these values were .81 and .83 for positive and negative affects, similar to the original scale.

Process

The study's ethics committee approval was granted by the Scientific Research and Publication Ethics Committee of Izmir Democracy University (Board Approval No: 2020 / 12-03). No additional permission was needed for the translation process because Dr. Sara Smock Jordan, one of the SBI developers, is also an author of this study. Data were collected in 2020 using online forms. Before starting the study, the participants were informed about participant rights, volunteerism, and confidentiality. Data were collected upon getting informed consent from the participant, and the duration was usually 10-15 minutes.

Translation Process

The back-translation method suggested by Brislin (1970) was used in the translation of the SBI. The experts who perform the translation process should know the population well and be well-versed in the study's subject (Tran, 2009). Two translation committee were formed to carry out the back-translation process; it consisted of seven English Language Teachers and three counselor educators with doctoral degrees proficient in English. Four English language teachers, two counselor educators in translation committee translated SBI into Turkish. During the translation, attention was paid to reflect the cultural characteristics of the people living in Turkey and the solution-focused thinking. Second, the resulting Turkish form was translated back into English by the translation committee's remaining members (three English language teachers and one counselor educator). Third, the back-translation was sent to one of the original authors (Dr.

Sara Smock Jordan) to check whether the translation reflects the original scale. Dr. Sara Smock Jordan confirmed that there is no difference between the meanings of the items. Fourth, the scale's linguistic equivalence study was conducted with 51 third-grade English language teaching students whose English and Turkish levels are good within a three-week interval. They first filled the form's English version and then the Turkish version. The linguistic equivalence of the scale was deemed appropriate regarding the participants' answers ($r = .82$).

Data Analysis

Before performing data analysis, a preliminary preparation was performed. First, erroneous/incomplete coding in the data and the participants with blank answers were checked using the frequency table. No missing data was found. Before analyzing the data, normality, which is a prerequisite, was tested. The one-way normality assumption test showed that kurtosis values were between -0.15 and -1.07 , and the skewness values were between 1.190 and -0.936 . The values in the $(-2; +2)$ range indicate normal distribution (George & Mallery, 2010). The Scatter plot matrix was used to test the multivariate normality assumption. The distribution was in the form of an ellipse, and it was concluded that the normality assumption was met.

DeVellis (2014) underlined that even for the measurement tools having a theoretical basis, it is necessary to perform validity and reliability analyzes in adaptation studies conducted in different cultures. Accordingly, the scale's construct validity was examined by exploratory factor analysis and confirmatory factor analysis. Apart from this, the scale's relationship with the Dispositional Hope Scale and Positive and Negative Affect Scale, whose validity and reliability studies had been already performed, was examined with Pearson correlation analysis. Finally, the Cronbach's alpha internal consistency coefficient was calculated for the reliability of the scale. SPSS and MPlus statistics programs were used in data analysis, and the significance level was taken as $p < .05$.

Results

Structure Validity

A factor analysis was conducted to adapt the potential items of the scale to Turkish culture. Principal components analysis was used to measure the construct validity of the scale. Regarding the results, factor loads of SFI's three items (Item A [I am able to focus on times when my situation is not so overwhelming, even a little bit.] = $.13$, Item B [If I woke up tomorrow and a miracle happened in my life I would be able to notice differences in myself and others.] = $.23$, and Item C [Dwelling on my problems may not be the best way to find solutions] = $.14$) were found low. Researchers discussed removing these items, whose factor loads were below $.32$ (Büyüköztürk, 2002). After further investigations, it was found that: (a) Item A referred to an exception question, and it can be removed because Item 4 is also an exception question, (b) Item B referred to a miracle question, and this item can be removed because it is difficult to understand in Turkish culture and some other cultures (reference), and (c) Item C was coded in reverse; thus participants might not understand it properly, so this item was also decided to be removed. Consequently, these three items were not included in the Turkish version of the SBI.

In the exploratory factor analysis, the criterion of eigenvalues greater than one was considered, and the items were found to be grouped in two sub-dimensions. They were named "Creating Solutions" and "Supporting Solutions." The scale items create solutions for existing problems (e.g., Item 1: I can generate solutions); or develop solutions regarding positive experiences in the past (e.g., Item 3: I can think about things that have made a positive difference for me). Dividing SFI into two dimensions was found to be compatible with Turkish culture and solution-focused thinking principles. Similarly, Şensoy and Siyez (2018) adapted a one-factor career distress scale addressing cultural expectations by dividing it into two sub-dimensions. In this context, the eigenvalues of the sub-dimensions were estimated as 4.38 and 1.05 . The sub-dimensions explained 39.81% and 9.57% of the total variance, and they cumulatively explained 49.38% of the total variance. The next step was confirmatory factor analysis, in which fit indices between the data and the model were examined. These fit indices must be in line with the acceptable or perfect fit values specified in the literature. Analysis results are shown in Table 2.

The result of the confirmatory factor analysis shows that the fit between the model and the data is inadequate ($\chi^2 = 114.46$, $p = .000$, $sd = 43$, $\chi^2 / df = 2.66$, $CFI = .91$, $TLI = .89$, $SRMR = .05$, $RMSEA = .08$). The modifications that can be performed to bring the fit indices to an adequate level were reviewed. Accordingly, the most appropriate modifications were performed, and item error covariances were associated. In the literature, Çapık (2014) mentioned the modifications made to strengthen the model; in many studies, it was stated that the modifications should be compatible with the theoretical infrastructure (Çokluk et al., 2014; Diamantopoulos et al., 2000). Accordingly,

confirmatory factor analysis was repeated after creating a correlation between items 4 and 8. The resulting fit between the data and the model was adequate. ($\chi^2 = 100.19$, $p = .000$, $sd = 42$, $\chi^2 / sd = 2.39$, $CFI = .93$, $TLI = .91$, $SRMR = .05$, $RMSEA = .07$). These findings show that the fit index criteria specified in the literature were met (Keith, 2019; Şimşek, 2007; Tabachnick & Fidell, 2012). Standardized item estimation values of the scale's structural model are given in Figure 1.

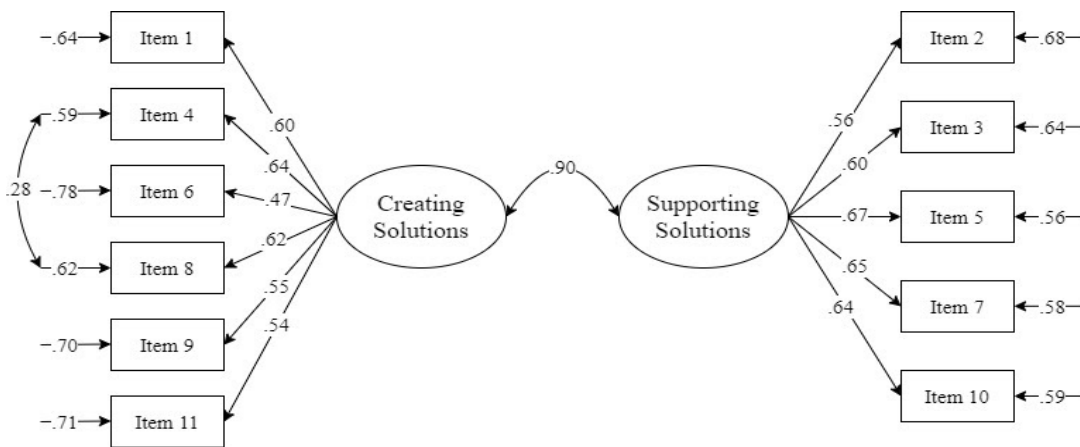
Table 2

Fit values obtained from confirmatory factor analysis

Structural Models	χ^2	sd	χ^2/sd	CFI	TLI	SRMR	RMSEA
Model 1	114.456	43	2.66	.91	.89	.05	.08
First Level							
Model 2	100.187	42	2.39	.93	.91	.05	.07
First Level Clause 4 and 8 errors							
Associated							

Figure 1

Confirmatory Factor Analysis for Solution Building Inventory



Regarding Figure 1, the items in both sub-dimensions of the SBI are significant in parameter estimation ($p < .05$). Item estimate values of 11 items of the scale are between .47 and .67. After correlating the error covariances of Items 4 and 8, the resulting correlation coefficient became .28.

Equivalent and Convergent Scale Validity

The equivalent scale validity of SBI was tested with scales whose validity and reliability had been proven in the literature. In this context, Dispositional Hope Scale and Positive Affect Scale (PANAS-P) were used as similar scales, and Negative Affect Scale (PANAS-N) was used as a convergent scale. First, the total scores were computed, and the normality assumption was tested. Kurtosis and skewness coefficients of the scales were between (-1;+1), and the data showed a normal distribution. Then, the relationships between these scales and SFI were analyzed by Pearson Product-Moment correlation. Findings are given in Table 3.

Table 3

Mean, Standard Deviation and Correlation Coefficients for Equivalent Scale Validity

	Mean	SD	SBI	SBI-CS	SBI-SS
SBI	42.30	6.97	-	.955*	.910*
SBI-CS	22.47	3.96	-	-	.748*
SBI-SS	19.84	2.82	-	-	-
DHS	47.78	7.67	.745*	.716*	.672*
PANAS-P	15.66	1.29	.191**	.168**	.193*
PANAS-N	14.39	1.39	-.376*	-.323*	-.393*

Note. SBI: Solution Building Inventory, SBI-CS: Solution Building Inventory-Creating Solutions, SBI-SS: Solution Building Inventory-Supporting Solutions, DHS: Dispositional Hope Scale, PANAS-P: Positive Affect Schedule; PANAS-N: Negative Affect Schedule, * $p < .001$, ** $p < .01$.

Regarding Table 5, the correlations of the overall SBI score and its sub-dimensions, SBI-CS and SBI-SS, with other scales are as expected. A positive and significant correlation was found between overall-SBI, SBI-CS, SBI-SS, and DHS and PANAS-P, whereas a negative and significant correlation was observed between them and PANAS-N. Besides, the correlations between SBI and its sub-dimensions were found to be significant and positive.

Reliability

SBI's reliability was derived from the Cronbach's alpha internal consistency coefficients, calculated from the data obtained from 278 participants and found to be .85 for the overall scale, .78 for the supporting solution, and .85 for the creating solution sub-dimensions. According to the literature, Cronbach's alpha values above .60 indicates sufficient reliability (Karagöz, 2017). Accordingly, it was concluded that the Turkish version of the SBI is reliable.

Discussion

This study aims to adapt Solution Building Inventory (SBI) to Turkish and examine its psychometric properties. For this purpose, the linguistic equivalence, construct validity, equivalent and convergent scale validity, and internal consistency of the inventory were computed. The exploratory factor analysis results showed that the factor loads of three items were lower than .32. According to the literature, the items below this value should be removed (Büyükoztürk, 2002). Besides, each of these three items has its specific reason to be removed from the inventory: being similar, not fitting Turkish culture, and intelligibility problems. The inventory's remaining items were grouped under two sub-factors and named "Creating Solutions" and "Supporting Solutions."

The researchers decided that the items of the creating solutions sub-dimension involve generating a solution in the face of a problem, whereas the items of the supporting solutions sub-dimension involve directing the existing situation to the better. This perspective also got the support of the original authors. Items grouped under these two factors explained 49.38% of the total variance. Afterward, confirmatory factor analysis was performed. Confirmatory factor analysis is a frequently used method in scale adaptation studies (Jackson et al., 2009) and examines the model's compatibility with the data (Graham et al., 2003). The analysis revealed that the fit indices were inadequate, and a modification was carried out. The findings obtained after the modification showed a good fit between the model and the data. This finding is consistent with the original form of the scale developed by Smock et al. (2010).

Regarding equivalent and convergent criterion validity, the following significant relationships were revealed: a positive, strong relationship with DHS, a moderate positive relationship with PANAS-P, and a moderate negative relationship with PANAS-N. These findings are consistent with the findings of Smock et al. (2010). Moreover, other studies proved that individuals with a high level of solution-focused thinking have high levels of hope and positive well-being (Kashdan & Rottenberg, 2010; Theeboom et al., 2015). In our study, there is no finding contradicting with the literature. Based on all these findings, it can be said that SFI's equivalent and convergent reliability was proven. Regarding the reliability analysis of the scale, Cronbach's alpha internal consistency coefficient was .89, which indicates that the scale is reliable (Karagöz, 2017). Besides, this finding is in line with the original study's reliability result (Smock et al., 2010).

It is concluded that SBI meets the needs of school counselors and other mental health professionals. Using this scale in the counseling process will permit to measure clients' solution-focused thinking and explain this thinking skill to them; thus, focusing on the solution rather than the problem could be ensured (Gündoğdu, 2020). This scale's main purpose is not trivializing the problem but developing solution-focused thinking (De Jong & Berg, 2013). It is believed that the acquisition of solution-focused thinking skills will bring a difference in the clients' lives.

Limitations and Recommendations

This study's limitation is that the number of female participants in the workgroup was higher than that of male participants. For future studies, it is recommended to perform the scale's validity and reliability analyses in different samples. The relationship between the concept of solution-focused thinking and other psychological and social factors should also be investigated. As a result, despite the limitations, it can be said that the SFI (Appendix) is a short, valid, and reliable measurement tool to measure solution-focused thinking in the Turkish population.

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Appendix

Solution Building Inventory-Turkish Version (Çözüm Odaklı Düşünme Ölçeği)

Aşağıdaki maddeler için, lütfen kesinlikle katılıyorum, katılıyorum, kararsızım, katılmıyorum veya kesinlikle katılmıyorum şeklinde yanıt veriniz.

5 = Kesinlikle katılıyorum

4 = Katılıyorum

3 = Kararsızım

2 = Katılmıyorum

1 = Kesinlikle katılmıyorum

MADDELER					
1. Hayatımdaki problemler için çözümler üretebiliyorum.	5	4	3	2	1
2. Çözüm üretebildiğim şeylere odaklanma yeteneğine sahibim.	5	4	3	2	1
3. Beni olumlu etkileyen şeyler hakkında fikir yürütebilirim.	5	4	3	2	1
4. Hayatımda zorluklarla iyi başa çıkabildiğim zamanlar vardır.	5	4	3	2	1
5. Kendimde ve etrafımda olan iyi şeyleri fark edebiliyorum.	5	4	3	2	1
6. Hayatın zorluklarıyla başa çıkabiliyorum.	5	4	3	2	1
7. Yaptığım küçük olumlu değişikliklerin farkındayım.	5	4	3	2	1
8. Zor durumlarla nasıl başa çıkabildiğimle ilgili, kendimle gerçekten gurur duyduğum anlar vardır.	5	4	3	2	1
9. Geçmişteki zorlukların başarıyla üstesinden geldim.	5	4	3	2	1
10. Yaşamımı geliştirmeye yönelik adımlar atıyorum.	5	4	3	2	1
11. İçinde bulunduğum durumun bazı kısımları içinden çıkılmaz gibi görünse de durumumda ki iyi şeyleri görebilirim.	5	4	3	2	1

ARTICLE**Solution-Focused Chronic Pain Self-Management Education:
A Pilot Study**

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Abstract

Roughly one out of every three adults in the U.S. today has chronic pain. For this reason, the U.S. government recently issued a National Pain Strategy that advocates, among other things, the education of patients in proactive self-management techniques. To evaluate the efficacy of Solution-Focused Chronic Pain Management (SFCPM)—a new outpatient psychoeducational program based on Solution-Focused Brief Therapy (SFBT)—a pilot study was conducted in Longmont, Colorado. Five self-report assessments were administered. Due to the small sample size ($n = 12$), only percent changes from baseline to follow-up were calculated. Improvements were noted in quality of life (41.4%), pain self-efficacy (22%), hope (16%), mental well-being (9.3%), and problem disengagement (12.3%). Initial results suggest that more rigorous investigation may be warranted. The solution-focused model offers a personalized, empowering alternative to more problem-focused approaches. Instead of fixating on what's wrong, participants focus on what's right with their bodies, minds, and lives—despite chronic pain.

Keywords: chronic pain, biopsychosocial, solution-focused, psychoeducation, self-management

Introduction

According to the Institute of Medicine, chronic pain afflicts roughly 100 million Americans (Institute of Medicine, 2011), or one out of every three adults in the U.S. today. Pain is typically considered chronic if it lasts longer than three to six months, the expected time for normal healing (Mersky & Bogduk, 1994). The longer pain persists, the more it dominates a person's life and consciousness. Not only does it undermine physical functioning, but also emotional, social, and (often) economic well-being (Foreman, 2014).

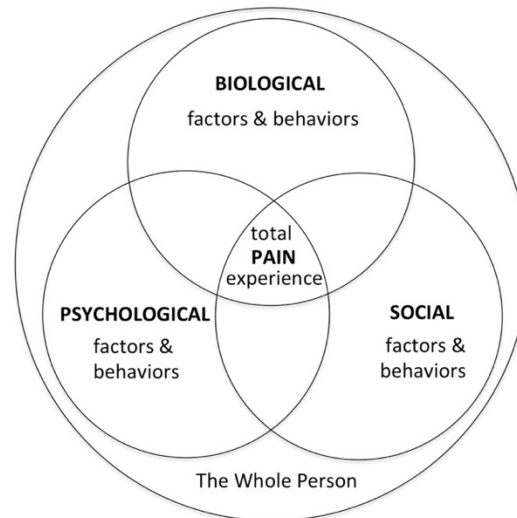
The extent of this suffering is reflected in the medical community's growing awareness that chronic pain treatment requires more holistic, "biopsychosocial" approaches (Gatchel et al., 2014; Moseley & Butler, 2015a; U.S. Department of Health & Human Services [HHS], 2016). Why? Because, according to modern pain science research, unlike acute pain, chronic pain never has just one cause (Moseley & Butler, 2015b). It is, in fact, a highly complex phenomenon with myriad causes and components. Pain is never simply a physiological problem. Biological, psychological, social, interpersonal, financial, even existential factors can and do both exacerbate and alleviate pain. The most effective solutions, therefore, must be multi-modal or *interdisciplinary*. They must transcend mere medication and even medical treatment by taking into account a broader range of biopsychosocial factors and behaviors (see Figure 1). The ultimate goal is to treat the whole person.

Supporting this growing awareness, the U.S. government recently issued its first-ever National Pain Strategy (HHS, 2016). This new patient-centered strategy seeks to tackle the epidemic of chronic pain—considered by some a disease in itself—by proposing, among other things, the adoption of interdisciplinary or biopsychosocial models of health care. Interdisciplinary care typically *integrates* some form of biological treatment (such as exercise or physical therapy and, typically, medication) with psychological treatment (such as meditation or psychotherapy), often in socially supportive group settings involving multiple health care providers and other patients or participants, even family members or friends. Finally, these biopsychosocial programs aim to educate patients in proactive *self-management* techniques.

The primary purpose of pain self-management is not so much to eliminate pain, but rather to cultivate an individual's capacity to live the best life he or she can, even if the pain never goes away (Simm et al., 2014; LeFort et al., 2015).

Self-management approaches focus on what people suffering from chronic pain can do for themselves (De Silva, 2011)—between doctor’s visits. In this regard, any form of self-management is complementary, not alternative, to conventional medical care.

Figure 1



Note. The biopsychosocial model of pain takes into account the influence of psychological (mental, emotional, existential) and social (interpersonal, economic, cultural) factors and behaviors, as well as biological causes and symptoms. Biopsychosocial care seeks to treat the whole person, not just the body.

Pain Self-Management Programs

In North America, several psychoeducational training courses in pain self-management have emerged in recent decades, alongside purely medical interventions. These include the Chronic Pain Self-Management Program (CPSMP) developed by Stanford University (LeFort et al., 1998), the Mindfulness-Based Stress Reduction (MBSR) course developed at the University of Massachusetts Medical School (Kabat-Zinn, 1990), and an enhanced Mindfulness-Based Chronic Pain Management (MBCPM) program developed at a hospital in Ontario, Canada (Gardner-Nix & Costin-Hall, 2009). Almost 15 years ago, the UK National Health Service (NHS) began developing its own pain management programs, based on well-known psychological interventions such as cognitive behavioral therapy (CBT) and acceptance and commitment therapy (ACT) (Simm et al., 2014). The UK Department of Health had published a new “Expert Patient” vision for the 21st century. It advocated the propagation of more patient-centered self-management programs in the NHS that would take into account the “knowledge and experience held by patients, which has been for too long an *untapped resource*” (UK Department of Health, 2001, p. 5). The U.S. National Pain Strategy echoes this approach.

However, few existing psychoeducational self-management programs actually treat patients suffering from chronic pain as “experts” in their own right. Instead, they are often seen as vessels needing to be filled by specialists—medical, mental health, and meditation experts—who believe *they* know what people ought to do, to think, or to learn. As a result, most programs focus on dispensing expert advice and teaching skills, information, and knowledge they feel patients currently *lack*. Such approaches represent largely deficit-based models of change, akin to the standard medical model (Simm et al., 2014).

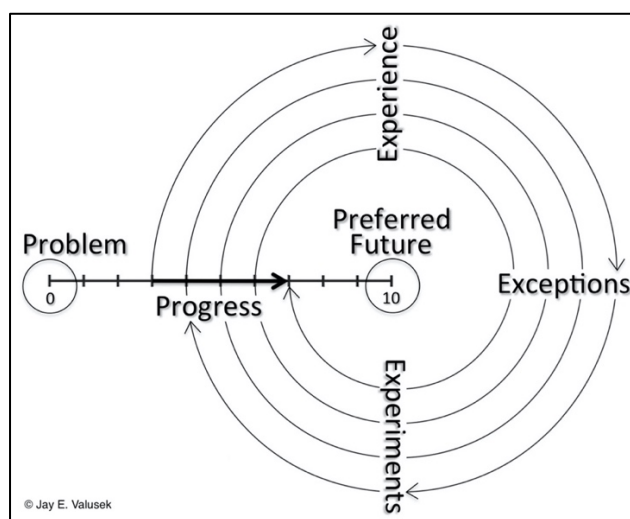
As an alternative, clinicians in the UK National Health Service decided to evaluate a significantly different approach to pain self-management—one that takes seriously the patient’s hard-won wisdom, existing resources, and implicit competence (Simm et al., 2014; Dargan et al., 2014). They developed a pioneering “solution-focused” pain management program, based primarily on the principles and practices of Solution-Focused Brief Therapy (SFBT).

SFBT is an evidence-based model of change developed in the 1980s by Steve de Shazer, Insoo Kim Berg and associates at the Brief Family Therapy Center in Milwaukee, Wisconsin (Franklin et al., 2012). Partly due to its simplicity and

applicability to a wide range of presenting problems (De Jong & Berg, 2008), solution-focused tools and techniques have spread beyond counseling and psychotherapy into other fields, including business coaching (Berg & Szabo, 2005; Szabo & Meier, 2009; Iveson et al., 2012), management and organizational consulting (Jackson & McKergow, 2007), education (Ajmal, 2018) and, more recently, health care (Franklin et al., 2012; Carr et al., 2014; Burns, 2016; Zhang et al., 2018). The term “solution-focused” is meant to distinguish this approach from traditional “problem-focused” and expert-driven models that continue to dominate psychology, medicine, and business.

Instead of teaching patients what the “experts” believe they should know or do, the solution-focused approach to pain self-management enables patients—through a dynamic, iterative process—to discover (with expert assistance) their own, often quite unique solutions to the complex biopsychosocial challenges of living with chronic pain (see Figure 2). It represents, therefore, a strengths-based model of change.

Figure 2



Note. The solution-focused change model shifts attention from the problem (in this case, chronic pain and its complex biopsychosocial impact), and places the patient’s “preferred future” at the center of a dynamic, iterative process. By exploring life experiences (past) and exceptions to the problem (present), session by session, people begin to recall, discover, or simply notice uniquely effective solutions of their own. By brainstorming new ideas, conducting experiments, and taking small steps day by day, they make incremental progress toward a future worth living for, despite chronic pain.

An initial outcome evaluation of this innovative new approach to pain self-management in the UK (Simm et al., 2014)—the first psychoeducational program of its kind in the world—included 85 patients from 28 to 83 years of age who were diagnosed with a variety of chronic pain conditions. From pre-test to post-test, participants in this eight-week program experienced a 22% average increase in mental and emotional well-being, and a 47% increase in pain self-efficacy or belief in one’s ability to live, work, and function effectively despite the presence of chronic pain. The NHS program was a true interdisciplinary service facilitated by physicians, psychologists, physical and occupational therapists, requiring more than 125 clinician hours per course and costing approximately \$500 per patient (Simm & Barker, 2018).

Unfortunately, the UK program’s design and contents are proprietary to the National Health Service (R. Simm, personal communication, January 29, 2016). Therefore, the only way to offer a similar solution-focused program would be, in effect, to reinvent the wheel based on the same underlying SFBT model. After corresponding with the lead psychologist for the UK program, and searching the literature for research and applications of SFBT to chronic pain (Cockburn et al., 1997; Berg & Dolan, 2001; Johnson & Webster, 2002; Nichols et al., 2011; Carr et al., 2014; Franklin et al., 2012; Simm et al., 2014; Dargan et al., 2014; Bray et al., 2015), that is exactly what the present author did to design the five-week pilot study described herein. This is the first specifically solution-focused adult education and training program for chronic pain self-management in North America.

Objectives of the Study

The purpose of the study was to pilot test a new outpatient psychoeducational program called Solution-Focused Chronic Pain Management (SFCPM), aimed at empowering adults to enhance the overall quality of their lives—physiologically, psychologically, and socially—despite chronic pain. As noted above, unlike medical pain management approaches, the goal was not necessarily to reduce the severity, frequency, or duration of actual pain sensations (although the door to that possibility was left open).

Because the program design was new and attempted to integrate the solution-focused model of change with the biopsychosocial model of pain, the overall intent of the study was simply to gather preliminary quantitative data on its efficacy, to demonstrate proof of concept. Five measurable objectives were identified: (1) to improve quality of life, as noted above, (2) to increase mental and emotional well-being, (3) to enhance hope for the future, (4) to improve pain self-efficacy, and (5) to shift participants' focus away from what's *wrong* (“problem-focused thinking”) toward what's *right* with their bodies, minds and lives (“solution-focused thinking”).

The hypothesis going into this pilot study was that participants would begin to experience at least small improvements in each of these areas within five weeks. The hope was that they would gain sufficient momentum during that time to sustain the journey toward greater biopsychosocial well-being over the longer term.

Methods

Design of the Study

A pretest-posttest design was used to quantify outcomes of the five-week program. At the beginning of session one, five baseline self-report measures were administered. Post-intervention measures were collected at the end of session five. Also at the end, participants wrote anonymous answers to two open-ended evaluation questions: (1) What did you find most helpful or beneficial about this program? and (2) What did you find most difficult or challenging about this program? There was no control group.

Other pain self-management courses tend to meet weekly for six or eight or up to 13 weeks, for up to three hours per session. That amount of time and energy seemed like a rather heavy commitment for people wrestling with chronic pain. Therefore, the SFCPM pilot program met for only five weeks, two hours per session, except for the first session, which lasted 2.5 hours.

Session topics and activities included brief presentations of the solution-focused model of change and the biopsychosocial model of pain and well-being, questions for reflection and discussion, written exercises, goal setting, action planning, and homework review. Unlike the model UK program, no *physical* exercises were part of the SFCPM pilot study, except for what participants chose to do outside of class. In addition, no “expert” advice of any kind was given. This differed from the UK program in that a *certain amount* of expert advice was offered there, although mostly “by invitation” (Simm et al., 2014, p. 52).

In keeping with the solution-focused methodology, SFCPM training was more *conversational than informational*. It focused on drawing out participants' inherent expertise through a proven series of “deceptively simple” (Grant et al., 2012, p. 334) questions (Bannik, 2006). The following core components of SFBT (Franklin et al., 2012; Pichot & Dolan, 2003) were part of the program design:

- *Minimal Problem Talk*. Maintaining a dominant focus on “what's right” (e.g. “What helps, what's working, what's better?”) rather than complaining about or diagnosing “what's wrong.”
- *Exceptions*. Searching for “exceptions” to the problems of living with chronic pain, i.e. times when physical, psychological, or social challenges are absent or even a little bit less severe.
- *Preferred Future*. Using the “miracle” question (i.e. “If a miracle happened, what would you be doing differently?”), and other future-oriented questions aimed at envisioning a “preferred future” worth striving for, a time when chronic pain would no longer undermine one's quality of life.

- *Difference and Relationship Questions.* Asking “difference” questions (e.g. “What positive difference would it make to do or to change X?”) and “relationship” questions (e.g. “Who else is involved with your pain? How? And what would they see you doing differently?”) to expand initial responses and perspectives.
- *Existing Expertise.* Identifying potential “solutions”—existing but overlooked, underappreciated, or forgotten self-management skills, knowledge, strategies and coping mechanisms (e.g. “What do you already know? What works, even a little bit?”).
- *Goals and Small Steps.* Setting small-scale goals, brainstorming experiments (e.g. “If what you’re doing clearly is not working, what could you do differently?”), self-assigning homework tasks, and taking small steps.
- *Scales.* Using 0-10 scales (where 0 = worst and 10 = best) to evaluate progress toward goals and preferred futures.
- *Compliments.* Noticing, reflecting back, and “complimenting” participants’ on apparent strengths, resources, and existing competence.

Pilot Study Participants

Pilot study participants were recruited through flyers posted in public places, mailings to health care professionals, a press release in the local newspaper, and referrals from staff at Longmont United Hospital. No random sampling was involved. Thirteen individuals signed up for the five-week program, and one dropped out at session three, so data are reported below only for those who finished (n = 12).

There were nine women (75%) and three men (25%), ranging in age from 41 to 73, with a mean of 59 years. Seven participants (58%) were still employed, full-time or part-time, while five (42%) were retired, unemployed, or receiving disability benefits from the government. Occupations included: acupuncturist, electrical engineer, part-time temp worker, physical therapist, retired dog groomer, retired nurse, sales support, teacher, and upholsterer.

Duration of chronic pain ranged from approximately two years to more than 25, with a mean of approximately 11 years. Types of chronic conditions included: arthritis, chronic fatigue, compression fractures, fibromyalgia, general musculoskeletal pain, high blood pressure, Lyme disease, lymphedema, myeloma, migraines, neuropathies (peripheral and unspecified), obesity, post-mastectomy pain syndrome, ruptured disks, scoliosis, and viral infection. Participants experienced chronic pain in the head, sinuses, neck, shoulders, upper and lower back, spine, chest wall, stomach, abdomen, pelvis, hips, hands, knees, legs, and “all over.”

Outcome Measures

Five pre-post self-report instruments were administered to measure outcomes of the five-week program. In keeping with the solution-focused model—which purposely steers attention away from what’s wrong (the problem)—no attempt was made to measure pain itself on a conventional 0-10 scale. Some studies suggest that a repeated focus on pain sensations may cause patients more harm than good (Bray et al., 2015), possibly because whatever one measures inevitably comes to dominate one’s awareness. Each of the outcome measures selected for this study was chosen for its overall “fit” with the solution-focused approach, which is more concerned with the cultivation of well-being than the reduction of negative symptoms (Simm et al., 2014). In addition, each instrument was chosen based on evidence of testing to ensure sufficient reliability and validity. Participants completed the following assessments:

1. *Quality of Life Uniscale* (Sloan, 2005) is a single-item scale from 0-10 (identical, in fact, to a conventional pain scale, but with 10 representing “as good as it can be”), which measures an individual’s overall (or average) quality of life during the past week. Solution-focused practitioners have been using similar 0-10 scales for decades. This particular uniscale emerged from numerous research studies with oncology patients (Frost & Sloan, 2002; Qi et al., 2009), indicating shorter assessments were as effective as longer, multiple-item questionnaires in detecting clinically significant changes in quality of life. Since the primary objective of chronic pain self-management is, in fact, improvement in quality of life, this scale may be considered a solution-focused alternative to the traditional problem-focused pain scale.
2. *Pain Self-Efficacy Questionnaire (PSEQ)* (Nicholas, 2007), is a 10-item assessment consisting of 0-6 Likert scales, which measure a participant’s belief in his or her ability to perform ordinary tasks and engage in positive activities, despite the presence of pain. This instrument was chosen because it was one of the tools used in the

- UK solution-focused pain management program (Simm et al., 2014), which inspired this five-week pilot study. Examples of questions include: “I can enjoy things, despite the pain,” “I can do most household tasks (cleaning, dishes, laundry, etc.), despite the pain,” and “I can do some form of work (paid or unpaid), despite the pain.”
3. *Warwick-Edinburgh Mental Well-Being Scale (WEBWBS)* (Tennant et al., 2007) is a 14-item assessment consisting of 1-5 Likert scales, which measure subjective mental and emotional well-being through positively worded statements. This tool was also chosen because it was used in the UK solution-focused pain management program, and because users in the NHS indicated they preferred this positive outcome measure over conventional tools (Simm et al., 2014) that focus on negative moods and emotions, such as depression or anxiety. Examples of questions include: “I’ve been feeling relaxed,” “I’ve been thinking clearly,” and “I’ve been interested in new things.”
 4. *State Hope Scale* (Snyder et al., 1996) is a 6-item assessment consisting of 1-8 Likert scales, which measure a participant’s orientation toward the future, or goal-directed thinking, at a particular moment in time. It has two subscales, and a score for total hope. One subscale measures “agency” thinking, which means an individual believes he or she is capable of having at least some influence over future outcomes. The other subscale measures “pathways” thinking, which means an individual can generate alternative routes toward a goal, especially when faced with obstacles or setbacks. The ability to detect an increase in hope is critical for people suffering from chronic pain, or they may lack sufficient motivation for the hard work of behavioral change.
 5. *Solution-Focused Inventory* (Grant et al., 2012), is a 12-item assessment consisting of 1-6 Likert scales intended to track changes in solution-focused (as opposed to problem-focused) thinking while participants engage in a goal-oriented coaching or therapeutic training program. It has three subscales: problem disengagement (PD), goal orientation (GO), and resource activation (RA). PD refers to the ability to avoid becoming enmeshed in negative thinking and ruminating on problems. GO refers to the ability to clearly envision goals, create action plans to achieve them, and monitor progress. RA refers to awareness and application of one’s own strengths and resources.

Results

Due primarily to the small sample size ($n = 12$), as well as lack of access to or expertise in SPSS and similar software, no statistical analyses were performed on the outcome data. Only percent changes from baseline to follow-up were calculated. Therefore, the quantitative data presented here are largely suggestive.

Table 1 provides the mean values and percent changes from pre-test to post-test over the SFCPM pilot study period of five weeks. Positive changes were found in quality of life, pain self-efficacy, mental well-being, hope (agency, pathways, and total score), and the problem disengagement (PD) subscale of solution-focused thinking. Negative changes were found in the goal orientation and resource activation subscales, as well as the total score for solution-focused thinking.

Discussion

The pilot study was intended as a preliminary evaluation of the efficacy of a new psychoeducational training program in chronic pain self-management based on Solution-Focused Brief Therapy and the emerging biopsychosocial model of pain and well-being. Although the sample size was not large enough to determine statistical significance, a few observations may be in order. Based on percent changes and written feedback from participants (anonymous comments from the end of session five), all five of the initial pilot study objectives were met, at least in principle.

Quality of Life

On a uniscale from 0 to 10 (where 10 meant “as good as it can be” and 0 “as bad as it can be”), participants’ pre-test responses ranged from a low of 1 to a high of 7, with a mean of 4.42. Post-test responses ranged from a low of 3 to a high of 9, with a mean of 6.25. This represented an average 41.4% improvement in quality of life, despite the presence and persistence of pain. Participant feedback supported this observation:

- “I feel a little bit more like my old self before the rug of life was yanked out from under me.”
- “I found this a positive new methodology for working on my own pain management.”
- “It helped to learn that I am already surprisingly good at managing my life despite chronic pain.”

Table 1

Mean changes in quality of life, pain self-efficacy, mental well-being, hope, and solution-focused thinking from pre-test to post-test five weeks later (n = 12).

Outcome Measure	Pre-SFCPM	Post-SFCPM	% change
Quality of Life	4.42	6.25	+ 41.4
Pain Self-Efficacy	31.3	38.2	+ 22.0
Mental Well-Being	44.3	48.4	+ 9.3
Hope (<i>agency</i>)	13.8	17.2	+ 24.6
Hope (<i>pathways</i>)	16.8	18.4	+ 9.5
Hope (<i>total</i>)	30.7	35.6	+ 16.0
SF* Thinking (<i>PD</i>)*	13.8	15.5	+ 12.3
SF Thinking (<i>GO</i>)*	17.3	15.3	- 11.6
SF Thinking (<i>RA</i>)*	18.3	17.8	- 2.7
SF Thinking (<i>total</i>)	50.0	48.7	- 2.6

Note. SF = solution-focused, PD = problem disengagement, GO = goal orientation, RA = resource activation.

Pain Self-Efficacy

Participants' perceived ability to live, work, and function well despite chronic pain improved an average 22% from pre-test to post-test. Recall that these improvements came not from expert advice or medical treatment, but from participants' application of the solution-focused process to their own experience and experiments. Participant feedback also reinforced this observation:

- “Learning to notice ‘exceptions’—times when there is no pain or less pain—and focusing on what I’m doing at those times was beneficial.”
- “I’m learning there are small steps I can take, things I can do to change my life. So I feel like I have more control.”
- “I have a new set of tools that I can use to manage my pain, and a brand-new outlook on my life.”

Mental and Emotional Well-Being

Despite suffering from chronic pain for many years, with all of its attendant moods and emotions, participants' mental and emotional well-being scores improved a mean of 9.3% from pre-test to post-test. This increase may appear modest, but given the range of psychological issues participants brought to the program—including grief, anger, disappointment, anxiety, fear, depression, guilt, regret, shame, low self-esteem, hopelessness, and meaninglessness—it may represent a promising shift in the right direction. Comments included:

- “One of the biggest things I’m learning is patience. Psychologically, it took years to get to where I’m at, so it’s not going to be solved overnight or even in a few weeks or months.”
- “I came to the realization that change is good, acceptance is good, and enjoying the moment is good.”
- “When I came here five weeks ago, I was so depressed. It felt like I had lost control. Now I feel I can whip any problem the world throws at me. I’m back on my feet. I’ve reclaimed my life.”

Hope: Agency and Pathways

While both subscales of the State Hope Scale (Snyder et al., 1996) showed positive improvements from pre-test to post-test, agency—the belief in one’s capacity to have at least some influence over the future—increased the most: an average of 24.6%. Like pain self-efficacy, this represents an internal shift in belief about oneself despite the ongoing presence of pain, obstacles or set-backs. Hope is essential to the motivation needed to persist on what may prove to be a long, difficult journey to greater health and well-being. Participant comments included:

- “There was a single moment the first week when I actually noticed I was not in pain. That was eye-opening. Maybe it was happening before, but I just didn’t notice. I’m feeling hopeful now—and it’s all from that one moment.”
- “I enjoyed looking for my preferred future.”
- “This process will allow me to find and remember the things that work, and apply them as a lifestyle change—not just next week, or next month, but forever.”

Solution-Focused Thinking

Pre-test to post-test changes on the Solution-Focused Inventory (Grant et al., 2012) showed a mean increase on one subscale and decreases on the other two. Goal Orientation (GO) declined an average 11.6% and Resource Activation (RA) dipped 2.7%. Why? One can only speculate. However, several factors may have been at work. For one thing, some participants may have realized they were doing just fine in the here and now. Others clearly struggled to imagine or define personal goals and “preferred futures.” People who suffer from chronic pain for a long time (in this case, an average of 11 years) often focus less on the future than simply “getting by” day to day. Without a compelling vision of the future in mind, however, it can prove daunting to generate concrete action plans, rally one’s seemingly meager resources, and monitor incremental progress week by week—all aspects of GO and RA. Another factor may have been the brevity of the program, which was, admittedly, shorter than other pain self-management courses. Participant feedback supported these observations:

- “It was challenging for me to set goals and identify small steps toward them.”
- “The course was too short to really see change. Two weeks on each of the three [biopsychosocial] areas might be better.”

Meanwhile, scores on the Problem Disengagement (PD) subscale improved 12.3%. This suggests that, over the course of the five-week program, participants actually began to switch their dominant focus from ruminating on “what’s wrong” (pain and problems) to discovering and noticing “what’s right” (exceptions and solutions)—which was, in fact, one of this study’s objectives. Comments included:

- “The change in perspective was one of the most beneficial aspects of the program.”
- “It helped to shift from thinking about how many bad days I have to focusing more on how many good—or amazing—days I’m having.”
- “Learning to look at problems associated with chronic pain from a positive, rather than negative, viewpoint was helpful.”

Social Connection and Support

Another positive outcome of the SFCPM pilot study was the apparent enhancement of social connection, engagement and support. All too often, social isolation and loneliness accompany chronic pain (LeFort et al., 2015). The

biopsychosocial model stresses that social—as well as physical, psychological and even spiritual—factors contribute to the total subjective experience of pain (Bray et al., 2015). In addition, the solution-focused model, which originated within the field of family therapy, regularly investigates the impact of relationships, social context, and other people's perspectives (Pichot & Dolan, 2003).

While no instrument was administered specifically to measure perceived changes in social well-being, two items on the Pain Self-Efficacy Questionnaire (“I can socialize with friends or family as often as I used to, despite the pain,” and “I can do some form of work (paid or unpaid), despite the pain”) and three on the Mental Well-Being Scale (“I've been feeling interested in other people,” “I've been feeling close to other people,” “I've been feeling loved”) addressed the social impact of chronic pain. Responses to these five social questions revealed a mean increase of just 6.4% from pre-test to post-test. Despite this seemingly small change, participants noted various social benefits they gained from meeting and working together:

- “Finding what works for me and working on goals in a supportive group proved useful.”
- “The group was an emotionally safe place where I could be seen and accepted.”
- “The small class size, the sharing of personal stories, and the group discussion were all helpful to me.”
- “It was therapeutic to be with others in a group, all facing the limitations of chronic pain. Listening to others set goals and watching them accomplish small steps was very helpful as a role model to me.”
- “The social aspects of the course make you feel you are not alone in this.”

Strengths and Limitations

A particular strength of the SFCPM pilot study was that, unlike its UK predecessor, it evaluated a novel solution-focused approach to chronic pain self-management in which no expert advice or education (apart from the methodology itself) was offered. This means that all reported post-intervention gains reflect the expertise and initiative of the participants themselves, not the actions or expertise of the facilitator or anyone else. Therefore, this appears to be the first solution-focused psychoeducational pain management program in the world that made no attempt to fill any gaps in the participants' knowledge, skills, or experience. To do so required a radical trust on the part of the facilitator in both the underlying model and in people's inherent capacity to discover their own solutions.

Another strength of this particular study was that it was facilitated by a single, well-trained professional, rather than a multidisciplinary team, offering a true biopsychosocial approach at a fraction of the clinical investment.

Clearly, however, the pilot study suffered from various methodological limitations including the small sample size, lack of random sampling or a control group, absence of longitudinal follow-up, and lack of statistical expertise and analysis. In addition, all data were collected and reported by the same individual who delivered the training. As such, social desirability bias on the part of participants could not be ruled out.

The primary reason for these limitations was that no funding whatsoever and only limited institutional resources and assistance were available. The author—the primary sponsor and facilitator—was a solution-focused practitioner in private practice, with only a shoe-string budget. Co-sponsorship by Longmont United Hospital consisted of moral support, permission to use the hospital's name, distribution of flyers, referrals, and use of a conference room for some of the program meetings.

Conclusions

Based on observations and lessons learned while facilitating this pilot study, many subtle changes were made to improve both the design and delivery of the Solution-Focused Chronic Pain Management training program. Despite the study's limitations, improvements in all five of its initial measurable objectives, as well as enhanced social support, appear quite promising or at the very least suggestive. Preliminary outcomes—including open-ended feedback from participants regarding benefits they received from the program—suggest that this new approach may warrant further, more rigorous investigation in the future.

Meanwhile, health care professionals and medical facilities serving patients who suffer from chronic pain might consider exploring SFCPM as a complementary component of either an integrative or interdisciplinary team approach to pain management. Combined with the biopsychosocial model of pain and well-being, the solution-focused model offers a tantalizing, highly personalized, proactive, and potentially empowering alternative to familiar problem-focused,

expert-driven approaches to chronic pain self-management. Instead of fixating on or attempting to fix what's wrong, SFCPM enables participants to focus on and amplify what's still right with their bodies, minds, and lives—despite chronic pain.

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ARTICLE**A Case for Videorecording Practice**

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Introduction

For therapists or coaches and their clients, talking matters. It is through talking that practitioners learn about their clients, perhaps eliciting their clients' hopes for the future or discovering what they might find useful. By listening carefully, practitioners can discern much, perhaps evidence for the client's current strengths and resources. Through talking together, they might draw the client's attention to what is already going well. In the process, they encourage the client to articulate the next small step towards a preferred future and signs of progress. In these conversations, clients may gain insights, come to understandings, and make decisions.

One arena for talking is *face-to-face dialogue*: Practitioners and clients sit down together, watch and listen to each other, and have a conversation. Dialogue, whether face to face or on the telephone, has a few unique characteristics. These are worth considering, because they have implications for practice. Here, I introduce four of these characteristics as apparent contradictions.

Face-to-Face Dialogue is Both Persistent and Ephemeral

Take a moment to recall one of your more recent conversations. Close your eyes and really focus on what you remember.

Moments from that conversation may persist in your memory. These outcomes may be fragmentary snapshots of something the other person said or did, a few back-and-forth exchanges, how you felt at a particular moment, or the general impression you were left with afterwards. Our memories of conversations do more than exist passively in the background. Recollections of conversations influence concrete actions in the world. Some consequences are relatively inconsequential (e.g., taking up a friend's recommendation for a new TV series). Others are potentially life-changing (e.g., starting a particular treatment after a consultation with the doctor). In conversations with therapists and coaches, what can persist for clients are, for example, hopes, insights, plans, next steps, new perspectives. New perceptions of one's self and one's story may motivate concrete, life-enhancing actions.

Despite all these persistent, consequential outcomes, conversations themselves are ephemeral happenings. People say a lot, they nod, they laugh, they move their eyebrows, and their hands and arms. They also say words in different ways, imbuing their speech with emphasis and demonstrative tone. As fleeting phenomena, a myriad of details pass unnoticed, leaving no discernable trace. The sheer abundance of detail, including our inability to view ourselves, makes it no wonder that memories of these details can be neither complete nor accurate.

Dialogue's dual characteristics of persistence and ephemerality combine such that we often leave conversations with impressions, new ideas, or decisions, yet we cannot fully recall the processes by which they came about. Consequential things happened, but precisely how they happened can remain a mystery to the interlocutors.

Face-to-Face Dialogue is Both Quantum and Incremental

Conversations sometimes generate "a-ha" moments, that is, moments of sudden insight or discovery (Oxford English Dictionary, 2020). A-ha moments can be characterized as quantum, in the sense of being abrupt transitions (whether small or large). For clients, such quantum leaps may be an unexpected and entirely new way of thinking about the past, or the sudden realization that they have already been creating their preferred future, in hitherto unnoticed ways. During conversations, these unnoticed aspects of the past can be suddenly available for reflection, appreciation, and amplification. Consider an example. It is from an actual therapy session (de Shazer, 1994). The client had been

tend to use them to indicate indecision about what to say (Debras, 2017); the therapist's use during the silence after the word "without" suggests this usage. He also stretches his arms out wide, in a more embodied interactive gesture, which encourages the client to provide the end of the question. The client again cooperates by supplying what he would like to be without: problems. Thus, by line 10, the two have co-constructed the question: In the last few weeks, what was the most recent good day without problems. The therapist confirms this construction of the question in line 11, and by keeping quiet for the 3.0 seconds it takes before the client replies, the therapist provides space for the client to think before answering. After this full three second pause – a long duration compared to the other silences in this short excerpt - the client shares his insight that just about every day in the recent past has been a good day without problems. He shakes his head as he answers. As with facial shrugs, the meaning of this head movement is highly contextualized (McClave, 2000); in this case, when integrated with his slightly surprised tone of voice and abrupt change in topic from the earlier part of the interaction, it could indicate intensification of the insight.

This brief journey through a fraction of a much longer conversation demonstrates that the therapist laid the groundwork for the client's insight well ahead of time, orienting the client to the recent past, confirming that some days have been better than others, and allowing the client and therapist to co-construct the question. The therapist used his words and particularly visible actions to invite the client's active participation. Bit by bit, the two individuals in this conversation responded to each other, building new understandings incrementally that led to perhaps a quantum shift in how the client was able to interpret his recent past. Conversations between clients and therapists or coaches are full of interesting moments, fertile ground for examining and reflecting on the process that led up to them.

A Divergence into Practicalities

Although the main point of this essay is to promote the use of video for examining moments of practice, one or two practical matters must be mentioned here. First, in the excerpt, I was able to include an analysis of visible behaviors, but only those that were captured by the videorecording, which was filmed moving from the therapist to the client. The camera showed the therapist from most of line one (the word "weeks" and the 0.5 s of silence) through to line 12 (during the client's words, "just about every day"). Consequently, how the client may have integrated facial action, head movements, or gesture with his own speech in lines 4, 6, 10, and 12 is unavailable for analysis. Additionally, what the client did while listening, something that was visible to the therapist, is invisible to the analyst. When the camera changed the view from therapist to client (line 12, at the client's 0.64 s of silence, through to the end of the excerpt), any visible actions from the therapist were rendered unavailable to analysis. Thus, the first practical matter for those planning to use video to observe their own practice is that both practitioner and client should be captured in the recording view, so that the visible micro-contingencies during the interaction are available for close analysis.

The second practical matter is the following: My interpretation of the sequences of interaction was guided by microanalysis of face-to-face dialogue (Bavelas et al., 2016), in that I used what we call a "microanalytic lens" (Gerwing et al., 2019). This lens is the interpretive discipline that guides our (and many others') analysis of interaction. It includes four components: (a) focus on observable behaviors (e.g., words and visible actions), (a) analyze those behaviors during specific moments in the interaction (such as the moments examined above), (c) derive the meaning of participants' behaviors using their timing in sequence (i.e., note what happens immediately before and afterwards), and (d) use those observations and the overall context to consider how this behavior is functioning in that moment. I have supplemented the brief analysis with some literature that used a compatible lens. In addition to microanalysis, I drew on theory and experimental evidence that shows how participants integrate their speech with visible actions (e.g., Bavelas & Chovil, 2000). Indeed, Steve de Shazer, the therapist in the example, gave silences, gestures, and facial expressions the same status as words as part of language (de Shazer, 1994). Finally, without naming it as such, I drew on empirical work showing that interlocutors co-construct meaning using the micro-process of calibrating (Bavelas et al., 2017; De Jong et al., 2020).

If you are inspired to record and reflect on your own practice but you are concerned that you lack sufficient relevant scientific background, do not let that stop you. The brief analysis I presented here was from my own position as a researcher, for whom the study of language use has been a particular passion and occupation. While I happen to be familiar with certain methodologies, theory, and literature, attaining this level of knowledge is certainly not a prerequisite for using video to learn from one's own practice (although I hope my citations provoke some curiosity). Rather than being dissuaded by notions of specific expertise, one can nurture curiosities simply by starting to watch videorecorded actual practice, either one's own or others. Close, utterance-by-utterance examination of how the

practitioner and client respond to each other (perhaps guided by the four components of the microanalytic lens) can generate helpful insights that can have implications for practice.

In Conclusion: Responsibility as Practitioners

Clients' insights during conversations with a therapist or coach might persist as outcomes, perhaps providing a new sense of strengths and resources. Due to the ephemeral nature of dialogue, clients would probably not remember the details of the process that led to these insights. But there is no need for them to do so; it would be enough if those insights helped to mobilize further progress.

For practitioners, if they did not videorecord a session, the exact details of the interaction would be similarly inaccessible for reflection. When looking back on sessions, they might remember that they had asked a few questions that the client responded to with interest, but they might not be able to recall and reflect upon the myriad of micro-behaviors that unfolded incrementally to make those moments happen. In the end, these practitioners might fixate on just the specific interventions themselves, such as the questions they asked. They might get focused on how to formulate good questions, rather than noticing all the co-constructive work that led up to them.

The inaccessibility of every conversational detail constitutes the reality of our everyday experiences, and usually it does not really matter. But for practitioners who use talk as their medium of practice, capturing what was ephemeral can be a primary means for reflective practice. A videorecording of practice that shows both the therapist and the client reveals the observable details that led, incrementally, to interesting moments in the conversation. It can allow practitioners to locate those exact moments and discover how they occurred. In the excerpt presented here, some observable clues for a quantum shift were the client's significant pause before answering, a subtle change in his intonation, and the transformation from "some days have been better" to "just about every day". How those moments occurred was a process to which both interlocutors contributed, as the therapist and client co-constructed the question and allowed sufficient time for the client to answer. A videorecording lays bare the co-constructive process that is always going on in dialogue, whether we choose to be aware of it or not. Such recordings allow practitioners to examine precisely how they influenced the unfolding interaction. Talking truly does matter; capturing the details of talk is an essential element for developing a reflective meta-awareness about one's own and others' practice.

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ARTICLE**Creating a Common Language: How Solution Focused Brief Therapy Reflects Current Principles of Change and Common Factors**

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Introduction

The debate between advocates for a common factors and principles of change perspective versus proponents of a model-specific approach has been going on for quite some time (Sprenkle et al., 2009). In this paper we will provide a brief overview of the common factors/mechanism of change literature, a brief review of the solution-focused brief therapy (SFBT) approach, and we will articulate why valuing both perspectives may contribute an expanded evidence-base for SFBT. In addition, we will consider the benefits for SFBT clinicians to be able to converse with other clinicians and stakeholders in a common language about the effectiveness of SFBT and how SFBT utilizes similar mechanisms of change as other approaches. Finally, we will consider research and clinical implications of this broadened perspective.

Literature Review**Common Factors/Mechanisms of Change**

The importance of identifying the factors that produce change in psychotherapy despite specific modalities and understanding how psychotherapy produces benefits has been a point of interest for many over an extended period of time. The subject of common factors in various methods of psychotherapy was first addressed by Rosenzweig (1936). He is quoted by McAleavey and Castonguay (2015) that “psychotherapies that are different do indeed have many similar features, and these similar features may be responsible in some way for the fact that proponents of many treatments report success” (pp. 2). McAleavey and Castonguay also state that “it is not in-controversial to say that psychotherapies of many origins share several features of process and content, and it follows that better understating the patterns of these commonalities may be an important part of better understanding the effects of psychotherapy” (pp. 2).

The idea of common factors and core principles of change has not been met with universal support. Some feel that this approach may dilute the importance of “specific or unique” factors for each school of psychotherapy (Mulder et al., 2017). For many reasons (both personal and political), there is pressure to demonstrate how one treatment modality is more effective than others. Although this may benefit the “the school” or “the theory”, it does not help create a core consensus or understanding in our field. Nor does it help individuals within the field evaluate different approaches in a uniform way. This lack of consensus often leads to arguments and efforts to prove each other wrong, instead of attempts to understand and collaborate with one another for the benefit of all clients. Goldfried (2018) purports there is a disconnect between our past and our present in the field of psychotherapy. He states that psychotherapy “lacks a common core and always seems to be at the cutting edge, not building upon past contribution and instead emphasizing with what is new” (p. 3). This pressure to be on the cutting edge pushes clinicians to emphasize where they stand apart and where they are making a unique contribution to the field, rather than acknowledging what shoulders they stand on, or how they are building on the philosophies and under-standing from those who have come before. This approach is in stark contrast to much of science,

which attempts to build on the past while adopting new modalities which facilitates a mutual understanding and agreement.

Currently, psychotherapy advocates that being on the cutting edge is valuable and important, but equally important is the need to understand what factors contribute to change for clients, some of which are consistent across treatment modalities. Identifying common change factors allows clinicians to work effectively with clients without needing to recreate the wheel each time. In addition, identifying unique or specific factors that work for each clinician or each approach may enhance the work for each individual clinician. Without studying the interaction of common factors/mechanisms of change, unique therapist factors, and unique approach factors, we are at risk of not being useful to our clients. As Goldfried (2018) said, “having different theory based language systems prevents us from ever learning of any similarities and points of complementarity across orientations” (pp. 2). The absence of a common language keeps psychotherapy from coming to a consensus about what works and what does not within psychotherapy (Norcross & Thomas, 1998).

Although we come from a solution focused brief therapy (SFBT) background, we are working toward two goals with this article. The first goal by presenting this research analysis is that SFBT therapists will be able to express, in a shared language, what we do well. Hopefully, the shared description and language provided will make agreements more accessible between SFBT therapists and their colleagues who work from different approaches. Hopefully, SFBT practitioners will be more easily able to describe shared avenues of change versus differentiating strategies and theories, thus making it more feasible to meet the goals of organizations to do the “best” therapy.

Our second goal is to demonstrate how SFBT reflects these common factors and principles and how these principles broaden the evidence-base for SFBT as a therapeutic approach. We hope this broadened evidence-base will help make an impact both within individual sessions and generally within the profession.

Solution Focused Brief Therapy

Solution Focused Brief Therapy was originally developed by Steve de Shazer, Insoo Kim Berg and their colleagues (de Shazer et al., 2007). SFBT is founded on the simple practices of: (a) looking for resources rather than deficits, (b) exploring possible and preferred futures through detailed conversations, and (c) investigating what is already happening that contributes to these preferred futures (George et al., 2017). Typically, SFBT sessions begin by assessing the client's best hopes or desired outcome from the session and transition to eliciting a detailed description associated with the presence of this desired outcome. Time may be spent investigating with the client, through questions, resources the client has that would help bring this desired outcome to pass, instances where pieces of the preferred future are already occurring or highlighting progress that has already taken place (George et al.). SFBT sessions are language-based and co-construct with the client new realities through the use of changes in language (de Shazer et al.). We were interested in identifying how this language-focused approach works to create lasting change in ways that were similar to, and perhaps different than other therapeutic approaches.

Methods

As a first step to identifying SFBT's fit within the common factors/mechanisms of change literature, we reviewed the current common factors literature in order to determine which perspectives to include in this modified content analysis. Content analyses are used to identify common patterns of themes in written documents and to make inferences based on these patterns (Hsiu-Fang & Shannon, 2005). The articles included in this study were each:

1. Published/produced in the last 15 years (since 2005). This was to ensure relevance regarding most recent literature.
2. Published/produced by an author(s) who has/have written or contributed significantly to the common factors literature base.
3. Consistent with mainstream literature regarding common factors.

These criteria, although not significantly rigorous, served the purpose of having a well-founded literature base. Although many other articles may have met these criteria, it was determined that since the focus of this study was on applying the common factors literature to the solution focused approach, and not on evaluating the common factors validity, that face validity and content validity of the included studies were the most important factors. In addition, because the focus of this paper was on applying the themes to SFBT and not providing a comprehensive representation of all common factors

literature, that an exhaustive inclusion of all potential articles was not needed, but rather a representative sample would be sufficient.

Included Articles

For the purposes of this paper – to work towards the potential of creating a common language and to demonstrate how SFBT reflects these factors and principles--we have presented the research of the following papers:

1. *The Question of Expertise in Psychotherapy* (2008) by Scott Miller, Mark Hubble and Daryl Chow
2. *Obtaining Consensus in Psychotherapy: What Hold Us Back* (2008) by Marvin Goldfried
3. *General Change Mechanisms: The Relation Between Problem Activation and Resource Activation in Successful and Unsuccessful Therapeutic Interactions* (2006) by Daniel Gassman and Klaus Grawe
4. *How Important are the Common Factors in Psychotherapy? An Update* (2015) by Bruce Wampold

Below we provide a brief summary of each of the articles included in the analysis.

Miller, Hubble, and Chow

This article asserts that all treatment that applies current common factors will lead to good therapy. In their Common Factors Model there are four areas including: (a) therapeutic technique, (b) expectancy and placebo, (c) therapeutic relationships, and (d) client factors. The authors posited that therapeutic techniques account for 15% of change, expectancy and placebo 15%, the therapeutic relationship accounts for 30-50%, use of client factors is responsible for 40% of change. Their model is the only model (of the included articles within this study) that gives specific percentages – but the research on all models generally seems to substantiate these numbers. Thus, emphasis should be on all factors that support strong alliance with the client and the many ways of utilizing client factors.

Goldfried

Goldfried presents his research on principles and mechanisms of change. He promotes moving the field of psychotherapy from theoretical considerations to agree upon principles of change. The specific intervention and techniques may then be thought of as methods of implementing these principles. They can be summed up as "...clients change when they are motivated and have positive expectations of change, work with a therapist with whom they have a good alliance, become better aware of what is causing the problem, take steps to make changes, ... and engage in ongoing reality testing ...". (p 6). His core principle of change can be described as working to-wards "the client doing something not done before". It does not matter how or under what circumstances the change takes place or whether it is phenomenological or observable.

Gassman and Grawe

Gassman and Grawe focused on the processes underlying change. They emphasized the role and balance of problem activation versus resource activations across therapies to support therapeutic change. They concluded that therapists who viewed the client as capable and more than the "sum of their parts," and engaged the client very early on in the session with the healthy parts of the client's life and personality, created an environment that promoted more productive work with the client. They found that these clients left the session with "higher activated resources" than when they entered.

Wampold

The final model we included in this study was Wampold's Contextual Model. His overall observation was that all therapies with a structure provided by an empathetic and caring therapist, which facilitates client engagement in healthy behaviors will have equal effects. He presents three interacting but "reasonably independent" pathways. These three pathways echo all the current research on common factors and principles of change. These include *Pathway 1 – Real Relationship*, *Pathway 2 – Expectations*, and *Pathway 3- Specific Ingredients*. Wampold, as well as the other researchers reviewed in this paper emphasize two further points, 1) the importance of "robust therapists," that is, the therapists having ability to form strong alliances, possessing strong interpersonal skills and engaging in practice outside the therapy sessions, and 2) the importance of inviting ongoing feedback from the client with regular monitoring of progress and process either formally or informally.

Inter-rater Reliability

After the included articles/studies were identified, Beverley Kort (BK) and Cecil Walker (CW) each did an initial qualitative content analysis review of the articles to identify specific com-mon factors and principles of change identified within each of the articles. The reviewers began with open coding, then moved to axial coding while maintaining field notes regarding their decision making (Stauss & Corbin, 1998). Qualitative inter-rater reliability was evaluated and Adam Froerer (AF) served as an arbitrator through this reliability process. Seven themes were identified across the included studies (see Table 1 in the Results Section for more extensive definitions). These themes included: (a) Ideology/Rational, (b) Expectation/Hope and Resource Activation, (c) Therapeutic Alliance, (d) Tasks of Therapy, (e) Use of Client Factors, (f) Therapist Effects and Self Regulation, and (g) Monitoring and Process Outcome.

Once the Common Factor/Mechanisms of Change themes were identified, the researchers then did a second modified qualitative content analysis comparison applying the seven identified themes to the Briefer practice manual (George et al., 2017) to evaluate how SFBT fits within the common factors and principles of change identified during phase one of the content analysis. Again, BK and CW served as independent reviewers during this process and qualitative inter-rater reliability was checked again, with AF serving as arbitrator when needed (see Table 2 for results).

Results

Step One of the content analysis resulted in seven themes being identified. See Table 1 for a breakdown of the overall themes with how each article fit within the themes.

The results of the second qualitative content analysis looked at how SFBT fit within the themes identified in Step One. The results of this second analysis are included in Table 2. It is important to note that *Ideology and Rationale* was excluded from the Table 2 results because this is an overall principle and is not specifically noted within practice/treatment manuals.

Discussion and Conclusion

The seven factors identified in the qualitative content analysis fit nicely with SFBT and help SFBT to fit into the larger frame of psychotherapy. We will first discuss each of the seven themes and why they have been deemed necessary for effective psychotherapy. Then after each of the themes is discussed, we will discuss in an applications section the specific theme from a non-SFBT and a SFBT perspective to facilitate mutual understanding of how different practitioners can attend to the same important factors but do so in different ways.

Table 1*Common Factor and Mechanisms of Change Themes*

	Miller, Hubble & Chow	Goldfried	Gassman & Grawe	Wampold
Theme				
Ideology/ Rationale	All treatment that is a reflection of current common factors will lead to good therapy. - Therapeutic technique - Expectancy and Placebo - Therapeutic relationship - Client factors	Move from theoretical considerations to Principles of change. Clients change when: - Motivated and have positive expectations of change - Work with a therapist with whom they have a good alliance - Awareness of what is causing problems - Take steps to make changes in thinking, feeling and behavior - Engage in ongoing reality testing	“Resource activation is an empirically strongly supported change mechanism... realized in interventions that focus not on the patient’s problems, but rather on the sound and healthy parts of the patient’s personality.”	All therapies with a structure or given by an empathetic and caring therapist, which facilitates client engagement in healthy behaviors will have equal effects. All treatment achieve their effects through three interacting but reasonably independent Pathways Pathway 1 : Real Relationship Pathway 2: Expectations Pathway 3 : Specific Ingredients
Expectations / Hope	Expectancy and Placebo - Creating hope greatly influenced by therapist attitude toward patient in <i>early moments</i> of therapy	- Promote client expectations and motivation that therapy can help - Recognizing/ experiencing what positive change would be like	Successful therapists in study focused right at the beginning of the session markedly on what worked well with patient-Resource Activation	Pathway 2: Expectations - Client is provided with an adaptive context that allows for solutions - Client believes participating will be helpful - Agreement of goals and tasks increases the therapeutic alliance
Therapeutic Alliance	Therapeutic Relations - Experience change early on in therapy, increases therapeutic alliance - Positive client experience of therapeutic alliance. - Therapist creates an environment that matches client’s definition of empathy, genuineness, respectfulness and worldview	Therapeutic Alliance Defined as: - Good bond - Agreement to the goals of therapy and methods used - Most important transtheoretical principle of change	Engaging in early Resource Activation created an environment where the patient was perceived as a well-functioning person	Pathway 1: Real Relationship - Occurs through social support, interpersonal connection and belongingness or attachment between client and therapist - Early symptom relief leads to therapeutic alliance and successful outcomes - Goal collaboration led to most successful outcomes

Tasks of Therapy	<ul style="list-style-type: none"> - Emphasis on client's goals vs history and psychopathology - Across all models therapists expect their clients to, 1) Do something different, 2) Develop new understandings, 3) Feel emotions, 4) Face fears, 5) Take risks, 6) Alter old patterns 	<ul style="list-style-type: none"> - Agreement about goals of therapy and methods to achieve these goals - Facilitating client awareness of factors associated with their difficulties - Core principle of change is client does something not done before - Reality Testing 	<p>Clients leave a session with even higher activated resources that they experienced when they entered the session.</p>	<p>Pathway 3 - Specific Ingredients</p> <ul style="list-style-type: none"> - Treatment that a client finds acceptable that will lead to healthy actions that will decrease their distress - Induce client to enact healthy actions regardless of treatment specifics
Use of Client Factors	<ul style="list-style-type: none"> - More client involvement leads to more possibility of change - Take into account strengths, resources, current situation, fortuitous events, world view, etc. 	<p>Recognize and make use of previous life experiences that may be helpful with current difficulties</p>	<p>View of client as capable and more than the sum of their problems</p>	<ul style="list-style-type: none"> - Explanation/rationale must be acceptable to client - Explanations congruent to cultural and personal beliefs
Therapist Effect and Self Regulation	<p>Engage in "deliberate practice" to improve skills and maintain best practices in the following:</p> <ul style="list-style-type: none"> - Quality of the therapeutic relationship - Creation of hope and expectation of change - Provision of plausible rationale and healing rituals - Understanding and use of client strengths - Therapist self regulation 	<ul style="list-style-type: none"> - Learn skills that reflect commonalities that exist across theoretical orientations - Get supervision from therapists that are still actively in practice 	<p>Respond quickly to activated resource - no lag time</p>	<p>Robust therapists:</p> <ul style="list-style-type: none"> - Able to form a strong alliance across a range of clients - Have a greater level of facilitative interpersonal skills - Express more personal self doubt - Engage in practice outside therapy sessions
Monitoring and Process Outcome	<p>Use Feedback Informed Therapy tools</p>	<ul style="list-style-type: none"> - Monitoring process and outcome on a session by session basis - Utilize the feedback to inform your therapy 		

Table 2*SFBT Ideas for Implementation based on Briefer: A Solution Focused Practice Manual**

Expectation and Hope	Therapeutic Alliance	Tasks of Therapy	Use of Client Factors	Therapist Effect/Self Regulation	Monitoring Progress and Outcome
<ul style="list-style-type: none"> - Best Hopes - What do you want instead? - Future Focus - Direction established by client - Client takes credit for change - Nurture sense of possibility: "So far" "As yet" "In spite of" - Noticing - Instances/ exceptions - Noticing small signs of progress - Start each subsequent session with "What's better"? 	<ul style="list-style-type: none"> - Resource talk and Best Hopes - Use of client language, description, world view - Collaboration on client's desired outcome - One foot in the present and one foot in possibilities - Checking in regularly to make sure going in the right direction - Safety scaling questions 	<ul style="list-style-type: none"> - Questions as a provocation for client to think about, to notice, and name differences - Desired outcome drives the session - Preferred Future - Client given credit through scales - Questions that remove contingencies in the way - Instances and exceptions - Noticing changes - Coping questions - Constructive history questions - Identity questions 	<ul style="list-style-type: none"> - Instances and exceptions - Pre-meeting change - "What's better" - Coping questions - Building on already existing skills - Identity questions - Lists - "What else questions" to expand present and past successes - "Scaling questions" to discover what client has already accomplished 	<ul style="list-style-type: none"> - Asking "What does the client want from therapy?"- How does that influence the next questions? - Making room for client/ identity, background, beliefs and views - Letting go of assumptions - Staying neutral and marginal in the client's life 	<ul style="list-style-type: none"> - First small signs of progress - Scaling - Checking in with client on direction of session during each session - Magnifying change - Exceptions and Instances of change

George et al. (2017)*Ideology/Rationale**

Brown (2015) states that it is an ethical imperative for clinicians to base their services on "evidence-supported" practices (p. 307). He goes on to say that since most therapies appear to be effective according to reviews of psychotherapy regardless of technique, it is becoming more apparent that "highlighting treatment principles rather than treatment strategies as a way of discussing active ingredients of change" (p. 307) would yield better results.

In his implications for therapists he emphasizes the importance of focusing on common factors that highlight both process and content (for example, the client therapist relationship and client experience of change). He further emphasizes the importance of focusing on principles rather than strategies of change. This allows the therapist to be "drawn directly to a range of therapies that are evidence supported and provide principles that evoke thinking across therapies in dealing effectively with clients" (pp. 311-312).

In their review of current psychotherapy research and reports by therapists of diverse allegiance, Castonguay et al (2015) discovered that "many behaved in ways that were more similar than dissimilar" (pp. 4). Many of the 'unique' interventions of particular orientations are idiosyncratic manifestation of more general strategies or principles of change, such as increase of positive expectations, provision of a new view of self or testing of change with day to day reality (Goldfried, 1980; Goldfried & Padawer, 1982).

Applications

Non-SFBT. From other non-SFBT therapeutic approaches, it is important to spend at least 2-3 sessions doing psycho-social assessment and information gathering about history and problem in order to properly evaluate client concerns and arrive at a diagnosis. The treatment process follows the diagnosis, and the goal is to alleviate symptoms.

SFBT. From a SFBT perspective, through conversations with the client, SF practitioners co-construct the client's vision of their desired outcome to determine where they want to go rather than a description of where they have been or what problems they are experiencing. First sessions are often treated as "working sessions" as the assumption is that each session may be the last. Solution Focused practitioners hold the belief that clients are the experts of their lives and should contribute their content-expertise to the process-expertise of the clinician. Both SFBT and non-SFBT perspectives hold values about how to help and aid clients, but enact these beliefs in different ways.

Expectation/Hope

Hope and expectancy are commonly cited as responsible for a substantial percentage of the variance in the outcomes of therapy (Lambert, 1992). Hope is best described as "the sum of the mental willpower and way power that you have towards your goals" (Snyder, 1994, p. 5). It is well established that a model that can activate hope and positive expectations in clients tends to have more positive therapeutic outcomes. Potential reasoning for that positive relationship includes the tendency of hope to be accompanied by positive affect (Ciarrochi et al., 2015) which can have extensive influence on an individual's cognitive flexibility and access to mental resources (Estrada et al., 1994). The client's expectations play a direct role in stimulating positive change (Constantino & Westra, 2012).

Applications

Non-SFBT. A common way therapeutic models build and make use of hope is in the construction of goals, since defined objectives and forward thinking are central to developing hope (Cheavens et al., 2006). Non-SFBT models might also emphasize how the execution of their interventions will help clients progress towards goal attainment, such as completing homework or finding insight in genograms. These insight- and task-oriented explanations offer clients a consistent approach that meets their expectations about the process of overcoming problems, whether through faulty cognitions or relational triangulation, or other problem-focused conceptualizations. Hope is often fostered through developing insight and goals for overcoming challenges.

SFBT. Solution Focused Brief Therapy emphasizes the significance of increasing positive expectancy and hope (Reiter, 2010). SFBT begins work with clients by inquiring about each client's best hopes (George et al., 2017). Through detail-oriented questions, SFBT therapists build realities that are founded on the best hopes established right at the beginning of each session. SFBT therapists continue building hope by asking clients to detail times where the problem was not so significant (exceptions) or even better, times when pieces of the best hopes were previously present in the client's life (instances). SFBT therapists infuse hope into questions throughout sessions by using presuppositions that highlight the client's strengths, resources, or abilities (Bavelas et al., 2013). SFBT is effective at building hope because of the way it manifests to clients the ways their present reality might connect to a preferred future, an understanding of which is a key facet of hopefulness (Rand & Cheavens, 2009).

Therapeutic Alliance

Therapeutic or working alliance is the common factor that has received the most attention. Horvath et al. (2011) identified over 200 research reports on the working alliance (for individual therapy for adults) that supports its robustness in correlation with positive outcomes in therapy. The quality of the therapeutic relationship in general, and the alliance in particular, are obvious 'common factors' shared by most if not all psychotherapies (Horvath et al., 2011). Other relationship variables that cut across theoretical orientations and received empirical support include empathy and positive regard. Several of the other therapeutic factors are enhanced by or inversely contribute to the therapeutic alliance, giving it exponential influence in the outcomes of therapy.

Applications

Non-SFBT. Most therapy models seem to agree on the importance of the therapeutic alliance. From non-SFBT theoretical perspectives, the therapeutic alliance is established through intentionally fostering an empathetic bond, joining, and expressing empathy for problems encountered by clients. More specifically, some approaches even seek to construct an attachment bond between the client and the therapist or join the family system and learn the rules that govern it. Within these other modalities, these bonds are built through respect towards the client, validating their experiences, and the agreement on goals and therapy tasks.

SFBT. Although SFBT does not overtly include “alliance-building” as a part of the theoretical approach, a focus on developing a working relationship with clients is absolutely at the forefront of what SFBT clinicians do. This working relationship is built on language and happens through the co-constructive process. This building of conversations on the clients’ perspective and understanding fosters significance and relevance for the client, which in turn translates to trust and a more positive view of therapy.

Tasks of Therapy

Within the therapeutic process, the tasks of therapy involve the “behaviors and processes within the therapy session that constitute the actual work of therapy. Both the therapist and client must view these tasks as important and appropriate for a strong therapeutic alliance to exist” (Asay & Lambert, 1999, p. 35). The tasks included in any model are strongly tied to the expectancy it can build in clients, the construction of goals, as well as the therapeutic alliance. Positive outcomes depend on the fostering of the client’s trust that the “means” of therapy are guiding them in a productive and hopeful direction. The tasks of therapy are observable mechanisms within therapeutic interactions to which clients might attribute the action of progress.

Applications

Non-SFBT: Non-SFBT approaches can have a variety of tasks of therapy, all sharing the understanding that these tasks will move the therapy forward. Examples of this might include family sculpting (Experiential), cognitive reframing (CBT), or heightening emotions (Emotionally Focused Therapy). All of these tasks provide the client with action that might explain or induce their potential progress. Therapeutic tasks are the tools clinicians from any approach use to assist clients in the change process. The theoretical assumptions underlying the approach have direct influence over the specific tasks that are selected and utilized by various practitioners.

SFBT. The tasks within SFBT are exclusively based on language. These may include inquiring about best hopes, focusing on the preferred future, discussing resources, noticing exceptions and instances, and asking questions about coping and resilience, among other questions. While the interaction is very conversational and dependent on the clients’ words and perspective, these conversations lead to observable actions and positive change.

Client Factors

Client factors are the most robust predictors of successful therapy. Bohart and Tallman (2010) assert that although specific techniques and approaches can influence therapy outcomes, it is the client's ability to operate upon their therapist's input that ultimately brings about a positive result. Clients use and tailor what each approach provides to address their specific problems. Bohart and Tallman continue by promoting, "instead of technical know-how, the therapist helps primarily by supporting, nurturing, or guiding and structures the client's self-change efforts" (pp. 95). Their suggestions include some of the following: promoting client strengths, resources and personal agency, believing all clients are motivated, and privileging clients' experiences and ideas.

Applications

Non-SFBT. When looking at the client from the perspective of other approaches, a therapist might examine what the client has done to perpetuate their problem, or what maladaptive beliefs perpetuate problems. Similarly, therapists might assess the client's level of motivation, personality, and symptomatology to increase positive therapeutic outcomes. Many psychotherapy approaches may buy into the belief that, "things might get worse before they get better".

SFBT. In SFBT, the goal is also to increase positive therapeutic outcomes by engaging client factors, but the way the client factors are utilized looks a little different. SFBT will draw on client factors through language rather than behavior interventions or homework tasks, etc. SFBT utilizes the client's strengths and resources as well as evidence of past successes to be applied to the current situation. The assumption is that all clients who present for therapy want to change, so their level of motivation is not questioned, their personality is not assessed, nor are the symptoms of the problem seen as valuable as their desired outcome.

Therapist Effect

While effective therapy requires an organized ideology and relies heavily on the relationship established between client and therapist, there is still room for the influence of the clinician's therapeutic skill. The clients of effective psychotherapists improve at a rate 50% higher and drop out 50% lower than less effective therapists (Skovholt & Jennings, 2004). Similar to how general therapeutic principles are more influential than the specific approach being used, the clinician and his/her clinical skills are also more important than the specific treatment being implemented in contributing to patient outcomes (Sperry & Carlson, 2013). Likely because of its relation to the therapeutic alliance, who the person is as the clinician can make a difference in therapeutic outcomes (Horvath et al., 2011).

Applications

Non-SFBT. In other therapeutic strategies, there is a focus on the clinical ability to execute the particular approach and concentrate on developing interventions and/or psychoeducation suggestions as a framework following diagnostic principles. The therapist must be skilled in understanding clinical diagnoses as well as the appropriate clinical responses to them. In many approaches there are predetermined directions for the therapeutic process that clinicians must be capable of accurately following. In many approaches the therapist is seen as the expert and holds a significant responsibility for creating change on behalf of clients.

SFBT. In SFBT, there is more of a focus on how well the therapist listens and sticks to the client's use of language to develop a rich description of their preferred future. It is important to make room for the client's background and the client's views and let go of any assumptions about the direction or outcome the client wants from therapy. A skilled SFBT therapist is able to stay neutral about the clients' life or choices. The therapist should be very skilled at asking detailed questions and helping the client co-construct a detailed description of the client's preferred future, while leaving their own options and expectations outside of the developed description.

Monitoring Process and Outcome

It is easy for the therapist to develop an inaccurate view of the client's treatment process (Walfish et al., 2012). The client's own subjective experience of change early in the treatment process, however, is a good predictor of treatment success (Norcross, 2002). The client's evaluation of the quality of the psychotherapeutic relationship is a better predictor of the therapeutic alliance and treatment outcome than is the psychotherapist's evaluation of the therapeutic alliance (Horvath et al., 2011). Several of the factors identified in this paper as well as positive outcomes in general all seem to rely heavily on the client's regard of the therapy process. This all supports why means of monitoring the process and measuring outcomes is beneficial to the efficacy of the therapeutic approach in providing the client and therapist with shared tools for observing change.

Applications

Non-SFBT. Many clinics use ORS and SRS and other outcome measures to determine whether therapy is successful. Other less formal ways may involve occasionally asking clients how therapy is going for them or monitoring homework or severity of symptoms.

SBFT. SFBT does not suggest any formal scales to monitor process and progress, but there are many practices that involve checking in with the client at every appointment. For example: starting every session with a variation on "what's better, what's changed, what have you noticed since our last appointment that you are pleased with, how are you coping (if things are worse), etc." SF therapists are also listening for small signs of progress and magnifying them, through questions, to increase the chance that the client will be able to take credit for the changes.

Implications

Research Implications

We live in an era where understanding what we do and understanding why it is effective within therapeutic settings is being emphasized, it is essential to be able to articulate in a meaningful way how SFBT is evidence-based. There is significant research that provides empirical support for SFBT (Kim, 2008; Kim et al., 2019) and there is significant process research that increases our understanding of what happens in sessions that might contribute to the abundance of positive outcome data (Franklin et al., 2017). However, understanding the research that supports the common factors and understanding where the common factors align with SFBT will further broaden the evidence-base of SFBT.

First, the utilization of a treatment manual strengthens the foundation of the evidence-base for a particular therapeutic approach, because it increases the likelihood that various clinicians are doing the same thing and it increases the likelihood that one clinician practices consistently with various clients (Trepper et al., 2012). Ensuring that the utilized treatment manual is consistent with best-practices and empirically supported practices is another essential step in understanding and solidifying the evidence-base of an approach. The findings of this study demonstrate that solution focused brief therapy has factors (as identified in Briefer: A SFBT Practice Manual; George et al., 2017) that directly link to each of the identified common factors that are supported by empirical research (See Table 2).

Second, by linking the factors from the SFBT treatment manual to the factors that contribute to effective outcomes across therapeutic modalities, we link our evidence to the broader network of evidence of effective modalities (See Table 1). This allows SFBT practitioners and researchers to assert with added certainty that SFBT is evidence-based. It also allows SFBT practitioners and researchers to also communicate with confidence about how SFBT utilizes the common factors to bring about lasting change with clients; a task that is imperative when advocating for the effectiveness of SFBT with third-party payers, with funding agencies, and with clients.

Third, by making this evidence-based link with the common factors, an avenue is created for SFBT practitioners and researchers to communicate commonalities across therapeutic domains that can lead to greater understanding and acceptance of SFBT as a worthwhile approach (face validity) with various stakeholders. This common language allows SFBT clinicians and researchers to co-construct a new reality with other practitioners and researchers who may not initially see or appreciate the effective work of SFBT. By identifying common ground with other modalities (not advocating that we are doing the exact same things but identifying that different approaches can lead to similar outcomes), we may avoid unnecessary debates and arguments, thereby building relationships of collaboration and mutual respect.

Clinical Implications

One of the goals and purposes of this study was to help SFBT clinicians communicate better with clinicians working from different modalities with a common language about what they are doing that is useful in creating change. We hope that by providing the information in Table 2, SFBT clinicians will be able to not only understand how SFBT fits within a larger framework but will be able to articulate this fit to other non-SFBT clinicians. In addition, the information in Table 3, below, has been provided to help SFBT clinicians conduct self-assessments and engage in dialogue with non-SFBT peers about how various modalities may differ, but can still achieve similar therapeutic outcomes.

In addition to being able to talk with other clinicians about the work we do, it is anticipated that clinicians can use the self-assessment to evaluate their own work and make purposeful decisions about how they can work best and most effectively with clients. It is hoped that SFBT practitioners will integrate their clients' language in meaningful ways to build hope and expectation, to activate resources, to utilize external client factors, and strengthen the therapeutic alliance. By purposefully attending to the common factors and useful mechanisms of change, we believe clients will be better served and positive outcomes will be more likely. When acting purposefully, SFBT clinicians can bring the combined evidence-base of common factors and SFBT to bear with their clients.

Limitations

Although this study provides valuable information about the integration of the common factors and mechanisms of change with SFBT, there are some limitations that should be noted. First, the authors did not include a comprehensive consideration of all the mechanisms of change and common factors literature. Because the purpose of this study was to apply the principles to SFBT rather than provide a comprehensive overview, there may be other factors the authors did not include that could provide added insight or understanding. These additional factors not considered in this paper would likely serve to further strengthen the results of this study.

Second, this study provides a first connection through qualitative means to connect the common factors and mechanisms of change literature to SFBT but does not consider the quantitative correlation or causation of these factors to produce particular outcomes. Additional research is needed to draw these types of conclusions.

Conclusion

This paper sought to demonstrate that SFBT can be strengthened as an evidence-based practice by correlating what is done in SFBT sessions with the larger factors that are known to create effective outcomes. We hope that by illustrating how SFBT utilizes these factors through correlations to the Briefer Practice Manual and by providing a self-assessment tool, SFBT practitioners will be more clear about what they are doing in sessions and why, will be able to communicate these efforts to other practitioners (both SFBT and non-SFBT), and will be more purposeful in helping their clients to achieve lasting change.

Table 3*Self-Assessment and Cross-Modality Discussion Questions*

Expectation and Hope	Therapeutic Alliance	Tasks of Therapy	Use of Client Factors	Therapist Effect and Self Regulation	Monitoring Process and Outcome
<p>* How do you inspire hope in your client? * How do you make use of expectancy factors from the outset? * How do clients experience what positive change looks like? * How do you deal with unrealistic hopes? * How do you draw on client strengths and resources to help them achieve their goals? * How early in the session do you recognize those strengths and resources? * In what ways do you draw attention to the client's evidence of competence, past success?</p> <p>* In what ways do you check for any change that has occurred between the initial phone call and the appt. and incorporate it into the first session and therapy process?</p>	<p>* How do you collaborate with clients to find their own goal(s)? * How do you establish a strong working alliance? * What do you do to engage clients in therapy? * How do you engage those that seem unmotivated? * What do you do to provide empathy, genuineness, and respect? How do you tailor these to each client? * In what ways do you express thoughtful appreciation for the clients' problems?</p> <p>* In what ways do you follow/ use the client's language, worldview and culture rather than treatment approach? * In what ways do you identify clients that are not progressing and subsequently re-evaluate your work together?</p>	<p>* What strategies do you use to work collaboratively with your clients to develop their own strategies and tasks that may help them reach their desired outcome? * How often do you notice the ideas/tasks/strategies the client develops are the ones that you can't possibly have thought of and come from their own personal experience? * What do you do that might encourage your client to make use of past experiences that help them change? * How do you help your client see themselves from multiple perspectives?</p> <p>* How do you help your client remove contingencies that interfere with their goals?</p> <p>* How do you deal with issues of safety?</p>	<p>* In what ways do you take into account and use the client's environment and existing supports? * In what ways do you expand on the spontaneous changes that clients experience outside therapy? * How do you draw attention to the importance of the fortuitous events in the lives of the client that have led to change and self-efficacy? * In what ways do you utilize your client's input, participation and involvement to determine directions for therapy? * How do you make sure your client takes credit for change?</p>	<p>* What are your strategies to practice careful listening combined with questions aimed at defining and refining the client's goals for therapy? * How do you maintain emotional neutrality and self-regulation? * What have you put in place to ensure you have the kind of ongoing supervision and professional development that is right for you?</p>	<p>* In what ways have you incorporated the following in your practice: How are you? How are we? How is this? * How often do you check in with your client regarding the quality of your therapeutic relationship and their progress? * Do you use a formal assessment tool or more informal feedback? * How do you describe your process? * How does feedback you receive influence your practice? * How do you follow up to determine if the change your client has experienced is stable and long-lasting?</p>

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*ARTICLE***Solution-Focused Zone of Proximal Development: A Vygotskyan Contribution to Solution-Focused Therapy**

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Abstract

This theoretical paper explores the possibility of combining principles of solution-focused therapy with theories of learning and development by the psychologist Lev Vygotsky, whose thinking led to the development of Cultural-Historical Activity Theory. The similarities and complementarities between these traditions merit attention. Further, SFT has been characterized as an eclectic and constantly evolving approach, the theoretical and philosophical foundations of which are somewhat scattered. Hence, the article attempts to redefine the philosophical and theoretical location of SFT through a “Vygotskyan and CHAT-informed” lens. Since the emphasis in SFT seems to be on the identification and detailed description of the client’s skills, the author offers a new view of SFT as a pragmatic version of social constructionism. Based on Vygotsky’s concepts of ‘cultural mediation and ‘the zone of proximal development’, the author proposes a new concept, namely solution-focused zone of proximal development. The concept highlights learning-in-SFT as an optimally designed non-individualistic and expansive process, leading to empowered independence and creativity.

Keywords: solution-focused therapy, solution-focused practice, learning, Lev Vygotsky, socio- cultural theory, cultural-historical activity theory, the zone of proximal development, cultural mediation, pragmatism

Introduction

This exploratory theoretical paper explores the possibility of combining principles of solution-focused (brief) therapy (SFT and SFBT)¹ (e.g. De Jong & Berg 2018; Furman, 1994; Furman & Ahola, 2012) with theories of learning and development by the psychologist Lev Vygotsky, whose thinking led to the development of Cultural-Historical Activity Theory (CHAT)² (Cole, 1997; Engeström, 1987; Freeman, 2007, 2015; Leontjev, 1978; Stetsenko, 2005; Vygotsky, 1978). As a scholar and practitioner of CHAT and Solution Focused Brief Therapy, I have found similarities and complementarities between the two traditions. It is, however, an under-researched topic and merits further attention.

SFT has been characterized as an eclectic and constantly evolving approach (Furman, 1994; De Jong & Berg, 2008), the theoretical and philosophical foundations of which are somewhat scattered. Philosophically, SFT has been linked to ‘social constructivism’ (see Berger & Luckmann, 1967; Caputo, 1997; Foucault, 1977; Gergen, 1985), which itself is a fuzzy umbrella term for a field of study that draws on a variety of disciplines (see also Miettinen, 2000). On a generic level, social constructivism is interested in language as a medium for social change. While intentional language use is at the core of SFT, it is, however, much more than this. Hence, the aim of this paper, which is to re-examine SFT’s philosophical and theoretical location through a “Vygotskyan and CHAT -informed” lens.

Enhancing the client’s ability to make informed decisions and take action in the face of unexpected challenges via minimal intervention is the primary objective of SFT (Furman & Ahola, 2012; Berg & Miller, 1992; De Jong & Berg, 2018). The SF approach has been characterized as future- oriented, outcome-oriented, client-centered, exception-and progress-focused, co-operative, creative, playful, humorous, eclectic, pathology-avoiding, positive feedback-centered,

¹ Henceforth SBT (including SFBT).

² Henceforth CHAT.

and merit-centered (Furman, 1994). In essence, the aim of the SFB practitioner is to find useful change in the ways in which the client presents their wishes.

In a similar fashion, Vygotsky and his followers (e.g. Engeström, 1987; Leontjev, 1978; Vygotsky, 1978) adhere to the idea that people are capable of change, given the appropriate cultural tools and social support. Further, CHAT practitioners avoid pathologizing psychological phenomena; instead, they prefer minimal intervention by the helper and see higher mental functions as grounded in concrete goal- and future-oriented action and collaborative activity (e.g. Cole, 1997; Engeström, 1987; Leontjev, 1978; Vygotsky, 1978, 1982). These fundamental commonalities between SFT and CHAT enable a deeper look at some of the basic assumptions and tools of SFT.

The SF therapist uses open-ended questions³ to direct attention to the client's unique skills and qualities, past successes, concrete actions, future hopes, and social networks (De Jong & Berg, 2018). The therapist approaches the client from a stance of 'not knowing' (De Jong & Berg, 2018, 30-58) and utilizes the client's vocabulary when formulating questions (De Jong & Berg, 2018, p. 31). Hence, the client feels respected, and is more willing to collaborate (De Jong & Berg, 2018, pp. 349-350).

In addition, future and goal-oriented questions are used in an affirmative fashion, hence making it easier for the client to vision a way forward. Once clients understand that they play an active role in transcending life's challenges, they are more likely to succeed in finding new, potential solutions to test and evaluate. (Berg & Miller, 1992; De Jong & Berg, 2018). The therapist steers clients to see how they could utilize their qualities and abilities by concentrating on their own unique skills. As clients come to the realization that they already have some tools at their disposal, they feel empowered and more ready to further develop their skillset.

Since the emphasis in SFT seems to be on the identification and detailed description of the *client's skills*, it seems justifiable to examine SFT from the viewpoint of Vygotsky's well-established theories on learning and development (see also Engeström, 1987; Vygotsky, 1978, 1982). This article has a two-fold agenda. The first research question is philosophical in nature: *Where can SFT be located philosophically, given that client skills and change are a central linguistic topic in therapy sessions? The second research question is more theoretical and conceptual: How does SFT appear through the lens of CHAT, or more specifically, through Vygotsky's concepts of 'cultural mediation' and 'zone of proximal development'?*

I start with a philosophical discussion of SFT and social constructionism, and offer an alternative viewpoint, informed by CHAT and pragmatism. I then introduce the concept of 'cultural mediation' (Vygotsky, 1978), which is the core concept of CHAT. After this, I examine SFT through the concept of the 'zone of proximal development' (Vygotsky, 1978). Finally, I offer a new concept, namely *solution-focused zone of proximal development*, to better understand the core intention of SFT. I conclude by discussing the implications of these new ideas for SFT.

Towards a Pragmatic Version of Social Constructivism

De Jong & Berg (2018, pp. 349-350) locate SFT in the arena of social constructivism. On a very general level, social constructivism focuses on the role of language in the emergence of socially-mediated and situated realities (cf. Berger & Luckman, 1967; Foucault, 1977; Foucault, 1982; Gergen & Davis, 1985; Mills 1940). The individual is seen as an active participant and learner in society (cf. Berger & Luckman, 1967; Heiskala, 1994; Hirvihuhta & Litovaara, 2003; Miettinen, 2000). Reality is constructed through reciprocal meaning-making (De Jong & Berg 2018, p. 350). Because meaning-making is tied to the individual's experiential history, the act of understanding the other is always a process of negotiation. Hence, identity itself seems to be negotiable, a result of dialogue.

SFT has also been linked to Derrida's 'radical constructivism' (see Pihlaja & Pihlaja, 2020). Derrida's concept of 'deconstruction' points to the method of making rendering power relations, different points of view and societal conflicts (Caputo, 1997; Derrida, 1995). It is a critical method of reading, in which text is not merely text: text contains contradictions (Rolfe, 2004). Authority is in a sense put 'out of joint' (Derrida, 1995). Deconstruction is thus the enemy of the authoritarian text (Rolfe, 2004, p. 276). I would interpret the SF therapist's attitude of 'not-knowing', that is, not assuming too much about the client beforehand, not only as an act of valuing the client and forming the basis for

³ Open-ended questions are also used in qualitative research for gathering authentic research material.

collaborative non-pathologizing therapy (De Jong & Berg, 2018, pp. 30-58) but also as a strategic “Derridean” attempt to deconstruct therapist dominance.

Although SFT is based on the idea of democracy (De Jong & Berg, 2018, p. 350), it is not totally power-free. Language can be used as a strategic tool for exerting power (Freeman, 2011, p. 157)⁴. Since language creates reality for both therapist and client, it is extremely important that SFT practitioners stay alert in choosing their words. What is said, as much as what is not said, has an impact on the client. In the end, however, it is the therapist who steers the direction of the conversation.

Since one cannot escape language-as-power, the next best thing is to be aware of the fact. Some questions are more uplifting and agency-enhancing than others. SFT questions have clearly been designed with the intention of enhancing client self-efficacy. However, the therapist needs to be sensitive with regards to what, when and how questions are put to the client. Timing is crucial, as timing is power.

‘Social constructivism’ is an umbrella concept for a variety of different approaches (Miettinen, 2000). The wider the arena of social constructivism becomes, the fuzzier the concept. As Miettinen (2000) reminds us, it is important to ask what is being constructed when we talk about social constructivism. Are we constructing (a) the individual’s knowledge and conceptual thinking, (b) a co-interpretation of something in a dialogue (c) a rule or institution, that individuals follow, or (d) an artifact or system of artifacts, for example, a house, a microscope, a computer program or a collection of poems (Miettinen, 2000, p. 276) (present author’s translation).

I would argue that all four of the above-mentioned modes of knowledge construction are present in an SFT session. What is uttered through words reflects larger societal discourses, concerns, and changes. The economic, social and political are reflected in the client’s personal narrative, irrespective of the reason for entering therapy. The client’s identities, interaction histories, value and belief systems, knowledge, and skills, are all intertwined. Hence, the therapeutic encounter is not just ad-hoc interaction. It is a conscious effort, on part of the therapist, to influence client well-being on the conceptual and concrete level.

Meanings are not constructed out of thin air, as the term ‘social constructionism’ might imply if used lightly. Meanings are always constructed in relation to an object of activity (e.g., Stetsenko, 2005), in the present context to the motives and goals set by the client in therapy. Thus, motivation is not a static or abstract phenomenon, nor is it solely innate or universal, but depends on what people concretely do, how they engage with the objects and people in their lives (Freeman, 2007, p. 6).

Knowledge construction in therapy is a multidimensional and systemic activity. It is unsurprising that SFT and ‘systems theory’ have been seen as connected (e.g., Pihlaja & Pihlaja, 2020). While systems theory was originally developed in the field of cybernetics, it is nowadays used as a generalized approach in explaining the interrelated and interdependent nature of the parts of any given phenomenon (see Skyttner, 1996, p. 16.). However, as I see it, a more scientifically closer systems theoretical approach to SFT would be CHAT, as its roots in cultural psychology and developmental psychology bring it closer to the world of therapy (see Cole, 1997 Engeström, 1987, 2004; Leontjev, 1978; Vygotsky, 1978).

When clients enter therapy, they bring their communities with them. The systemic nature of human activity (Engeström, 1987; 2004)⁵ can be seen when individuals move in and through their social networks. When one’s activities are running smoothly, one is not conscious of one’s network of communities. It is only when an individual’s goals clash with the goals of others who share that particular activity system, when the individual has to choose from among the contradictory goals of multiple activity systems or when someone leaves or joins the activity system, that their communities become visible. (see Freeman, 2007; 2011; 2015.) Hence, society is deeply reflected in the individual. There is a dialectical movement between history and the present, and between the individual and society (see Cole, 1997; Engeström, 1987).

SF therapists also bring their history into the session but make a conscious effort to keep it in the background. Further, the therapist relies on culturally and historically developing tools, rules, regulations, and divisions of labor in conducting SFT. Therapy is a learning process in which therapist and client co-create new meanings, tools, and innovations. In essence, each SFT session is both the user and producer of culturally mediated artifacts. A therapist who has a systemic understanding of human activity acknowledges that therapeutic work cannot be isolated from the cultural-historical

⁴ See also Billig et al., 1988; Fairclough, 1992; Foucault, 1982.

⁵ See Engeström (1987, pp. 73-87) concept of ‘activity system’, based on the work of Vygotsky and Leontjev.

developments of global society or from one's knowledge and skill development networks. Therapy work is itself a historically evolving linguistic and material institution.

SFT highlights the practical value of knowledge, that is, how clients can utilize their skills in concrete daily activities (see De Jong & Berg, 2008; Furman & Ahola, 2012). As I understand it, the striving of SFT - via linguistic means - for a concrete outcome of therapy from the outset, indicates not only social constructivism but also on pragmatism. Miettinen (2006, p. 389) analyzes the relation between pragmatism and CHAT:

...For both of the theories [John Dewey's pragmatism and cultural-historical activity theory as epistemologies and theories of transformative material activity], the concept of activity, the prototype of which is work, constitutes a basis for understanding the nature of knowledge and reality. This concept also implies for both theories a methodological approach of studying human behavior in which social experimentation and intervention play a central role. They also suggest that reflection and thought, mediated by language and semiotic artifacts, serve the reorientation of activity and is vital in the development of new, alternative ways of action...

On this view, SFT seems more pragmatic and culturally mediated than 'radical constructivism'. While it is true that behavior and roles differ somewhat from one context to another, there is also something very concrete and tangible about the human mind. The world of artifacts is essentially psychology externalized. Just one glance at the immediate material and digital world demonstrates that one's surroundings are steeped in products of the creative human mind.

Vygotsky's (1978) version of social constructivism, in his study of the socially originating human mind, also includes the world of cultural artifacts and material objects: "Psychological processes need to be conceptualized as object-related actions out in the world, making a difference in the world and participating in its construction and development" (Stetsenko, 2005, p. 82).

Philosophically speaking, I suggest that SFT be understood as a *pragmatic version of social constructivism*. Since SFT aims at anchoring the client's speech in concrete activity, I see Vygotsky and CHAT as complementing the SFT framework. In the next section, I introduce Vygotsky's concept of 'cultural mediation'.

'Cultural Mediation' as a Systemic Concept

Vygotsky's (1978) concept of 'cultural mediation' bypasses the behaviorist S-R model and the subject-idealism of introspection psychology (Leiman, 1992, p. 210). Likewise, Miettinen (2006, p. 389) notes that the idea of a culturally mediated act transcends the Cartesian subject-object dichotomy. Vygotsky was a courageous trailblazer, who adopted a critical stance towards psychological pathologizing and causal explanations (e.g., Cole, 1997). The avoidance of unnecessary pathologizing, determinism and blaming are also key principle of SFT (Ahola & Furman, 2016, p. 19).

The insightful idea of 'cultural mediation' points to the personal sense of social activity. It directs attention to all the linguistic and material tools that are acquired through socialization. According to Vygotsky, the most important process in the development of a child's psychology is the internalization of the culture in which the child is embedded. All cultural products created by people in their specific cultures are artifacts. And it is through all the things we use, from simple objects such as a spoon, pen, or table, to more complex things like language, traditions, beliefs, and art and science that culture influences development (Cole, 1997; Vygotsky, 1978).

Vygotsky offers an example of this insight by showing how the movement of a child's hand towards an object becomes a sign. The meaning of the hand movement changes when the child's mother or caretaker arrives to witness the behavior. It becomes a socially oriented act. The adult understands that the child desires the object and gives it to the child. It is only later that the child forms a link between pointing and social activity, and the motion becomes "the act of pointing". Hence, the act of pointing is also an act of pointing to a social relation (Vygotsky, 1978, p. 56).

It is therefore impossible to distinguish psychological development from the unique cultural and social situation of the individual. Consciousness is created in linguistic encounters with people, things, nature, and the whole universe. As Leiman (2011) notes, it is this sense that word meaning, as a unit of psychological activity, binds the intra-psychic and the interpersonal. For Vygotsky, 'word' is a microcosm of human consciousness (Vygotsky, 1986, p. 256) and 'sign' symbolizes togetherness (Leiman, 1992, p. 216). Further, language does not precede action but vice-versa: action came first, and word developed from it (Vygotsky, 1962, p. 153).

People create their private emotions and thoughts in the semiosphere, through context-specific actions (Valsiner, 2006, p. 9). It is through language and the use of cultural tools that we communicate with ourselves and others. Internal

speech is a psychological tool oriented to the private mode of the self. It is used to internalize what is happening in the world. Externalized speech is used to make internal thoughts visible, and to exert influence on the thinking of others and the world of objects. (Vygotsky, 1978.) The internalized social realities and the externalized internal realities exist in a dialogical relation. Psychological development, as explained by Vygotsky, comprises a continuous dialectical interplay among distinct, but interdependent, functions or processes of internalization and externalization (Lourenço, 2012, p. 283).

The cultural artifacts and tools we inherit are simultaneously material and conceptual. They are conceptual in the sense that their material properties have been influenced by their prior social history (Cole, 1997, p. 117) and that they express certain values and belief systems. By modifying old artifacts and creating new ones, we also create and modify our own and others' psychologies. In this way, important social capital is transferred and transformed from one generation to the next. New innovations emerge when "old" artifacts are assigned new meanings and use-purposes. (See Freeman, 2007; 2011; 2012; 2015). Through this lens, SFT can be viewed as an arena for co-creativity and innovation.

Socialization, personal re-orientation, and creative activity continue throughout life. The individual participates in many different social and professional communities and networks.⁶ In these social formations, the individual experiences different motive contradictions that, when successfully resolved, lead to meaningful new career and retirement paths (see Freeman, 2007; 2015).

These ideas are in line with the thinking of Milton H. Erikson (Haley, 1997, p. 39) on how developmental crises are a natural part of life. How the individual goes about solving these dilemmas and social transitional phases is of key importance. As Furman & Ahola (2012) emphasize, it is crucial to pay attention to exceptions and progress in SFT. Concentrating on situations and circumstances where things are better - when the problem is absent - strengthen the client's perceived self-efficacy and achievement. When the therapeutic focus is on healthy behavioral patterns, resources and skills, problems can be solved without consciously dwelling on unwanted behavior. (see Berg & Miller, 1992; De Jong & Berg, 2008; Furman & Ahola, 2012.)

Hence, SFT's skill-focused questions, combined with Vygotsky's thoughts on learning and development, offers the therapist an uplifting way to aid the client combat life's socially and culturally mediated challenges.

The Zone of Proximal Development and SFT

The zone of proximal development (ZDP) is based on the idea of culturally mediated human development, as described earlier. The concept of ZDP emerged from Vygotsky's observations on learning and development in the schooling context. He made a distinction between good and bad learning. Bad learning refers to transferring predetermined information and knowledge into the "heads" of individuals. Good learning, on the other hand, results in something that is unpredictable and new, something that did not previously exist. (Engeström, 2004, p. 19).

Although development does not often happen in the individual's comfort zone, overly difficult goals and future scenarios can be paralyzing. What is needed is an optimal zone of development, or as, Vygotsky defines it, a zone of proximal development:

...it [the zone of proximal development] is the distance between the actual developmental level as determined by independent problem solving and the level of potential development as determined through problem solving under adult guidance or in collaboration with more capable peers (Vygotsky, 1978, p. 86).

In other words, the ZDP is the distance between what individuals can achieve independently, and what they can do with a little help. The word 'proximal' means that the assistance given only slightly exceeds the learners' current level of skills, thereby complementing and building on their existing capabilities (Cole & Cole, 2001).

All this has important implications for SFT. The *therapist can be considered—momentarily—a forerunner of the SFT approach*, and hence a "more capable peer" with regard to the principles of SFT. The SF therapist is trained to ask open-ended questions that enable the client to act as expert. The test for therapists is their ability to activate and support the clients' independent problem-solving and the development of their life skills and self-efficacy. When faced with traumas and challenges, clients may temporarily "forget" what they know and can do. This is why it is important to map out the

⁶ Lave & Wenger (1991) use the term 'communities of practice'.

client's present skills via exceptions and progress-focused questions. It is equally important to invoke the client to think about the possibility of developing new skills. Essentially, it is new points of views that are created in the ZDP. While the therapist helps the client expand their *horizon of action*, it is up to the client to do the actual work.

In the field of education, ZDP has been operationalized through the notion of 'scaffolding'. The concept refers to activities where the teacher erects temporary supporting structures to help learners develop their understanding, conceptual thinking, and skills. As the learner acquires these new skills, the teacher withdraws support until the need arises for the learning of new skills. Later, the learner is able to transfer these new skills into new activity contexts (Hammond & Gibbons, 2005, pp. 7-8).

SFT encourages and supports the client to examine the current situation, establish goals, and do things differently (Pihlaja & Pihlaja, 2020). Hence, with the assistance of a sensitive ZDP-informed SF therapist, the client produces a kind of "map" of their ZDP. This includes a representation of how to move from A to B with regard to the issue at hand: what old skills can be mobilized, what new skills need to be learned in order to make a change, and who to turn to for support. SFT questions that focus on past successes and future miracles, including the therapeutic rating scale and social network mapping, ideally energize the client to take charge of their own life. In between sessions, the client rehearses newly acquired skills, viewpoints, and behavioral patterns. Each therapy session allows the client to conceptualize and make visible new internalized perspectives and behavioral patterns. The cyclical therapy process ends once sufficient independence is reached. Thus, therapeutic support is only temporary. Once the client has achieved the new target the scaffolding is quickly dismantled. Together, client and therapist evaluate the success of the therapeutic process. If they decide to continue, the focus is on a new skill or viewpoint that requires the transitory support of the therapist.

The ZDP is a creative arena for externalizing the psyche and internalizing the social. In fact, externalizing and internalizing form a continuous dialogical relation (Engeström, 1987; Vygotsky, 1978). In SFT, the term "externalization" refers to the tools that are used in detaching the problem from the person. Thus, externalization points to a specific technique used to minimize the emotional distress of the client. Detaching the problem from the client allows the objectivity needed to examine the challenge it presents. Some of these techniques includes using a white board, role play, and externalizing the problem into a creature that the client can feel comfortable with. (see Pihlaja & Pihlaja, 2020). However, theoretically speaking, the act of externalizing has already happened before the use of these externalizing techniques, precisely at the point when the client finds words for the problem. Hence, it might be conceptually more accurate to speak about *SFT distancing techniques*.

The therapist invites the client to externalize their thoughts through the use of SF questions. The therapeutic dialogue contributes to the possibility of an updated idea of self. Once the new view of "me" is internalized in the private sphere of the self, long-lasting behavioral changes are possible. And with them new kinds of social dynamics, and identities, new "we's". The outcome of therapy is the result of the mystery of collaboration.

The unpredictability of learning has been discussed in the field of education by Engeström (1987). His concept, 'expansive learning', is directly based on Vygotsky's ideas, among others. However, his systemic model of learning emphasizes the collective over the individual. The object of learning is not seen as a given or static phenomenon, but as something that evolves and expands with the learning process. This learning process advances as follows: (a) questioning the current practice, (b) analyzing the current practice, (c) modeling the new solution, (d) examining and testing the new model, (e) implementing the new model, and (f) consolidating, reflecting on, and generalizing the new model of activity. The cycle begins again when the current model encounters contradictions. (See Engeström, 2004, pp. 59-63).

SFT can be viewed as a ZDP-informed expansive learning process, in which the therapist and client negotiate and define the objectives of therapy with the help of specific SFT questions. For instance, the use of 'the miracle question', builds hope of a better tomorrow by helping to concretely envision this change. The client is asked to imagine a situation where the problem has miraculously disappeared, and to verbalize what is different, how it will be known that the problem no longer exists, who will know first, how will they know, and so on. (De Jong & Berg 2008, p. 88). Hence, the miracle question evokes new viewpoints, new behavior, and new social dynamics. To my mind, it accords well with Engeström's (1987; 2004) and Vygotsky's (1978) ideas of learning as a constantly expanding cyclical and systemic process, the outcome of which is an innovative eye-opener.

A therapist who relies on the Vygotskian idea of good learning understands that individual motivation is the result of positive and timely feedback. As De Jong & Berg (2008, pp. 116-139) note, positive feedback and merit are important

from the point of view of client empowerment. In my previous research, I have found that the desire for recognition⁷ is an important social force motivating an individual to participate and contribute to collective activity (Freeman, 2007, 2015). Therapy is no exception: the client needs to be motivated to participate to make a difference.

However, positive feedback needs to be anchored in the individual's concrete linguistic actions and collective activities. Unmerited praise of the client does not lead to future independence. Conversely, once the scaffolding is removed it can lead to unrealistic objectives and learning paralysis. It is often the case that a person needs to transcend their old values and belief systems to genuinely learn something new. Hence, I would argue that expansive learning also requires the skillful toleration of change as well as the ability to constantly re-assess and realign one's objectives.

Solution-Focused Zone of Proximal Development (SFZPD) – Tentative Guidelines

Create the possibility for 'good learning' based on the ZPD. A therapist who understands the meaning of 'good learning', recognizes that learning, personal growth, and creativity require that a person is not only aware of their current skill base, but is also willing to expand it, one small step at a time.

Create the possibility for continuous reflection, re-definition, re-assessment, and realigning of life objectives. The SF therapist should encourage and support independent SFT-informed thinking, including the ability to redefine personal traits, see things from new perspectives, reflect via distancing, and be vigilant and realistic with respect to setting objectives. Learning requires redefining the social. 'Perceived self-efficacy' (Bandura, 1977) could thus be viewed as the ability to see one's possibilities and seek to acquire the agency to realize them.

Encourage the ability to face fears that may stand in the way of continuous learning and creative self-expression. SFT is about collaboratively learning something that does not yet exist. This involves moving towards the unknown, a situation that can bring with it fears and emotional baggage. Although SFT doesn't emphasize focusing on the negative aspects of life, this does not mean that difficult emotions should be avoided or denied. Instead, they are handled in a more empowering way. By building an understanding of the client's current capabilities, the therapist builds a safe foundation on which to examine any fears that may inhibit good learning. In essence, the client moves from a state of "I can" to "I am learning, and I have the courage to attempt something totally new". This transition is of importance as it encourages the client to trust the learning process and master the unexpected. Hence 'perceived self-efficacy' (Bandura, 1977) can be also understood as the courage to do things differently and make peace with the unknown.

Encourage the symbiosis-seeking client to experience the feeling of separateness and independence. SFT in the ZPD is a useful approach for dealing with addictions, as it stimulates independence and healthy psychological separateness. It is often the case that people with an addiction search for solutions "outside" themselves, leading them to form unhealthy attachments to people, objects, and substances. However, SFT encourages finding solutions from within the self: from one's skills, one's resources – from things and people that boost and support the formation of a healthier life.

In my experience, people challenged by addictions may exhibit a tendency to form attachments to peer-support groups and see themselves as examples of psychopathological categories. Despite the good intentions of addiction programs, there is a danger in using expressions like "recovering from X or Z" or "Hi, my name is C, I am an X or Z". These phrases invite the person to consider their membership of their addiction group as lifelong. They are deterministic and deny the possibility of freedom. There is also a tendency for people with addiction histories to remain dependent on therapy or therapies. In turn, a therapist who has unresolved addictions may hold on to the client for too long.

On the basis on this theoretical synthesis, I would suggest adding the following to Furman's (1994) list of the characteristics of SFT: pragmatism, mindful language use, skill-centeredness, and working within the SFZTD to ensure Vygotskian 'good learning' and healthy independence.

Conclusion and Discussion

The tentative new concept of a *solution-focused zone of proximal development* (FSZPD) proposed in this paper highlights *learning-in-SFT as an optimally designed non-individualistic and expansive process, leading to empowered independence and creativity*. Moreover, it connects SFT to a strong socio-cultural and activity-theoretical tradition. Vygotsky's approach can

⁷ See Miettinen (2005) for a discussion of the concept of 'artifact-mediated desire for recognition'.

be seen as a forerunner of systemic thinking in the field of psychology. His work represents a form of social constructionism that includes material artifacts in the linguistic study of the creative human mind. I suggest that from a philosophical perspective, SFT can best be understood as a hybrid form of pragmatism and social constructionism or, in other words, a *pragmatic version of social constructionism*. Hence, the paper contributes to the ongoing dialogue related to the theoretical and philosophical foundations of solution-focused therapy.

The position taken in this paper is that understanding the human mind means studying individuals' activities, including their creative output and innovations (Freeman, 2007; 2015; Miettinen et al., 2008). My earlier studies on motivation (Freeman, 2007, 2011, 2013, 2014, 2015) show clearly that a meaningful life is active and creative. This notion has important implications for the evaluation of SFT. What if, instead of using numerical self-assessment forms, we ask ex-clients about their daily creative linguistic and material actions? Might this not reveal more about their well-being than their fluctuating daily emotional states? Distinguishing between "creative and non-creative people and industries" distorts life. All fields and people are potentially creative. SFT, coupled with socio-cultural and activity theoretical thinking, has the potential to democratize creativity.

I will now quickly revisit the notion of 'self-efficacy. Bandura (1977) draws a distinction between 'perceived self-efficacy' and 'self-esteem': the former refers to individuals' subjective beliefs about their skills and abilities in relation to their set goals, while the latter refers to individuals' beliefs and evaluation of their worth. (Bandura, 1977, p. 309.) I would argue that perceived self-efficacy and self-esteem cannot be separated: the individual uses both psychological structures in forming an understanding of their possibilities. Moreover, mastering a new skill contributes to both perceived self-efficacy and self-worth.

A therapist who favors a SFZDP approach helps the client with minimal intervention. In this approach, the therapist supports and reinforces their clients' self-efficacy, self-worth and a healthy sense of independence via helping them identify and develop their skills and abilities. The idea underlying SF help is to ensure that the client's ZDP is realized in small, manageable steps. The helper, or therapist, aids the individual in creating a realistic, but hopeful motivational state. A good helper knows when to back off, give space, and eventually set free. The day the therapeutic relationship ends is a moment to celebrate. Berg & Miller (1992, p. 11), for example, recall a client saying: "You got me started and then you got the hell out of my way".

According to Leiman (2011, p. 441), psychotherapy takes place on the interface between the interpersonal and intrapsychic: between what is shared with others and what is constructed in the private sphere. This leads to questions of honesty and trust. A person can lie to others and the self, but the body rarely lies. I therefore consider it important, through increasing somatic awareness, to take the client's bodily expressions and sensations into account. As Burkitt (1999, p. 14) puts it, we are 'thinking bodies. The tools that we use, on the other hand, are extensions of our bodies (Shotter, 1975, p. 58). For example, when constructing an appropriate SFZDP, it is important to be sensitive to the client's energetic and non-linguistic cues. It is often the case that an individual's body language will indicate whether the goals being set are realistic. It is also important that the therapist's SF appraisal is genuine, as it impacts the achievement of set goals.

SFT is a form of therapy that centers around clients' ability to find and develop the resources and skills they need to make informed decisions about their lives. As Shotter (1975) points out when discussing the "dangers of psychology" in his classic book "Images of Man in Psychological Research", psychology should study how we take responsibility for our behavior instead of searching for "laws the govern behavior" (Shotter, 1975, pp. 60-61). The ZDP-informed SF therapist creates a safe and optimal space that encourages learning, change, creativity, and the expression of agency. Further, the therapist helps clients to accept themselves as part of a historical and cultural continuum. A good teacher does the same. In this sense, therapy work and teaching resemble one another: the teacher aims at helping the student to become an independent learner, while the *SF therapist aims at helping the client to become an independent user of SF thinking*.

I now return to the principle of 'not knowing' in SFT (De Jong & Berg, 2008, pp. 30-58). The idea that the therapist abstains from making any assumptions about the client or the client's challenges beforehand is an important attitudinal tool. It is the basis both of supportive collaboration and fresh new redefinitions. Not knowing leaves more room for the client to be the expert.

How then, is it possible for the therapist to not know, while at the same time possessing a large body of knowledge and a wide range of skills and abilities? How does the therapist reach a state of not knowing? In my experience, this can be done by knowing oneself: practicing a meditative state of being-in-the-world, where fleeting but precious ego-free moments can be experienced. Hence, not knowing could be viewed as a *conscious meditative state*.

Indeed, the SFT principle of ‘not knowing’ opens up interesting questions for future research in relation to the concept of ‘consciousness’. We often deal with fluctuating states of the mind as we move about in our daily activities. Could the meditative state of not knowing be viewed as a distinct ‘state of mind’ or ‘mode of being’? Or would it perhaps be seen as a category of action; ‘pure action’ or ‘acting without acting’? What might Eastern Yogic and Buddhist philosophers have to say about SFT’s pragmatic social constructivist notion of not knowing? I would think the interplay between action and non-action would certainly be a topic of interest.

Finally, I suggest *expanding the notion of ‘not knowing’ to also reflect the outcome of therapy*: the creation of something new and unanticipated. A skilled SF therapist is humble and understands that every interaction is a unique historical and social opportunity for learning, creativity, and innovation.

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*RESPONSE ARTICLE***The Paradox History of Ideas: Some Remarks on Arnold Beisser's
*The Paradoxical Theory of Change (1970)***

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The Paradox History of Ideas

The history of ideas is a given – and all the same it is an illusionary product of our imagination. Thus, it is also a creative justification of who we choose to be and how we evaluate and design the “given”.

Usually – for example, when we talk of a paradigm shift in the field of psychotherapy by the solution-focused stance – we are happy to believe, ideas that were new, groundbreaking and revolutionary in our own thinking, really were “new” and “groundbreaking” and “revolutionary” within the history of ideas. And, of course, sometimes this might be true.

However, quite often the *Copernican revolutions*¹ turn out to be not exclusively performed by the people we hold accountable for in the widely agreed upon history of ideas. Historically, quite often even hidden to experts of the field, there are other people who expressed these ideas some years, sometimes even centuries before they appeared for the “first time”. Copernicus, Darwin, Freud, Pearls, de Shazer ... these names are not just names of interesting people of our past, but they became names in stories that are told in order to tell stories to justify who we choose to be. And, of course, sometimes these stories might not be true.

Thus, being conscious of alternative ways of telling the story called “History of Ideas” helps us to be flexible and creative in our ways of world-making² and not becoming disciples within a community of ideas, who then resemble plaster casts of other peoples thinking instead of living examples of thoughtful thinkers and creators in communication with others.

For the pleasure of the latter, we are reprinting a short, yet classical, paper written in 1970 by the American psychiatrist and Gestalt therapist Arnold Beisser, which is the most frequently referenced article in the body of Gestalt therapy literature next to the works of Frederick Perls. Nonetheless, it might be unknown to many readers of the *Journal of Solution Focused Practices*, just as Beisser's inspiring account of how he coped with being a quadriplegic after a polio infection at the age of 25 with the very “solution-focused” title: *Flying without Wings*.

At a time, when Solution-Focused Brief Therapy (SFBT) was not yet conceived, Beisser looked back on almost half a century of Frederick Perls' professional life which he found at odds with the “psychological establishments”.

Many who are familiar with the development of SFBT would probably and interestingly agree, if one would replace the name *Frederick Pearls* with the name *Steve de Shazer* in the first paragraph of the article. Give it a try.

However, by 1970 Steve de Shazer had not published anything and the first sentences of his first publication in 1974, though it is concerned with the issue of change as well, to me sound much less in line with solution-focused thinking than Beisser's article. De Shazer's first sentences reads:

The goal of the family therapist, whatever his theoretical orientation, is to promote change, and the initial problem he faces is finding a way to break into a rigid system. Interventions which deliver a shock to the system and throw it out of equilibrium, are an effective way to initiate change.³

¹ A (maybe) first exploration into this idea in the field of solution-focused thinking was done by Jenny Clarke (2012). <https://sfwork.com/pdf/2012AnotherCopernicanRevolution.pdf> read 27.5.2021.

² A term connected to another story by Nelson Godman (1978): *Ways of Worldmaking*. Hackett.

³ de Shazer, Steve (1974): On getting unstuck. Some change initiating tactics. In: *Family Therapy* 1 (1), p.19.

Instead, the paradoxical theory of change that Beisser describes, is briefly summed up like this: *“that change occurs when one becomes what he is, not when he tries to become what he is not.”*⁴

The paradoxical idea that change starts to unfold, when people stop trying to live up to past or jet to come versions of themselves, is much closer to the idea of *radical acceptance*⁵ of clients ways of being, than to the strategic system-thinking in tradition of MRI from where solution-focused practice developed. You are invited to explore further differences and similarities of two models – Gestalt therapy and SF practice – that are not often compared and related.

Now, let me just draw your attention to some of Beisser’s formulations, that hit a tune that many might want to hum along with.

We there find a rather radical version of describing a “not-knowing” position, where wanting to be helpful is already seen as a claim of knowledge: *“A therapist who seeks to help a patient has left the egalitarian position and become the knowing expert”*. We also find an interactional argument to keep changing, what we are doing as we go along, with every specific client: *“This kind of mutual interaction leads to the possibility that a therapist may be most effective when he changes most, for when he is open to change, he will likely have his greatest impact on his patient”*. This is something we might forget sometimes, when we are too enthusiastic with minimalism or a specific idea of what is or is not solution-focused or how SFBT should look like. Sometimes it is precisely questions beyond what is expected in solution-focused conversations that are particularly important to remain solution-focused.

Another topic which Beisser addressed in 1970 was long out of sight of solution-focused practitioners, or even deliberately set aside: “social change” and the “compartmentalization” of communities.

Well, have a look at this journal’s statement on missions and visions⁶ or other recent activities, as for example the *Solution-Focused Manifesto for Social Change*⁷ to become aware that at least some solution-focused practitioners would wholeheartedly agree with Beisser, who says: *“it is proposed that the same principles are relevant to social change, that the individual change process is but a microcosm of the social change process.”* And Beisser also calls for an ethical obligation to find ways to create new relationships between compartmentalized people: *“The compartmentalization of old people, young people, rich people, poor people, black people, white people, academic people, service people, etc., each separated from the others by generational, geographical, or social gaps, is a threat to the survival of mankind. We must find ways of relating these compartmentalized fragments to one another as levels of a participating, integrated system of systems.”* Fifty years later this description and demand is sadly still right up to date.

Looking back into the “History of Ideas” we discover the paradox, which is that it does not exist. What exists are the different stories we tell each other and that we do or do not listen to. Or maybe put differently, what exists are the people united or separated in the way they co-create mutual communication. Beisser’s point was that **paradoxically** *“change (...) does take place if one takes the time and effort to be what he is – to be fully invested in his current positions”*. And – before you might choose to explore his article yourself – I would like to add my conviction, that in order to become fully invested in our current positions, we need to be fully invested in *listening* to the current positions of others.

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⁴ This and the following quotes in italic are from the reprinted article by A. Beisser (1970).

⁵ An idea that appears relatively late in the field of solution-focused writing. See for example: de Shazer, Steve (1997): Radical acceptance. In: Families, Systems & Health 15, p. 375–378.

⁶ Journal of Solution Focused Practices, Missions and Visions (2021). <https://digitalscholarship.unlv.edu/journalsfp/aimsandscope.html>

⁷ The Solution-Focused Collective, (2019). A Solution-Focused Manifesto for Social Change. <https://solfocollective.net/the-manifesto-for-text-readers/> read 27.5.2021.

*RE-PRINT***The Paradoxical Theory of Change**Arnold Beisser, M.D.

This manuscript is a reprint presented in its original version. The original manuscript can be found at <https://www.gestalt.org/arnie.htm>

The Paradoxical Theory of Change

For nearly a half century, the major part of his professional life, Frederick Perls was in conflict with the psychiatric and psychological establishments. He worked uncompromisingly in his own direction, which often involved fights with representatives of more conventional views. In the past few years, however, Perls and his Gestalt therapy have come to find harmony with an increasingly large segment of mental health theory and professional practice. The change that has taken place is not because Perls has modified his position, although his work has undergone some transformation, but because the trends and concepts of the field have moved closer to him and his work.

Perls's own conflict with the existing order contains the seeds of his change theory. He did not explicitly delineate this change theory, but it underlies much of his work and is implied in the practice of Gestalt techniques. I will call it the paradoxical theory of change, for reasons that shall become obvious. Briefly stated, it is this: *that change occurs when one becomes what he is, not when he tries to become what he is not*. Change does not take place through a coercive attempt by the individual or by another person to change him, but it does take place if one takes the time and effort to be what he is -- to be fully invested in his current positions. By rejecting the role of change agent, we make meaningful and orderly change possible.

The Gestalt therapist rejects the role of "changer," for his strategy is to encourage, even insist, that the patient be where and what he is. He believes change does not take place by "trying," coercion, or persuasion, or by insight, interpretation, or any other such means. Rather, change can occur when the patient abandons, at least for the moment, what he would like to become and attempts to be what he is. The premise is that one must stand in one place in order to have firm footing to move and that it is difficult or impossible to move without that footing.

The person seeking change by coming to therapy is in conflict with at least two warring intrapsychic factions. He is constantly moving between what he "should be" and what he thinks he "is," never fully identifying with either. The Gestalt therapist asks the person to invest himself fully in his roles, one at a time. Whichever role he begins with, the patient soon shifts to another. The Gestalt therapist asks simply that he be what he is at the moment.

The patient comes to the therapist because he wishes to be changed. Many therapies accept this as a legitimate objective and set out through various means to try to change him, establishing what Perls calls the "topdog/under-dog" dichotomy. A therapist who seeks to help a patient has left the egalitarian position and become the knowing expert, with the patient playing the helpless person, yet his goal is that he and the patient should become equals. The Gestalt therapist believes that the topdog/under-dog dichotomy already exists within the patient, with one part trying to change the other, and that the therapist must avoid becoming locked into one of these roles. He tries to avoid this trap by encouraging the patient to accept both of them, one at a time, as his own.

The analytic therapist, by contrast, uses devices such as dreams, free associations, transference, and interpretation to achieve insight that, in turn, may lead to change. The behaviorist therapist rewards or punishes behavior in order to modify it. The Gestalt therapist believes in encouraging the patient to enter and become whatever he is experiencing at the moment. He believes with Proust, "To heal a suffering one must experience it to the full."

The Gestalt therapist further believes that the natural state of man is as a single, whole being -- not fragmented into two or more opposing parts. In the natural state, there is constant change based on the dynamic transaction between the self and the environment.

Kardiner has observed that in developing his structural theory of defense mechanisms, Freud changed processes into structures (for example, *denying into denial*). The Gestalt therapist views change as a possibility when the reverse occurs,

that is, when structures are transformed into processes. When this occurs, one is open to participant interchange with his environment.

If alienated, fragmentary selves in an individual take on separate, compartmentalized roles, the Gestalt therapist encourages communication between the roles; he may actually ask them to talk to one another. If the patient objects to this or indicates a block, the therapist asks him simply to invest himself fully in the objection or the block. Experience has shown that when the patient identifies with the alienated fragments, integration does occur. Thus, by being what one is--fully--one can become something else.

The therapist, himself, is one who does not seek change, but seeks only to be who he is. The patient's efforts to fit the therapist into one of his own stereotypes of people, such as a helper or a top-dog, create conflict between them. The end point is reached when each can be himself while still maintaining intimate contact with the other. The therapist, too, is moved to change as he seeks to be himself with another person. This kind of mutual interaction leads to the possibility that a therapist may be most effective when he changes most, for when he is open to change, he will likely have his greatest impact on his patient.

What has happened in the past fifty years to make this change theory, implicit in Perls's work, acceptable, current, and valuable? Perls's assumptions have not changed, but society has. For the first time in the history of mankind, man finds himself in a position where, rather than needing to adapt himself to an existing order, he must be able to adapt himself to a series of changing orders. For the first time in the history of mankind, the length of the individual life span is greater than the length of time necessary for major social and cultural change to take place. Moreover, the rapidity with which this change occurs is accelerating.

Those therapies that direct themselves to the past and to individual history do so under the assumption that if an individual once resolves the issues around a traumatic personal event (usually in infancy or childhood), he will be prepared for all time to deal with the world; for the world is considered a stable order. Today, however, the problem becomes one of discerning where one stands in relationship to a shifting society. Confronted with a pluralistic, multifaceted, changing system, the individual is left to his own devices to find stability. He must do this through an approach that allows him to move dynamically and flexibly with the times while still maintaining some central gyroscope to guide him. He can no longer do this with ideologies, which become obsolete, but must do it with a change theory, whether explicit or implicit. The goal of therapy becomes not so much to develop a good, fixed character but to be able to move with the times while retaining some individual stability.

In addition to social change, which has brought contemporary needs into line with his change theory, Perls's own stubbornness and unwillingness to be what he was not allowed him to be ready for society when it was ready for him. Perls had to be what he was despite, or perhaps even because of, opposition from society. However, in his own lifetime he has become integrated with many of the professional forces in his field in the same way that the individual may become integrated with alienated parts of himself through effective therapy.

The field of concern in psychiatry has now expanded beyond the individual as it has become apparent that the most crucial issue before us is the development of a society that supports the individual in his individuality. I believe that the same change theory outlined here is also applicable to social systems, that orderly change within social systems is in the direction of integration and holism; further, that the social-change agent has as his major function to 'work with and in an organization so that it can change consistently with the changing dynamic equilibrium both within and outside the organization. This requires that the system become conscious of alienated fragments within and without so it can bring them into the main functional activities by processes similar to identification in the individual. First, there is an awareness within the system that an alienated fragment exists; next that fragment is accepted as a legitimate outgrowth of a functional need that is then explicitly and deliberately mobilized and given power to operate as an explicit force. This, in turn, leads to communication with other subsystems and facilitates an integrated, harmonious development of the whole system.

With change accelerating at an exponential pace, it is crucial for the survival of mankind that an orderly method of social change be found. The change theory proposed here has its roots in psychotherapy. It was developed as a result of dyadic therapeutic relationships. But it is proposed that the same principles are relevant to social change, that the individual change process is but a microcosm of the social change process. Disparate, unintegrated, warring elements present a major threat to society, just as they do to the individual. The compartmentalization of old people, young people, rich people, poor people, black people, white people, academic people, service people, etc., each separated from the others by generational, geographical, or social gaps, is a threat to the survival of mankind. We must find ways of relating these compartmentalized fragments to one another as levels of a participating, integrated system of systems.

The paradoxical social change theory proposed here is based on the strategies developed by Perls in his Gestalt therapy. They are applicable, in the judgment of this author, to community organization, community development and other change processes consistent with the democratic political framework.

*RESPONSE ARTICLE***Narratives of Distinctiveness or Similarity and Connection – A Response to Korman, De Jong, and Jordan’s *Steve de Shazer’s Theory Development***

Guy Shennan

The Solution-Focused Collective

Abstract

In 2020 the Journal of Solution Focused Practices published an article called *Steve de Shazer’s Theory Development*. This surveyed the whole of de Shazer’s career, which the authors divided into four phases, from which they distilled six axioms they believe are foundational to de Shazer’s thinking and practice. In their commentary on the six axioms there is a considerable emphasis on the distinctiveness of SFBT, which the authors are keen to establish as different, in each of its foundational aspects, from most or perhaps all other therapies. This article is a response to this particular aspect of *Steve de Shazer’s Theory Development*. It suggests that, in comparing different approaches in the field, it is possible to construct both narratives of distinctiveness and narratives of similarity and connection. Some arguments for developing more narratives of similarity and connection are advanced.

Narratives of Distinctiveness or Similarity and Connection

I believe that the article on the development of Steve de Shazer’s theoretical thinking recently published in this journal (Korman et al., 2020) will become an instant classic. I thoroughly enjoyed reading it, so much so that I read it twice in relatively quick succession (the other reason for the second reading, beyond plain enjoyment, I will come to shortly). Steve de Shazer left a large body of work, when all his journal articles and papers are added to his books (de Shazer, 1982, 1985, 1988, 1991, 1994; de Shazer et al., 2007), and although this rewards careful reading, it is unrealistic to suppose that the majority of solution-focused practitioners or other interested people are going to find the time to read through all of it. And even if someone were to, the task of discerning and distilling from this large body a coherent account of de Shazer’s theory development is something else again. So a debt of gratitude is owed to the authors of this article for their coherent and compelling account.

I read the article again as it was chosen as the focus of the first meeting in 2021 of the Solution-Focused Collective Reading Group. This context led me to read - or misread, as de Shazer (1991, 1993) might have said, following the deconstructionists - the article in a particular way, which influenced my contributions in the reading group. One feature of the article stood out to me on this second reading, and I have written this response just in relation to this. One of de Shazer’s great legacies was his emphasis on the importance of conversation, not only in seeing therapy as conversation, but in encouraging it within the solution-focused community. I hope that this response might help in developing a conversation, and that other conversations will develop in relation to other aspects of the article. For example, the continuity it presents in de Shazer’s thought seems to me to cut across notions of an SFBT 1.0 and 2.0 that have been mooted in recent times (McKergow, 2016).

The aspect of the article I am going to explore and respond to here concerns the extent to which solution-focused brief therapy (SFBT) is distinctive from other talking therapies and approaches to helping, on the one hand, and ways in which it is similar to other approaches, on the other, and the potential effects of writing and talking about it as either distinctive or similar (or both). I will share an idea that has developed as I have read, thought about and discussed this, which is that it is possible to construct narratives of difference or narratives of similarity and connection from the same material, and that these different narratives will have different effects.

Within four phases of de Shazer's theory development, the authors¹ distil six axioms they propose are "foundational to an understanding of SFBT" (p. 47²). They add that, being foundational to an understanding of SFBT, each axiom "contributes to distinguishing SFBT from other talk therapies". When I am teaching SF,³ I do occasionally contrast it - or aspects of it - with other approaches, invariably adding what I see as an important caveat, that when I do this I am not saying it is better than other approaches, just different, and that the contrast can help to bring out what is distinctive about SF. In other words, I do sometimes draw on a distinctiveness narrative, in the context of helping people to learn the approach. I also wonder, whenever I do this, how necessary it is. In any case, as my contrasts are made with a view to aiding an understanding of SF, they are a means to this end, albeit a means infrequently used. In this article, these means and ends sometimes appear to be reversed, as can be seen in the abstract: "an understanding of SFBT... contributes to distinguishing SFBT from other talk therapies" (p. 47). It is this apparent importance given to establishing SFBT as distinctive that I wish to question.

Before examining how this is done, let me take a detour into the idea of constructing narratives and how different ones can be created. A clear statement of this can be found in the writing of de Shazer himself. In Phase 4 of his theory development (Korman et al., 2020), de Shazer began to talk about therapy conversations as stories or narratives (de Shazer, 1991, p. 91). In considering the narratives developed in SFBT conversations, de Shazer drew on the work of Gergen and Gergen (1983, 1986), according to whom there are three narrative types available for describing and evaluating people's lives: progressive narratives, which depict people as moving in a preferred direction; stability narratives, which show life as unchanging, and regressive (de Shazer preferred digressive) narratives, in which people are moving away from their goals (de Shazer, 1991, p. 92). The therapy conversation, according to this view, does not explore an external reality, the meaning of which has been fixed beforehand and is awaiting discovery in the therapy, but develops a narrative constructed by the therapist and client together. Solution-focused therapists seek to construct progressive narratives, as de Shazer (1994, p. 135) makes clear with regard to the purposes of a follow-up solution-focused session, which include "*constructing the interval* between sessions as having included some improvement" (emphasis added). The same point emerges clearly in the report of the seminal "change talk" research study (Gingerich et al., 1988), where the breakthrough move was made to bring "*constructing change*" (emphasis added) forward into the initial session.

There is a clear implication that other narratives could be constructed than the progressive ones typical of solution-focused conversations. It seems evident, for example, that the interval between any two sessions for any client could be constructed as having included some problem, or something that does not fit with the client's preferred direction at that time. As we know, from our belief in the existence of exceptions, nothing always happens (de Shazer, 1985, p. 161, 1988, p. 52), so "improvement" will not have been happening continuously between sessions, just as much as problems will not have been. Gergen and Gergen provided a typology of three narratives for describing and evaluating people's lives. I would like to tentatively suggest a typology of narratives for comparing things, for example, ways of doing therapy, which would also include three types of narrative: a distinctiveness narrative, a similarity, or connection, narrative, and a both-similar-and-different narrative.

The de Shazer theory development article develops a narrative which highlights the distinctiveness of SFBT from the outset, and this is emphasised in particular when each of the six axioms are introduced. I shall consider each axiom in turn. Under the first proposed - *Therapy is an observable interactional process, that is, a conversation* (p. 50) - the authors state that de Shazer "begins to clearly distinguish his theoretical focus from that of therapies that focus on what is happening inside the client which is not observable and not focused on client-therapist interaction" (p. 50, emphasis added). However, the same point about what it is that de Shazer is doing here could also be made within a connection narrative, which might include the following: "he begins to *clearly ally* his theoretical focus with those therapies that are focused on client-therapist interactions, rather than on what is happening inside the client which is not observable" (emphasis added). It would be hard to claim that de Shazer was alone in focusing on client-therapist interactions, and in fact the authors do not claim this in their comment under Axiom 1.

¹ Each time I use the phrase "the authors" from here onwards, I will be referring to Harry Korman, Peter De Jong and Sara Smock Jordan, the authors of the 2020 article I am responding to.

² All page numbers refer to Korman, De Jong and Jordan, 2020, unless marked otherwise.

³ Given that I focus more widely than just on therapy in my own work, I will use the abbreviation SF rather than SFBT when I am referring to this.

An example of another conversational approach to therapy that will be familiar to many SF practitioners was developed by Harlene Anderson and Harold Goolishian, who co-founded the Houston Galveston Institute in 1978, coincidentally the same year that Steve de Shazer, Insoo Kim Berg and their colleagues founded the Brief Family Therapy Center. In a chapter in an edited collection of social constructionist approaches to therapy, Anderson and Goolishian (1992) refer to their therapy as having been evolving over the previous twenty-five years, which would cover the whole of the first three phases of de Shazer's theory development. I imagine readers of this journal will be less familiar with the Conversational Model of British psychotherapist, Robert Hobson, whose 1985 book, *Forms of Feeling*, sets out the eclectic approach to therapy he had been developing over the previous thirty years. It would be easy to create a distinctiveness narrative contrasting the Conversational Model with SFBT, but there are wonderful similarities too, not least given the straightforwardness of Hobson's approach and his insistence that "the therapist is always involved in a two-person situation" (Hobson, 1985, p. 202).

This comment is interesting in the light of the second axiom the authors propose for de Shazer's theory: *The minimum unit of analysis is the therapist interacting with the client in the therapy setting. This unit cannot be subdivided further* (p. 51). Hobson might be saying something similar. The authors make a bold comment under Axiom 2: "With this axiom a clear boundary was set towards basically all other theories in the field" (p. 51). The meaning of the word "basically" in this sentence is not clear, and it might be that it is intended as qualifying the "all" that follows, to mean "most" or "maybe all". I think this would be a sensible qualification, in that there is always a chance that there are theories or models of which one is not aware.

There has already been at least one similarity/connection narrative developed that posits similarities between SFBT and the person-centered therapy of Carl Rogers (Hales, 1999). One of the "core conditions" of person-centered therapy is empathy, and it has been suggested that solution-focused brief therapists have not been very interested in this (Turnell & Lipchik, 1999). Empathy might be thought of as something the therapist possesses, or more behaviorally, as consisting of responses by the therapist to the client. However, two leading British person-centered therapists describe it in a way that appears to connect it with Axiom 1, as an interactive process, which "must take into account not only the verbal response of the counsellor and how this is perceived by the client, but also the interaction sequence which has led up to that response" (Mearns & Thorne, 2007, p. 70).

Turning to the third axiom proposed by the authors - *Change is the purpose of the therapist and client meeting* (p. 54) - I am tempted to begin another conversation, or re-enter one might be more accurate, given my reflections in the *Theory of Solution-Focused Practice* produced by the European Brief Therapy Association (Sundman et al., 2020, pp. 101-109). I put forward a view there about SF being "a process with hope at its center... rather than change" (p. 107). However, that was a view of mine and these axioms concern de Shazer's theory, and in any case it is not the focus of this response. Returning to this, I realize that in order to make my case, I am myself constructing a narrative of difference between me and the authors. I need to be careful! In their comment under Axiom 3, the authors highlight that solution-focused therapists "are not interested in the problem or the causes of the problem" and refer to "the enormous differences this leads to in practice compared to almost everything else in the world of psychology and psychiatry" (p. 54). One of the features of SFBT that seemed most distinctive to me, and excited me most when I was first trained in it, was this lack of interest in the problem. At the same time, it was not so much "enormous differences" in practice this would lead to that excited me, but rather the support it gave me to practice in the way I wanted to. This might have been connected to my coming not from the world of psychology or psychiatry, but from the world of social work. Debates have long raged about whether assessment or change efforts should be at the centre of social work, and as a child protection social worker I had written an internal paper advocating a change in approach for my team, which would see us shift the balance from assessment towards change. What we needed was a model and a skill set that would enable us to do this, and this is what SFBT provided me and by extension my team with.

This leads to one of the main reasons I have for thinking there are potentially beneficial effects in developing, at least in part or at least on occasions, a similarity/connection narrative for SFBT. As a trainer, I often suggest to people learning SF that they look out for ways it fits with their preferred ways of working. There are at least a couple of reasons for this. First, it seems likely that people will form a good impression of the approach when first coming across it if they see connections with ways they already like to work. Second, it can be a difficult task for many learners, especially those whose work context is not as straightforward as therapy (for using SF at least), to adapt and integrate SF into what they do. It therefore seems to make sense to look for where it will fit, rather than where it might jar, with pre-existing approaches. This is what happened in my own case. As well as fitting with my desire to focus more on

change and less on assessment, SFBT also connected with my preferred approaches to social work. In particular, task-centered social work had been developed as a brief alternative to traditional social casework (Reid & Shyne, 1969; Reid & Epstein, 1972), and during my social work training I had been attracted by its client-led, goal focus and absence of esoteric theory. I am not alone in making connections between task-centred work and SF practice. In an account of an SF approach to social work practice teaching, Bucknell (2000) discusses both similarities and differences. In the standard British text-book on task-centered practice, two of my former social work lecturers challenge the idea that “getting to the root of the problem” is an essential precursor of change, and cite de Shazer admirably: “Indeed, there are brief therapies which start with the goal and leave the problems untouched. After all, it is possible to start untangling a ball of wool and to learn how to keep it tangled without knowing how it got untangled in the first place” (Doel & Marsh, 1992, p. 94).

The fourth axiom - *Client change via therapy occurs through observable interactions in which the therapist finds ways to cooperate with the client* (p. 54) - relates to the major breakthrough that de Shazer made in relation to the idea that clients resist the therapist (de Shazer, 1984). Given how groundbreaking this was, a distinctiveness narrative makes sense when recounting that time, when de Shazer “question[ed] and dismiss[ed] many established concepts in the family therapy field and, thereby, continued to differentiate how therapy was being done at BFTC compared to many other family therapy clinics...”. However, I am not as convinced by the final two words of this sentence: “... both then and today” (p. 54).

In 1996, a year after I first trained in SFBT, I embarked on two years’ training in family therapy and systemic practice. I had been aware of the types of family therapy prevalent in the 1980s through working during that period at a young people’s psychiatric unit, and the contrast in my later training was marked. The focus then was firmly on collaborative and so-called second-order approaches, in which therapists and teams took non-expert positions. This has been described by Lynn Hoffman (2002) as a “new paradigm” for family therapy, with the shift becoming noticeable in the late 1980s and early 1990s, exemplified by Anderson and Goolishian (1992), Tom Andersen and his reflecting team approach (1987), the post-Milan work of Cecchin (1987) and the social constructionist approaches summarized in McNamee and Gergen (1992). Solution-focused brief therapy is of course distinct from all of these approaches, and at the same time, they are all collaborative and cooperative endeavors to a greater or lesser extent. Since this period, similarity/connection narratives in this respect are both possible and have often been told (see, for example, Friedman, 1993).

The fifth axiom - *Brief therapy is about developing solutions with clients* (p. 63) - is intended to encapsulate the solution-focused process as developed in Phase 3 of de Shazer’s theory development. I am not convinced by this axiom’s wording, which perhaps reflects my training and work with BRIEF and subsequent accounts of the “BRIEF version” of solution-focused practice (Shennan, 2019). However, I now believe that, though there are some material differences between versions of the approach, others are more superficial and a function of the way it is presented. While I do not describe what I do as “developing solutions” with clients, the more detailed comment that unpacks the axiom does reflect my practice, involving as it does the twin activities of “working cooperatively to continue changes already occurring in the client’s life, specifically those changes in the direction of the more positive future the client wants”, and “inviting clients to expand and construct the details of their definitions of a more satisfying future” (p. 63).

The last two sentences in this “unpacking” paragraph beneath Axiom 5 offer a clear example of the distinctiveness narrative that led me to want to make this response. Following an emphasis on de Shazer’s interactional stance and the “therapy-as-a-system” promoting client change, the paragraph ends: “In contrast, solution development is not about viewing clients as having problems conceptualized as puzzles to be assessed and solved. In this respect, de Shazer clearly distinguished SFBT from most other therapies” (p. 63). What is implied is a monolithic view of most therapy as being about assessing and solving problems, conceptualized as puzzles, which seems both a generalization and something of a caricature. Added to the collaborative, postmodern and social constructionist therapies referred to above, it is difficult to see person-centered, humanistic, existential and many integrative and creative therapies as based on assessment and problem-solving in this manner. Moreover, having set out what “solution development” positively consists of, the necessity of adding that it does not involve certain other activities is questionable. Finally, even if that contrast is useful in clarifying the solution-focused process, ending the paragraph with the clinching note that thereby “de Shazer clearly distinguished SFBT from most other therapies” suggests that demonstrating this distinctiveness was the aim all along. Why would this be the case?

Having seen Michael White’s work for the first time, and in response to a both-similar-and-different narrative comparing SFBT and narrative therapy (Chang & Phillips, 1993), Steve de Shazer (1993) wrote a very strong

distinctiveness narrative of his own. He concluded: “‘unique outcomes’ and ‘exceptions’ are vastly different concepts. They lead to, follow from, and are related to vastly different clinical practices and theories of change” (de Shazer, 1993, p. 119). I believe that unique outcomes and exceptions are actually quite similar, but even if we accept there are differences between them, de Shazer’s use of the word “vastly”, twice in rapid succession, seems curiously hyperbolic. His conclusion might have been influenced by his misunderstanding of the term *unique outcomes* and why the sociologist, Erving Goffman, coined it. He assumes that the uniqueness of a unique outcome refers to it being a one-off event, which, being an outcome, comes at the end of a long process (de Shazer, 1993, p. 118). However, in his classic account of mental hospitals as “total institutions”, Goffman (1961, p. 119) used *unique outcomes* to refer to aspects of a person which are neglected when the person is considered as a member of a social category - that of mental patient for example - aspects that are unique to that individual. White borrowed the term to refer to “aspects of lived experience that fall outside of the dominant story” (White & Epston, 1990, p15), where the dominant story is usually a ‘problem-saturated’ one. Different to exceptions? Perhaps, but surely not much and definitely not vastly. We can only conjecture about the reasons for such an extreme distinctiveness narrative, yet it would be understandable if these great therapists (White (1993) had concluded similarly), being in the process of establishing their relatively new approaches, felt the need to emphasize their distinctiveness in order to do so. Almost thirty years on, and this particular reason for constructing distinctive narratives seems less pressing.

The sixth and final proposed axiom - *Therapy is a visible interactional, dialogic process negotiating the meanings of the client’s language* (p. 66) - reflects de Shazer’s developing interest in Wittgenstein and post-structuralist ideas about how meaning is made in the interactions between people. Its connection to the first axiom, regarding therapy being an interactive process, which the authors see as having emerged in de Shazer’s first phase between 1969 and 1978, is testament to the continuity and consistency of de Shazer’s thinking and vision over the years. There is a glimmer of a similarity narrative in the authors’ comment under Axiom 6, before a return to distinctiveness: “While some other post-modern therapies may share this theoretical view, most therapies in the field are not post-modern and function as though words describing client difficulties and their solutions have essential meanings” (p. 66). I can attest to other post-modern therapies sharing this view, as the most input I have received on post-structuralism was when attending training on narrative therapy in 2014 and 2015.

The authors say that the post-structural view is more often today known as social constructionism (p. 63), and in their reflections on “the therapeutic power of post-structuralism”, Drewery and Monk (1994, p. 304) see social constructionism as “fall(ing) within the diverse range of implications deriving from post-structuralist insights”. They are reflecting as counsellors, yet address social as well as personal change and end their piece looking to the potential of social constructionism “far beyond the micro-context of the counselling interview” (Drewery & Monk, 1994, p. 312). This returns me to where I began, which was my reading of the Steve de Shazer theory development article for a meeting of the Solution-Focused Collective reading group.

I believe it was reading the article in this context that led me to see and reflect upon its distinctiveness narrative aspects, and to explain this, I will refer to the solution-focused manifesto for social change (Solution-Focused Collective, 2019). The manifesto is based upon a belief in the potential of the solution-focused approach to “be harnessed in the pursuit of social justice”. It sets out a number of intentions aimed at increasing social justice through solution-focused means, including that “we build links with movements for social justice and equality, and with practitioners of other approaches committed to these aims, so that we learn from and enhance each other’s work”. I appreciate the distinctiveness of solution-focused practice, my perception of which contributed to it changing my life and career virtually overnight when first training in it in 1995. I also appreciate that it offered me a way of working that fitted with how I wanted to see and work with people. I am sure that other approaches would also have fitted with this, but you can only attend one training course at a time, and it is probably in part an accident of my circumstances in the late summer of 1995 that I work as a solution-focused practitioner now. I am pleased to have come across similarities with other approaches since then, and perhaps the construction of some similarity and connection narratives, or at least some both-similar-and-different narratives, will aid in the creation of the links and alliances across approaches to change that are needed for the construction of a better world.

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RESPONSE ARTICLE

We Don't Want to Blur the Boundaries: A Response to Guy Shennan and the Solution Focused Collective

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We Don't Want to Blur the Boundaries

First, we want to thank Guy for commenting on our paper and the thoughtful process he put into it.

Guy would have liked our paper to be more about how solution focused brief therapy theory is connected to and similar to other approaches and less about how it is different. He says that our paper could have been written with a “narrative of similarity and connection” instead of how we wrote it, which was writing a “narrative of differences”.

In 2006 one of the authors (Harry Korman) took a long walk with Insoo Kim Berg in Vancouver. We had spent a day with Janet Bavelas and her colleagues in Victoria on Vancouver Island, and we were both fascinated by the microanalysis research that Bavelas had been doing for many years.

We talked about the fact that if we looked at a therapy session together we knew within just a few minutes if this was a solution focused session or not. We would know this even if the therapist hadn't asked any typical solution focused questions during those few minutes. We were both fascinated by this but even more fascinated by the fact that we had absolutely no idea how we knew. What was it that we saw and heard that clearly distinguished a solution focused session from everything else that we had seen live or on video. What was IT? What we had learnt during that visit with Janet Bavelas was that since we could see IT – even if we didn't have words or concepts to describe what it was we saw, it had to be something visible and/or audible. This led to 10 years of microanalysis research by the three authors together with Janet Bavelas.

After having discovered/described what IT was (IT is what is distinctive about solution focused brief therapy compared to other therapies) we moved on to other things that interested us. Among other things - writing the article about de Shazer's theory development.

We think that Guy is absolutely right when he says that we wrote a “narrative of differences” and yes - we could have emphasized similarity and connection with other therapy models. We wrote in good faith though, as we tried to condense de Shazer's writing, continuing to do what we think de Shazer did – which was emphasizing the uniqueness of the work at BFTC. Doing the opposite – emphasizing similarity to other therapy approaches – would have been altering what de Shazer did in ways that we would have felt very uncomfortable with.

We have to be honest though. We do believe that SFBT is different from most (if not all) other therapies. How solution focused brief therapists carefully choose what they listen, select and build on from what the client said. The lexical choices they make and the presuppositions of their questions. These are the visible and audible things that we see that distinguishes SFBT from everything else. With this in mind it is of course possible that we read de Shazer's work selectively, cherry-picking what he wrote about how SFBT is different and unique (confirmation bias) - and thus perhaps missing what he might have written about how SFBT is similar to, and connected to other approaches. Someone would have to re-read everything he wrote with this in mind to check for papers, articles or phrases where de Shazer perhaps emphasized similarity and connectedness with other approaches.

Then again we have to decide and if possible agree on what kind of similarities and connectedness that we are talking about. When therapists of different persuasions meet with someone for the first time they all say “hi” and everybody would probably agree that this is a banal similarity. In the same vein; the fact that two authors describe their therapies using the same positively laden words, doesn't mean that the therapy models are similar or connected. We have to look at actual practice (or recordings of it) to be able to claim similarities and differences. De Shazer always refused to say anything about therapies that he had not actually seen (see *Vive la difference*).

Shennan suggests that we could have constructed a similarity narrative and makes an argument for why that is possible and gives an example of how it can be done:

... De Shazer “begins to clearly distinguish his theoretical focus from that of therapies that focus on what is happening inside the client which is not observable and not focused on client-therapist interaction” (p. 50, emphasis added). However, the same point about what it is that de Shazer is doing here could also be made within a connection narrative, which might include the following: “he begins to clearly ally his theoretical focus with those therapies that are focused on client-therapist interactions, rather than on what is happening inside the client which is not observable”.

He is right of course. One can create narratives of similarity or distinctiveness or both and our question is “Why would one want to do that?” Blurring the distinctions and differences to what purpose? As we search Shennan's comments for why he wants us to do it, we find towards the end the part where Shennan identifies what led him to respond to what he terms, the “distinctiveness narrative aspects” of our article. He refers to “the solution-focused manifesto for social change (Solution-Focused Collective, 2019). The manifesto is based upon a belief in the potential of the solution-focused approach to ‘be harnessed in the pursuit of social justice.’” He continues that this initiative involves “... build(ing) links with movements for social justice and equality, and with practitioners of other approaches committed to these aims, so that we learn from and enhance each other's work.” The last phrase of Shennan's comments is “... perhaps the construction of some similarity and connection narratives, or at least some both-similar-and-different narratives, will aid in the creation of the links and alliances across approaches to change that are needed for the construction of a better world.”

So – Shennan implies that our emphasis on differences and uniqueness might hinder the creation of the links and alliances across approaches to change that are needed for the work on social justice that Shennan and the solution focused collective has committed themselves to and branded as solution focused. Branding by simply naming their aims as A Solution Focused Manifesto for Social Change.

While we applaud Shennan's wish to promote social justice in a troubled world, we believe this is a goal he wants to add to SFBT practice. We encountered nothing in our study of de Shazer's writings that suggested de Shazer favored “harness(ing)” the SF approach in any practitioner-driven agenda, no matter how worthy. We resent being put in the position of being against doing political work for social justice to create a better world, because we agree only with half the title of the manifesto. We think that using solution focus “in the pursuit of social justice” with clients, is doing something that is not solution focused brief therapy. We have a fundamental disagreement with for instance (picking from the manifesto for social change:

TO REALISE OUR HOPES, WE AIM TO DEVELOP OUR PRACTICE SO THAT...

- it acknowledges the social, structural and environmental causes of people's distress and difficulties
- its application with individuals pays attention to the social context

Our Axiom 5 of de Shazer's thinking indicates, solutions are developed “in the direction of the more positive future the client wants.” And, as our Axiom 6 states, de Shazer emphasized these client-driven definitions of a more positive future are developed in dialogue with the practitioner around the client's meanings and in the client's language—not the practitioner's. We don't understand how any social justice agenda of the practitioner might fit with doing SFBT as de Shazer and his colleagues theorized about and practiced it.

Simply said: When you do social justice work you have an agenda – a preferred outcome – and regardless of how good and worthwhile that outcome is – it breaks a fundamental or core solution focused way of being in the relationship. In our view when the therapist has an agenda for the client he is no longer doing solution focused brief therapy.

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Journal of Solution Focused Practices – 69

TRANSLATED ARTICLE

From Here to There to Who Knows Where: The Continuing Evolution of Solution-Focused Brief Therapy

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Background

Beginning in 1982, Insoo Kim Berg, Steve de Shazer, and their colleagues at BFTC (and their clients) have been developing a solution-focused approach to doing therapy that is significantly different from other approaches (Berg & Miller, 1992; de Shazer, 1985, 1988, 1991). In comparison to other approaches, there are differences in theory, in assumptions, in practice and resulting differences in the way of conducting sessions; there are fewer sessions involved¹ and longer intervals between sessions (de Shazer, 1991). The approach encompasses a different view of therapy, a different view of clients, and thus a different view of therapists and their tasks.

Prior to 1982, we were using a problem solving model of therapy based on the idea that the therapist's intervention needed to fit with the patterns of the client's problem in a very particular and specific manner (de Shazer, 1982). Like most models of therapy, we focused on describing the problem or the client's complaint, based on the assumption that the nature of the problem (or at least the description of the patterns of the problem) determined what the intervention should look like and, therefore, what the eventual resolution should look like. Like many other models, we saw the client's complaints (including the patterns around them) as continuing to occur because they seemed to follow rules similar to the rules that can be seen to govern and pattern all human interactions.

"The problem isn't trying to adapt therapy to a particular [diagnostic] classification, but: What potentialities does the patient disclose to you of their capacity to do this or to do that?" -- Milton H. Erickson (Haley, 1985, p. 126).

While many therapists group problems into categories, i.e., 1) psychological problems with obscure origins, 2) psychological problems with obvious origins, 3) organic disorders, or 4) by standard diagnostic categories, we tended to group cases together according to their responses to our initial intervention, particularly the homework tasks we gave at the end of the session. The form the intervention took depended on behavioral sequences around the complaint and the meanings the clients gave to their situation.

¹ Although many models of brief therapy are defined in part by various time limits or limits on the number of sessions, we do not use any time limits at all. When asked we say as few sessions as possible and not one more than necessary". For the past five years, we have averaged 4.5 sessions per case and 97% of the cases come for fewer than 10 session. We have no selection criteria and we see anyone who comes to see us.

From a Problem-Focus to a Solution-Focus

In mid-1982, we had a case that forced us to radically change our minds about therapy, clients, therapists, problems, complaints, and solutions (a process that has taken a number of years and is still continuing). After the therapist asked "What brings you in today?" the mother began to describe her concerns but, before the therapist could begin to elicit a description of the patterns around that complaint, the father interrupted. He had his own concerns but, before the therapist could either return to mother's concerns or elicit a description of father's, the eldest child interrupted with her own concerns. During the course of the session, the family members continued this pattern and by the end of the session, the five of them had listed 27 different concerns. However, none of these were well enough described for the therapist and his team to use as a basis for an intervention task. (Every therapist who has interviewed more than two or three families has had a similar experience.)

It was clear to the team behind the see-through-mirror that this family had a "problem": They clearly had something to complain about and their coming to therapy seemed appropriate. However, none of their concerns had yet been put into a form that could be used as a guide for an intervention. Fortunately, some of the team had been influenced by the works of Milton H. Erickson (Haley, 1967) who suggests that if efforts made by the therapist to clear up the client's vagueness have led only to more vagueness, then the therapist should do something different and be at least as vague as the client has been and, eventually, this will lead to at least some clarity. The team thus developed this task which came to be known as the Formula First Session Task (FFST):

"Between now and next time we meet, we want you to observe, in such a way that you can tell us about it next time, observe what happens in your life that you want to continue to have happen" (de Shazer, 1985).

Two weeks later, when the family returned, my colleagues and I were surprised when the family described 27 different things that had happened that they wanted to continue to have happen. 25 of the 27 were directly related to the 27 concerns listed during session one. When asked, the family members said that they thought the problem that brought them to therapy was solved and therefore no more sessions were needed. Six months later, 20 of the 27 things listed in session two were seen as continuing to happen.

According to our problem solving model, this intervention should not have worked since it was not related to the patterns of any of the complaints the family members listed. But work it did! Therefore, we were faced with a choice: a) We could pretend it did not happen, ignore it, and thus describe it as some sort of fluke, or b) we could investigate it and thus risk changing or even rejecting the model/theory we had been constructing for 15 years. We choose that latter course.

Research<>Practice<>Theory²

During the course of the next two years we gave this same task to hundreds of clients (individuals, couples, families) and found that, about 90% of the time, clients will report having had something happen between sessions one and two that they want to continue to have happen. (It was, in fact, our rule to give this task at the end of the first session unless we had very good reasons not to: We gave the formula first session task to two-thirds of our clients during this investigation. Most frequently, they listed from 7 to 11 things in the second session.) Frequently these events were unrelated to the client's problems and complaints and yet are seen by the client to make things significantly better: We learned that what clients used to judge that things were significantly better are frequently very different from what professionally trained therapists or researchers would use or would think that the clients should use.

At this point we lost our highly valued connection between complaint and solution. Clearly, if this generic task can lead to descriptions of significant improvement regardless of the complaints involved, then the complaint does not determine the process of solution. The process of solution development can begin without the therapist knowing or the clients agreeing what the problem was or what the clients have to complain about.

² The symbol <> is used in chemistry to describe a reaction that goes in both directions. Sometimes the rate is more in one direction than another; at other times, an equilibrium is reached whereby both (all) contribute equally. The interaction between research and practice and theory seems to vary in a similar fashion at our center.

This investigation confirmed for us the idea that what the client does and what the therapist does while doing therapy, what goes on in therapy is more important to successful therapy than the problem or diagnosis or the client's situation or personality.

Central Premises

The central philosophy of solution-focused brief therapy (de Shazer, 1985, 1988, 1991) can be summed up as follows:

1. If it ain't broke, don't fix it.³
2. Once you know what works, do more of it.
3. If it doesn't work, don't do it again: Do something different.

These three premises may seem overly simple or perhaps even simple-minded when it comes to doing therapy: i.e., therapist and client working together (We doubt the usefulness of calling our work "therapy" but no viable alternative is readily apparent). Obviously, a tradition based on such simple premises is frequently going to be seen as deeply flawed. Surely the resolution of over-whelming, chronic human problems cannot be so simple. Interestingly, applying them in the "real world" of doing therapy certainly is not easy.

Premise 1: If it ain't broke, don't fix it. This premise is so central to life that it seems self-evident. In fact, there should be no need at all for this premise which, among other things, we take to mean the following: If something is not a problem for the client and, therefore, the client does not complain about it, then -- no matter how obviously problematic that something might be in the eyes of the therapist or "society" -- it is none of the therapist's business. Unlike most, or at least many, other types of therapy, solution-focused brief therapy is non-normative and thus the need for explicitly stating this premise.

Premise 2: Once you know what works, do more of it. On the surface, this premise should be so self-evident that stating it seems stupid. At BFTC, we serendipitously found out that, when asked in the right way and/or at the right time, many, perhaps most, clients will report that there are times when the complaint/problem does not happen, even though they had every reason to expect it to happen! And that there are times when things, in general, go along quite well given the clients' life circumstances. Whatever it is that the clients are doing at these exceptional times are exactly what the client needs to do more of: The client needs to continue doing what works.

Although the premise itself should go without saying, it is actually broader in its implications and applies to doing therapy as well. For brief therapists it means that a) if you know a solution that works, do not un-necessarily look for another way: Never forget what works; and b) if what you did in the previous session was effective in the client's judgment, then you should do it again. Furthermore, the therapist should resist doing anything additional.

Premise 3: If it doesn't work, don't do it again: Do something different. Since the problematic situation has been simply and clearly described as "the same damn thing over and over again," it also seems as if this third premise should be self-evident. However, given the folk-lore idea that "If at first you don't succeed, try, try again," this premise cannot be overstated primarily because it seems to run counter to common sense.

Clearly, problems have self-maintaining properties including (so-called) repeats of the same old failed attempts at solution. Obviously, things are not working and Premise 3 of the Central Philosophy suggests that -- in such a problematic situation -- someone needs to do something different if anything different is going to happen. In fact, when anyone in the problematic situation does something different, anything that cannot be seen as "the same damn thing over again," then the problem is on the way to resolution, i.e., what was problematic becomes just another example of "the one damn thing after another" that in fact constitutes normal, every-day life.

If progress has not been achieved within a few sessions, our view is that the therapist has also become part of the problematic situation and also needs to do something different since studies from all forms of therapy have shown that if progress is not made by 5 to 8 sessions, it is unlikely that it ever will be made. Since we do not use several sessions to do an assessment, we feel that if progress is not acknowledged by the client by the third session then the therapist needs to pay attention to premise 3. Examples of the therapist doing something different include changing teams, changing rooms, changing who sits where, changing which therapist (from the team) is in the room, radically varying appointment dates and times, changing who is invited to the session, etc.. Often the most effective difference is admitting to clients that we do not seem to be helping them so they need to help us.

³ In more correct, less colloquial English: If it is not broken, do not fix it. Or, if it works, do not fix it.

Case Illustration

Assumptions influence what therapist does or doesn't do. The following case helps to demonstrate how the assumptions that are held by the therapist direct his thinking and the questions that he asks. The client is a married woman with two grown children. She became blind 10 years earlier as a result of diabetes and recently learned that she has lupus.

Th: What brought you here today?

Cl: I just feel really depressed. I can't use my hand and my legs are all numb. I'm numb all over my body. I can control my left hand but I don't have any feeling in it.

Th: Right.

Cl: I can't telephone. I have to get the operator to place calls for me. All these things are bad because I'm used to doing all these things for myself.

Th: Yes, you're having to make a lot of adjustments and that's tough.

Cl: I don't want to live like this. I really don't. I don't have the thoughts of killing myself but I don't want to live like this either.

Th: Yes. There's a lot happening for you at the moment and all of it is new to you and tough. How are you coping with that?

Cl: I'm not. I just don't I can't prepare my meals...

Th: What would have to happen today for you to feel we've been helpful to you?

Cl: You can't because you can't make the feeling come back.

Clients generally need some reason to come to therapy: a problem or complaint that they may have about themselves or someone else or a problem or complaint that someone else has about them. If they did not have some reason or justification for being there, they would be mere window-shoppers. However that complaint or problem is simply their ticket to get in the door. Likewise if they have a noise in their car, they have a good reason to go to an auto repair shop. They may not know exactly what they want fixed. While they're there, they may want the mechanic to also look at the steering. Maybe they're not sure if the two problems are related so they attempt to describe in detail the symptoms in order to help the mechanic. Clients who come for psychotherapy do much the same: They describe in great detail the problems that are bothering them enough that they feel they need help. Often the therapist assumes that the client is there for relief of their symptoms and becomes frustrated when that is not possible.

In this particular case the client complains about her symptoms from the recently diagnosed lupus. She can not continue certain activities in her life such as knitting and swimming. She does not have feelings in her limbs. And she does not want to go on living like that. Because she is obviously suffering greatly from the combination of blindness and lupus, any therapist with an ounce of compassion would want to help this woman. Many therapists would feel obligated to show that compassion and to make suggestions to help relieve her symptoms. But do we really know what she wants in the way of help from us? Often therapists feel the need to jump in right away to help the client. We might ask questions to find out more about her physical complaints. We might do a suicide assessment, etc. In this particular case, the therapist (Ron Wilgosh)⁴ did not explore those avenues. Instead he listened very carefully for any indications of what the client did want instead of what she did not want and, importantly, he did not make the assumption that he knew what she wanted. She had been focusing on what she already knew she was not able to do. Obviously that added to her frustration and to her limited hope for change. Continued attention to that by the therapist would only add to that frustration; if he were to have done that, he would be joining her in doing more of the same of something that is not working. In fact, the client does not think the therapist can help relieve the symptoms. So her therapist simply acknowledged that he understood what she was saying.

Finding out what the client really wants. Most therapists (at least in the U. S.) are required to have goals for specific cases if for nothing else other than insurance purposes. For the sake of accountability, these goals must be measurable which means that they usually need to be described in behavioral terms. However, few forms of therapy specify the procedure for obtaining goals or the qualities of well-formed goals (Berg & Miller, 1992; de Shazer, 1991). The insurance

⁴ Ron saw this client while doing a month-long residency at BFTC and can be contacted at the Social Work Department, St. George's Hospital, Sutton's Lane Hornchurch, Essex, England, RM12 6RS.

forms have a space for goals which client and therapist are supposed to agree on together. So why not simply ask clients what their goals are? It has been our experience that this is not very productive for several reasons. Clients are frequently so focused on the problem that the goals are expressed as the absence of that problem or the stopping of something. The former is hard to measure and the latter cannot truly be achieved until death. In fact, defining goals this way often makes matters worse because it causes the client to focus more on undesirable behavior(s) and/or the problem. Often these goals involve very big leaps from the present reality and they usually involve someone else having to change in order to reach the goal. Moreover, it is our belief that if the client could express what they wanted in a different manner, it would be much easier not only to reach that goal but also to know when they are done with therapy. This relates to our third premise in that the "it" that's not working can be the client's way of thinking about things.

How best to help the client think in a different way so that they can best accomplish this? We have found that the use of what we call the miracle question (de Shazer, 1985, 1988, 1991) frees the client to think of solutions in the future without being burdened by the problems of the past and present. It is most appropriately used when the client has had sufficient time to describe the reason(s) for being in the therapist's office, i.e., the complaint or problem. We have found that, if the therapist tries to solve the problem too quickly (often joining with the client in doing more of what does not work), the client will continue to try to convince the therapist that he or she has good reason to be there by continuing to describe the problem. Similarly, if the therapist persists in asking lots of questions about the complaints, the client will continue to be helpful by answering more about the problems. If however the therapist just listens and acknowledges that they have heard what the client says, there usually comes a point at which the client starts to repeat or looks at the therapist for some indication of where to go next: i.e., Do more of the same or do something different? This is the point where we find asking the miracle question most appropriate.

Th: Let me ask you this. Imagine tonight you go to bed and while you're asleep, this miracle happens and the consequences of the miracle are that the problems you've come here with today are solved. What would be different in the morning? How would you know?

Cl: I would be able to feel my legs and my hands. I could feel again. I could brush my teeth. I could write. I could read braille. I could do things for myself.

Th: Uh, huh. What else would be happening that would let you know this miracle is happening?

Cl: I would just wake up and feel it....

Th: What would your husband notice you doing different that would let him know something happened overnight?

Cl: I'd be making breakfast, dialing that phone myself, pushing the VCR buttons myself, brushing my teeth, combing my hair, doing all the things I used to do.

Th: How would that be different for him, if you were able to do all these things?

Cl: He wouldn't have to get my medicines out, fix my breakfast for me, pour coffee, butter bread.

Th: Um, hmm. And how would that be different for you if he didn't have to do all these things?

Cl: I'd be glad because I'd do them for myself.

Th: Right. How would he be able to tell that you're glad?

Cl: I'd probably have a big smile on my face and we'd be talking about it.

The miracle question is not necessarily a substitute for the goal question; it is a way of helping clients think differently so that they can arrive at solutions that may have not been possible to imagine by focusing on the problems. The goal of the therapist is not to force the client to do the miracle they describe but to open many new possibilities that might lead to solutions. At this point the client and the therapist do not know which possibility might lead to a solution. They do not know what works so they do not know what to do more of; that will come later. So, the therapist does not latch onto any particular idea or attempt to establish priorities. The more numerous the examples, the more detailed the description, and the smaller the responses to the miracle question, the higher the probability that these behaviors or perceptions have already happened to some extent, might happen in the future, or might be noticed as having happened. In order to maximize the possibilities, it is necessary for the therapist to ask additional questions to assist the client in coming up with more and smaller possibilities. When clients come up with large or impossible responses (i.e., "I'll get the feelings back in my legs and hands"), rather than challenge that possibility which can only bring the client back to the unsolvable problem, the therapist can simply accept that as a perfectly legitimate desire and proceed by asking "What else?". As this conversation continues, the client is able to think about more and more because, after all, they are only pretending.

Because we are only looking for a small change anywhere in the client's life, we do not limit our conversation to only the person in the room with us; after all, the client's life is not limited in such a way. So we ask what we call relationship questions: What the client would notice other significant persons in their lives doing or what the other persons would notice the client doing. In some cases the identified client might not want or expect any difference on their part but want someone else to change. Again the more numerous and minute the responses, the more probable their reality. In this case the therapist continued to explore differences after the miracle that she would notice with her husband and her daughter.

Searching for Solutions. We talk of searching for solutions because the therapist's goal is not to be able to define the one solution for the client. Rather the client will be the one to know when the solution is found because they will decide that there's no further need for therapy. But since they usually do not think they have found the solution before coming to us, the question is "How can we help them?"

We believe it is important to help clients develop a rich picture of life without problems because no matter what means they choose to arrive there, they need to know when they are successful. In an analogous way if a person wants to get to Chicago, he has to have an idea how he will know it's Chicago. If it's by recognizing certain buildings, he might have to travel by car rather than by plane. The various responses to the miracle question provide a direction or vision toward which the client can focus. With this new focus, the client is better able to see past, present, and future examples of change. In other words, the client and the therapist do not have to decide to do anything new at this point.

So how does this help? Because the client now has a better picture of what they and others will be doing after the problems are solved, we assume that there is some probability that parts of this miracle picture are occurring or have already occurred. Unless the therapist asks, he will never find out.

In one study we asked the question: What have you noticed different about your situation since you called for the appointment? Two-thirds of the clients answered that something had changed in a positive direction and all of those said the changes were related to the reasons they came to therapy and were changes they wanted to see continue to happen (Weiner-Davis, de Shazer, and Gingerich, 1987). In some ways this finding is not surprising since other studies have shown that clients on waiting lists solve their problems without the help of therapists (up to 50% of the time). Knowing that pre-session change takes place so frequently helps us to listen for it and to ask about it in a different way and at a different time: After the miracle question, we ask "Are there times now that small pieces of this miracle happen?" By asking this question now we not only find examples of exceptions to the problems but also incidences of partial solutions: i.e., exceptions related to the goal. In this case, the client mentioned her previous adjustment to blindness.

Cl: That was the one hard thing I had to go through when I lost my sight. That was a real big adjustment for me.

Th: Boy!

Cl: I mean if it hadn't happened to me I wouldn't have believed it was possible that you could actually adjust to it because it was very, very hard.

Th: Right. So if it hadn't happened to you, you wouldn't have believed you could adjust to something like that.

Cl: Right.

Th: How did you adjust to something like that; how did you do that?

Cl: For a whole year I did nothing... I didn't eat very much... All I did was sleep. ... The only time I did anything was if I had to go to the bathroom. If I had a doctor's appointment, I'd get up and go there and come back. Basically, all I did was stay in bed.

Th: After that first year, what did you start to do that showed you that you were starting to adjust?

Cl: I went down to a program for the visually impaired and I tried to get out and go places myself and I walked to the store to shop.

Th: You had to learn all that?

Cl: Yeah.

Th: Wow!

Cl: And every time I managed to accomplish something I was real pleased with myself. I just did it till I knew I could do it on my own. I didn't have to keep doing it. Then I went on to something else.

Th: What else did you have to learn to do for yourself that you weren't used to before?

Cl: I had to change my ways of living.

Another way that the therapist can help the client search for solutions is to ask scaling questions in the first session: On a scale of one to ten, where 10 is when these problems are solved and 0 is when they are at their worst, where would

you say things are today? Some therapists might be reluctant to ask this question during the first session for fear of hearing the client respond with a low answer. However the focus is not on the number itself; the actual number is not important. The emphasis is on the positive direction; whatever the client's response, an inquiry is made as to how they got from zero to that number. (Even if the client's response is "0" we would inquire about how come it is not "-1" or "-2"? How come things did not get worse? which implies that they did something to prevent things from getting worse.) Clearly, the indication is that they have already started to solve their problem. In addition, it's helpful to find out what the next small step will look like. It is not necessary to ask or tell the client how to get to that step. Even with clients who say their life is at its absolute worst, picturing the next small step provides them with some hope because this small step is possibly closer to their grasp than trying to eliminate the presenting problem.

Th: Let me ask you: On a scale of zero to 10, where zero is the situation at its worst and 10 is the way your life can realistically be so you feel okay about it and you don't need to come here anymore, where would you say you are today?

Cl: Probably a one.

Th: A one.... How did you do that, how did you get from a zero to a one?

Cl: Well, maybe I should say I'm at a zero.

Th: Right, right, okay. You're sure; you've thought about that and you're at zero.

Cl: Yeah.

Th: If your husband were here and I asked him the same question, where does he think you are on that scale? What would he say?

Cl: He'd say zero too.

Th: That sounds like a tough place to be. What would a half look like: what would be happening at a half that's not happening now?

Cl: Maybe I'd be able to do a little bit for myself.

Th: What do you think that might be?

Cl: Dialing the telephone.

Th: Dialing the telephone. Would there be anything else that would tell you that you moved up a little bit?

Cl: Brushing my teeth with my right hand cuz I'm right handed and I can't do things with my right hand. I tried to do things with my left hand but it's really difficult.

Again the usual tendency of therapists would be to try to help this woman by telling her what to do or getting someone else to help her. But is that what she really wants from the therapist? If one listens closely, the indication is that she wants to do for herself and is not real sure what she wants from therapy other than to talk.

Th: How can we help you with the things you are facing?

Cl: I don't know. I guess maybe to be here for me to talk.

Th: Okay, how will that help you, talking to us? What difference will that make for you?

Cl: I don't know. You're somebody I don't have to think "you might be pitying me".

Th: Umm, that sounds important.

Cl: Yes, it is very important.

So in the message at the end of the session after a short break, we ask her help in thinking about how talking can be helpful in producing the changes she wants. We also offer compliments on how she has tried to adjust to this and other events in her life. This message is no longer called the intervention message because the word "intervention" suggests that our aim is to intervene or interfere in our clients' lives rather than assist them in finding their own solutions.

Th: Before we finish, I would like to share some of the thoughts of the team. We all wanted to say to you that it is a very difficult and very tough situation you have at the moment. We feel as impressed as you were surprised at how you adjusted to the changes that happened to you; you said you were most surprised out of the family at how you adjusted to being blind. We were impressed at how you have been able to come to terms with what's happened to you and to have worked through what is happening. That's very, very tough. We think it's a good idea you've come along here today. It's a good start for us and we've got to find out more about what's happening for you. We'd like to see you again soon. Would you like to come back?

Cl: Yes.

Evaluating progress. How do we know this seemingly minimalistic approach works? Since we maintain the assumption that clients have all the necessary tools to construct their own goals and solutions, we have to let them be

the judge of their progress. If there has been progress toward their goals, we expect their lives to be better. So we start off second and subsequent sessions by asking them:

Th: Since last week, what's been better? What have you noticed that's been happening that's been better?

Cl: Nothing's been better. Well, I'm brushing my teeth.

Th: You're brushing your teeth?

Cl: Yep, with a toothbrush.

Th: Wow!

Cl: And now I've been working more and more with this left hand.

Th: Uh huh, and how has that been helpful to you?

Cl: I think I did a better job with the brush than I did with the cloth....And try to eat more with my left hand and I seem to be getting a little more food on the fork or spoon.

Th: Gosh, you're eating as well with that hand. It sounds as if you've been working hard since last week.

Cl: Yeah.

Th: When your husband does notice that you've been making changes, how will that change things for the two of you?

Cl: It will just be less things he has to do for me.

Th: Umm, hmm. And how will that change things for the two of you when there are less things for him to do?

Cl: I don't know. We'll be able to devote more time to other things.

Th: What else has been happening that is different? Cl: I don't think I'm as depressed.

Th: I'm curious how you're not as depressed as you were. What have you been doing different that has helped?

Cl: I guess trying to do more things for myself.

Th: And that's been helpful for you?

Cl: Yeah.

It is not unusual for a client to respond by saying "nothing" initially. Given their initial problem-focused view, this response is neither unexpected nor surprising. After all, for clients to think and to notice positive change is a rather large shift for them. It takes some time for clients to be able to think in this different way. Therapists can be helpful by being patient (interesting word since it is usually used to refer to clients in medical settings so maybe it suggests shifting roles) and by allowing the client time to think differently. Our experience has been that approximately half of our clients answer this question in the affirmative and another quarter will answer in the affirmative after the therapist listens for a while for an affirmative description to develop or asks an additional question such as "Which was the best day of the week?" In particular, this client's initial response is also not unexpected since she was at a zero on the progress scale at the end of the first session. This means that, at that moment, she saw 100% of her life being consumed with problems. Thus, we cannot expect her to see the small relative change if she had been focusing on the problems: e.g., a change from 100% to 99% is only a 1% relative change. However, a change from 0% to 1% in the positive direction is mathematically approaching infinity. Again the therapist's questions can encourage the client to think in a different way so she can see changes by eliciting more positive change talk, amplifying those changes, and reinforcing the changes.

We generally ask scaling questions after this opening discussion to determine whether or not the changes are related to the goal: i.e., life could be better, but is it related to solving the problems that brought them here. In this case there was a small but discernible improvement in both progress toward the goal (i.e., the client said she had moved from 0 to 1.5) and in her confidence about eventually reaching the goal. Scaling questions often help the client to remember even more positive change. In this case the client described how she made an appointment for a manicure and got there all on her own.

And the client generally knows what the next step will look like. The therapist does not need to overwhelm the client by making lots of suggestions but rather simply needs to support the client's going in the direction she chooses. Of course, that direction may change in the course of therapy. For clients to know at the beginning of therapy exactly where they want to go is unrealistic; if they did, they probably would not need therapy. For this reason we do not find it necessary to contract with clients a) for a specific number of sessions or b) for specific goals or c) to measure progress on specific goals. To do so would again constrain and limit the possibilities for change.

Ultimately, clients will take enough steps toward constructing a solution satisfactory for them (solving their problems and reaching their goals) that they do not feel the need to continue therapy. In this particular case that happened in the third session. At that point she gave herself a 3.5 on the progress scale. The client said she was doing "better enough"

and that she did not feel the need to continue therapy. This "better enough" included getting out and doing more things for herself. Although her "better enough" was only at 3.5 on the scale, the therapist needs to accept her judgment even if he might want more for her: Since only the client can make the judgment that things are "better enough," any attempt to help her more would be intrusive and likely to meet with failure (premise 2). It is important to remember that, whereas her previous adjustment to blindness took a year just to get out of the house, this adjustment took only a few weeks. Experiencing the various changes she made gave her the confidence that she could be independent. Of course, "independence" for her meant not needing to be in therapy and going back to doing some of the things that had worked before. For instance, she had begun going regularly to a support group and had begun working as a phone volunteer on a local hotline.

Conclusion

Solution-focused brief therapy can be described as a way of developing solutions to human problems and there is an assumption (all too frequently implicit) that any individual in the same situation as the one the client describes would have the same problem. That is, problems are seen as primarily situational and as embedded in language, i.e., problems are more a result of the situation in which the clients find themselves and their definition of the situation, (i.e., how they are talked about) than they are a result of any causative underlying maladjustments or psychopathology or systemic dysfunctions (de Shazer, 1991) Furthermore, what qualifies as a "solution" is dependent upon the clients' judgment, i.e., the clients saying that things are "better enough" for therapy to stop. This way of thinking suggests that we need to look at how we have ordered the world in our language and how our language (which comes before us) has ordered our world. That is, rather than looking behind and beneath the language that clients and therapists use, the language they use is all that we have to go on.

Just as the "problem" has different meanings from client to client depending on their different situations, the "problem" has different meanings for the same client because the situation is never the same; even contexts vary over time. Although our approach is sometimes criticized for not getting to and treating "the problem" and thus cannot be long-lasting, our view is that it is unlikely that any approach can cure "the problem" because "the problem" is never the same. Thus, the solution cannot always be same. Frequently our clients tell us exactly that when we ask what worked when they had this problem before; they give us reasons why what "worked before" can not work now. Our follow-up studies have told us that clients have gained the ability to think differently so they can continue to solve problems -- whether they are recognized by them as the same ones or new ones. This difference is to us a measure of a long-lasting effect.

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BOOK REVIEW**The Next Generation of Solution Focused Practice: Stretching the World for New Opportunities and Progress**

Mark McKergow

Routledge, 2021, ISBN 978-0367428839, 212 pages, £24.99 paperback (Kindle edition available)

Review by Alasdair J. Macdonald

Retired Consultant Psychiatrist

Solution Focused Brief Therapy (SFBT) methods have been around for nearly fifty years, and have become used in many fields including coaching, education, social work, healthcare and organisational change. This efficient and effective approach has remained somewhat unappreciated; the pragmatic ‘not-knowing’ stance of practitioners treating every client as an individual can seem odd to those accustomed to conventional diagnosis and treatment. How is one supposed to treat mental illness with an approach that appears to discuss neither ‘mental’ nor ‘illness’? This dilemma has not been resolved by the existence of many treatments for mental disorders using medications, conversations and electricity.

In this very thorough book, Mark McKergow reviews the development of SFBT from its anthropological origins in the 1950s through the landmark work of Steve de Shazer, Insoo Kim Berg and colleagues at the Brief Family Therapy Center, Milwaukee through to more recent shifts in practice. Having been present himself at many of these changes, the author is able to give detailed and knowledgeable accounts of the processes involved and of the variety of cognitive and emotional concepts which have been called into use. He shows how this tradition has always been changing and continues to change. At the other end of the story, in this book he shows how a newly coherent form of SFBT has appeared in the 21st century based on ‘focused description development’. This offers both clarity to the practitioner and a new picture of how the practice works to build change by ‘stretching the world’ of the client.

This fresh take on SFBT shows how practitioners can bridge the apparent gap between focusing on their clients (to the apparent exclusion of theory) and having a story about how it works. New ideas from enactive cognition show precisely how skilled attention to the client and their words can immediately open new possibilities for attention and action.

There are five Es to be found in good SF practice: Effective, Efficient, Ethical, Energising and Elegant. The work privileges the client’s experience of their current difficulties rather than abstract theories of knowledge. Many practitioners have commented on the similarity with coaching.

Anthropologist Gregory Bateson identified the use of ‘circular communications’ in human transactions (perhaps the start of systems thinking). His contemporary Erickson drew on his own experience of ill-health and disability to advance the benefits of appropriate conversations. The use of language by families became a new topic of interest, as opposed to the dialogue between client and therapist. Workers began to think in terms of Contest versus Co-operation within the social group.

Scandinavian practice with Harry Korman and others became a major force in family work. They recognised the changes being wrought by these new ideas. The European Brief Therapy Association was formed in 1994 and continues to be a strong influence today. Many countries (including the United Kingdom) have also formed their own SF organisations and training regimes.

In 2011 Cynthia Franklin and her colleagues in the United States published a detailed review and summary of the state of SF teaching and research at that time. McKergow’s text explores some of the key concepts in use. The ‘miracle question’ has become almost a signature note for SF work, although as Mark points out it has largely been superseded for many practitioners. His discussion of how to end sessions constructively is a valuable part of this book. Like many European therapists, he spends some time on discussion of the role of the philosopher Wittgenstein in the development

of language and its subsequent relevance to conversations in therapy. He is also informative about enactive cognition as a tool for therapy, and its role in 'stretching the client's world'.

The work of Janet Beavin Bavelas with microanalysis of sessions shows very effectively how every word and every vocalisation lends precision to interaction with clients and colleagues.

Chris Iveson of the influential BRIEF practice in London likes the suggestion that a therapy session is like visiting an Art Gallery. After a pause at the Ticket Office, we buy a ticket for a potential future project; we are guided to enter the room with new views of the Future; we enter a room containing Instances of possible future events; we leave the building, perhaps selecting something for our future project from the Gift Shop. Adam Froerer has added the idea of a Resource room where we can obtain assets for our next steps.

The book includes detailed session transcripts with a commentary to show how these ideas appear in the nitty-gritty of practice. The use of scaling techniques and other skills are described well. Practitioners from all fields will find fresh perspectives on why they do what they do, and how they might do it even better. I know of no clearer record of the history of SF and the consequential events.

The reviewer

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BOOK REVIEW**Solution Focused Interactions in Nursing: Growth and Change**

Steve W. Smith

Cambridge Scholars Publishing, 2021, 175 pages, ISBN 978-1527563469, £58.99 hardback

Review by David Hains

 President of the Australasian Solution Focused Association, and coordinator of the Adelaide SFBT Community of Practice

For me it just makes sense, but that's coming from a bloke who is both a nurse and a solution focused nut. The solution focused approach sits so beautifully with the core tenets of nursing, and it was about time for another book on the subject. I was excited and asked to review the book as soon as I heard about it. The first Road Sign (*Andante ma non troppo*) occurred when Dr. Plamen Panayotov had begun his psychiatry internship in 1984. His trainer focused on the patient's goals and not on their symptoms. Further examples of this orientation were demonstrated by a mental health nurse in 1990.

The first nursing SF book that I read (McAllister, 2007) was a very different read: a multi-contributor text, looking at a solution focused model in various areas of nursing practice. Steve Smith has taken a different approach, building off of his doctoral thesis with a desire to demonstrate the application of a solution focused approach to nursing practice. Hence this book combines his research into nurse education along with clinical applications of the approach.

Smith has been a long-term enthusiast (20+ years) of the Solution Focused Approach, both as a student of the approach, a clinician, and an educator. He told me once of his desire, in the lead up to his retirement, was to "plant the seed that solution focused interactions were relevant in all domains of nursing practice (not just mental health) and that they enabled nurses to deliver high quality nursing care". Has he managed to achieve this?

Initially it was a little hard for me to work out who Smith was writing for, as throughout the book he seems to write from the different perspective of a nurse educator, a researcher, and a clinician. This in itself is not a bad thing as it provides a lot of very different information in the one book. However, the reader may need to consider this when opening the book. I found myself having to go back and re-read several chapters once I realised the structure of the book. Again, this is also not a bad thing (reading a book more than once).

Smith starts off as an educator, aligning the solution focused approach with the role of the nurse (as defined by the United Kingdom Nursing and Midwifery Council and the International Council of Nurses) and with nursing theory (Florence Nightingale, Denise Webster and others). In addition, he also provides general context of health (World Health Organisation) and Person-Centred Care (Carl Rogers). Through the first chapter Smith highlights some important points relating to health, care, and growth, in order to explain that nursing is not just about administering medication (and other practical tasks) but rather is about helping people to grow and change, i.e. "Change from a less healthy state to a more healthy state" (p.3).

In Chapter 1 Smith introduces the phrase "Solution Focused Interactions" which is the title of chapter 3, and this is what I think (as a clinician) is the key to the whole book. Here Smith writes more for and from a clinician's perspective. Nurses generally don't see themselves as therapists/psychotherapists, but in reality the right word said at the right time can make a huge difference in a person's recovery. Nurses have a unique role in healthcare, being the profession who (generally) has the most contact and the most communication with the patient. So, why not use this time, and our voices, to help with the growth/healing/recovery. Throughout the book there are several great examples of how solution focused techniques (for example scaling or the miracle question) can be used in conversation in that natural (non-therapist) way that nurses do their work. Smith also acknowledges that it is sometimes hard for nurses (and most healthcare professionals) to take the "not-knowing stance" which is often a key strategy. While I think all of this is the key to why the book was written, I am left wanting to read more about these practical applications of the approach. Perhaps that's something for the 2nd edition (Steve – surely you will be looking for something to do in your retirement?)

In the middle section of the book Smith writes from a research perspective, with several chapters focused on his Doctoral research where he studied implementing a solution focused approach into nursing knowledge. There is a lot here for the academics and researchers, but perhaps less for the clinicians. I was certainly intrigued by the personal experience of the nurses, but to be honest I started to lose interest in chapter 8 reading about hermeneutic phenomenology. Again this is not a criticism of Smith and his book, but rather it's about me as a clinician who has absolutely no idea what hermeneutics is all about. For some readers however this middle section could be the key reason for the book to be written.

The book concludes by attempting to link the nursing theory, doctoral research, and practical application to nursing education and clinical practice.

Smith's research and book is certainly a valuable addition to both solution-focused and to nursing literature. Smith has certainly "sown the seed" in respect to identifying how solution focused interactions can not only align with the core values of nursing, but also be a practical approach to helping nurse people back to health. He has also provided a valuable research base to implementing a solution focused approach into nursing training. Some (like me) will be drawn to both the clinical application and the personal experiences of the nurses involved in the research, while others (anyone who understands what "hermeneutic phenomenology" means) will be drawn to research and theoretical side. Parts of this book would also have direct relevance to non-nurses i.e. clinicians and educators from a wide variety of disciplines who want to implement solution focused interactions into their education or clinical work.

Overall, there is something for everyone.

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More background information can be found in this interview with the author: FBS Chat (2021) FBS Chat with Steve Smith <https://www.youtube.com/watch?v=0bYJjMmR2w>

The reviewer

David Hains is a mental health nurse with almost 20 years' experience working in emergency departments in Adelaide, South Australia. David is the President of the Australasian Solution Focused Association, and coordinator of the Adelaide SFBT Community of Practice. In his spare time David runs training in SFBT (through Left Turn Solutions, and The Possibilities Lab), and helps to coordinate the management side of the Journal of Solution Focused Practices.

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BOOK REVIEW**Solution Focused Practice in Schools: 80 Ideas and Strategies**

Yasmin Ajmal and Harvey Ratner

Routledge, 2020, 152 pages, ISBN 9781138640221, £88.00 hardback, £18.39 paperback, £18.39 ebook

Review by Guy Shennan

Solution-focused practitioner, consultant and trainer (UK)

One of the success stories of solution-focused practice (SFP) concerns its application in education. One of the main contributors to this success in the UK, unsurprisingly enough, has been BRIEF, the London-based training and clinical center. At the heart of this contribution - and I hope her co-writer of this excellent book will not mind me saying this - has been Yasmin Ajmal. This is the third book concerning SFP and schools that Yasmin (I hope I can be excused the informality and familiarity of using the authors' forenames, as I worked alongside them for some years) has been involved in, the first two being on the indie label of the BT Press (Ajmal & Rees, 2001; Rhodes & Ajmal, 1995), before this step up to the majors with Routledge. The earlier books are well worth seeking out, and yet this is the first one that really does justice to Yasmin's multitude of ideas on applying the approach in schools and her wonderful way of communicating them. Many people will have experienced this by attending one of Yasmin's training courses, and it is welcome indeed that many more will now be able to, via the medium of a book.

In foregrounding Yasmin in these opening comments, I do not mean to downplay the role played by Harvey Ratner, as the partnership is an important one. Much of the value of the book comes from his continuous involvement over more than 20 years with a secondary school (high school) in London, as a counsellor and coach. It also builds on the book Harvey co-wrote on brief coaching with children and young people (Ratner & Yusuf, 2015). There is some overlap between these two books, though what the latest one adds, as well as the exposure to Yasmin's work, is the wide range of applications the solution-focused approach can have in schools beyond direct work with individual children.

Although the book is sub-titled "80 ideas and strategies" - a useful and common marketing device nowadays - it actually contains many more than that. The number refers to the way the book is structured, as it contains eight parts that contain 80 separate sections between them. The first part provides a useful introduction to SFP, and its ninth section, "Adapting SFP to work in schools", constitutes a microcosm of the whole book. It probably contains 20 to 30 useful ideas and strategies on its own, so the sub-title might more accurately have replaced 80 with 2000.

The section includes various ideas about one-to-one work with students, as well as using SFP in everyday situations, with staff, and in the classroom. It also includes transcripts from work with a nine-year-old boy and a conversation with a head teacher, and suggestions for how to develop a five-minute conversation that builds on what is already working. I cannot resist mentioning in passing that the former transcript includes one of my favorite ever solution-focused responses. Freddie had described how he would enter the classroom on a good day, and the practitioner asked about an *instance* of this having happened: "Have you done that before, gone into class like that?" "No", Freddie stolidly replied. Undeterred, the practitioner came back with, "Wow, so that would be a real first".

As well as transcripts, the many real-life examples and stories throughout the book enhance its potential usefulness as a guide to applying the approach. Lots of the ideas come from teachers and other school staff themselves, which is the best evidence for their usability. After the introduction, the other parts include conversations with whole classes, individual work, consultations and meetings, groupwork, and creative adaptations for younger children. Creativity runs throughout the book, including this response suggested for when a student says they are at 10 on the scale: "What will an 11 look like?" Given the penchant for giving questions names, not least at BRIEF (The Best Hopes Question etc.), I am going to call this one The Spinal Tap Question.

One of the effects of the numbering structure is to make the book easy to dip into. Someone coming new to SFP - and the book will be relevant to newcomers to the approach as well as those more experienced in it - would be well advised to read all of Part 1 first. After that, Parts 2 to 6 can be consulted according to the role and interests of the

specific reader. It is probably not a book to read from cover to cover, as I think Parts 2 to 5 in particular might then feel a little repetitive, as the SFP structure and process is set out in a similar fashion in the range of contexts covered. Part 7, being a more extended account and transcript of a piece of work with one particular student, will repay careful study. The final Part 8 is something quite different, and provides a nice coda, focusing as it does on an educational research project Yasmin undertook in Zanzibar with her head teacher husband. Needless to say, they approached this in a solution-focused fashion, and it is an engaging and useful read.

I am very conscious of writing this review for a solution-focused journal. While there is much to learn from this book for existing solution-focused practitioners (and not just those working in schools - I am currently providing training for housing support workers, and I found that reading it was sparking lots of ideas for this), I think the readership who will benefit most from Yasmin and Harvey's book are those working in schools. The best recommendation I can make to anyone reading this review is to buy at least one copy, to give as a present to a teacher you know. If you are working in a multi-agency or multi-disciplinary setting, mention it to the education people you encounter. And help to spread the word from our solution-focused confines to the wider world outside. Let's crank it up to 11!

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The reviewer

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BOOK REVIEW

Beyond Coping: Finding Your Way Forward

Ben Scott, A. Biba Rbolj and Greg Oberbeck

BT Press, 2021, 136 pages, ISBN 978-1-871697-80-3, £10.00 paperback

Review by Louise Bower-Hatchard

IASTI Certified Solution-Focused Practitioner

This pocket-sized book is a light and easy introduction to solution-focused thinking that anyone and everyone can apply to their own lives and circumstances in a useful way. The book sets itself firmly in the COVID era, making it hugely current and helpful for thinking through our current reality and into our preferred future. The blurb pitches the book as a self-help resource that will give insights and learning to help readers to “thrive during the pandemic and in the post pandemic world” delivered through “a unique fairy tale for grown ups”. And this it does.

The book starts with a rich description of the main character’s experience of what many of us may feel is a clunky reality that resonates with our own daily grind of living through lock-down – a stressful mix of anxieties, frustrations, family conflict and the unrelenting cycle of housework and chores. And then the story unfolds with this character meeting others on an extended jog that becomes a journey of self-discovery. The people that she meets that day ask her useful questions that prompt her thinking, leading to new more positive ways of behaving. The fictional day-in-the-life of “The Jogger” takes the reader on a structured course through a solution-focused framework that gives both a great overview of solution focused thinking but also encourages self-reflection and personal growth. Also included are some beautiful illustrations along the way, which are a charming and unusual addition to a book aimed at adults.

Whilst reading I did have to suspend disbelief a couple of times about the incredible friendliness and wisdom of the strangers that The Jogger came across, and about how as a mother The Jogger was not constantly stressing about having to rush back to her family – however this may well say more about me and/or our current society than anything else. This is described as a fairy story after all. And in our collective preferred future wouldn’t we all wish for more meaningful, generous and insightful interactions with the people in our community? Wouldn’t all parents love to feel able to enjoy guilt-free escape time when family life feels overwhelming? In these ways I feel that the book also provokes reflection about the kind of community we want to be part of post-covid and how we want to interact with the wider world having been limited to only our own households for so very long.

Often when people are at their most stressed and at the limits of their coping abilities, a long heavy read is the last thing that people can engage with. This book however is a light and easy read, with each short chapter including self-coaching questions at the end which the reader is invited to reflect on personally. This book would make an excellent gift for a friend or relative who is struggling and wants a little time and support to think through how to come out of this pandemic stronger. It would also act as a great introduction to solution-focused thinking and approaches for anyone who is interested in understanding more about it, as it equips the reader with some excellent questions and a good insight into the underlying principles of the solution-focused approach. Although the main character is a parent, the language of the book is written in such clear and beautifully simple language that it would also be suitable for young people to read and use - “If you keep your focused on where you want to go and what it will be like, then your feet, and steps, will naturally follow” (p. 37).

I found it interesting and helpful to complete the activities myself as I read the book - and the good quality thinking that this provoked most definitely has helped me to reflect on my own way forward into my post-pandemic preferred future.

The reviewer

Louise Bower-Hatchard is an IASTI Certified Solution-Focused Practitioner. Louise works full time as a senior manager in Children & Families Services in Sheffield, UK, where she applies solution focused approaches to organisational change, provides coaching, and trains frontline practitioners in understanding solution-focused approaches to child protection and family wellbeing.

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BOOK REVIEW**Solution-Focused Brief Therapy with Families**

Thorana S. Nelson

Routledge, 2019, 215 pages, ISBN 978-1138541160 367187620

Review by Matthias Schwab

Psychologist & Conceptual Artist

In 1919 the later surrealist Max Ernst created a painting like construction which he called, what might be the motto for Thorana Nelsons book: *Fruit of a Long Experience*.

However, Max Ernst was at the very beginning of his artistic journey when he put together those small, partly painted pieces of wood. Things that might be rubbish or miscellaneous in a craftsman's workshop. Screws and glue hold together, what might be a periscope in a landscape or a vessel on a journey with unclear destination. There is also maybe a broken metal switch and some wire next to the poles of "plus" and "minus" and in the background imaginary zodiacs are created by means of a driller and pencil lines. All this is created in a dada-spirit to deconstruct the de facto given systems of making art at the beginning of the last century. His assembly of wooden leftovers of daily life looks simple to be made, but given the context of his time, was not that easy to come up with.

If one is familiar with the practice and development of the solution-focused approach, one can easily figure out, why this work of an artist comes to my mind. Many solution-focused practitioners have experience in putting together small things of daily life in a simple way and deconstructing former necessities in the art of doing therapy.

One hundred years later – having been a professor of family therapy at Utah State University and a founding member of the Solution-Focused Brief Therapy Association in America – Thorana Nelson shares the fruits of her experience with us. These fruits grew in different, although connected gardens. Looking at the Appendix of her book – created together with her students – we find a condensed description of thirteen (!) different gardens of therapeutic models of how to help families to grow and live together in a healthy way. Assumptions, concepts, goals of therapy, assessment and interventions, the role and self of the therapist of very different approaches are described in what Frank Thomas (in his foreword) calls a "gold mine for anyone wanting a concentrated yet profound overview of most major marriage and family therapy models". The entry gates to these gardens carry names like: Structural Family Therapy, Solution-Focused Brief Therapy, Cognitive-Behavioural Family Therapy, Contextual Family Therapy, Emotionally Focused Therapy, to name just a few.

The journey of the book takes us from systemic thinking to solution-focused brief therapy and back again. In purposeful iterations the circular relations of how to look at families and what to do with them in order to support (first and second order) change, the book not only introduces the fundamental concepts and assumptions of systemic thinking and solution-focused practice, but also shows how they were historically connected and disconnected and how they can be reconnected and integrated. Illustrated with fruits of her rich practice, the book on the one hand introduces readers to the revolutionary deconstructions of therapeutic beliefs that was developed with the solution-focused approach and its simple way of re-assembling what we hear of our clients' daily lives. Something, that – given the context of our time – is still not easy to do.

On the other hand the book also demonstrates how the art of being helpful to others is not limited to one way of thinking and how solution-focused practices can be integrated in other models and in a way vice versa. Thus, solution-focused minimalists might think there are a lot of ideas in this book, that we could do away with. However, they might be reminded that conversations with others are most valuable if you stay close to the language of the person with whom you talk. Here the book is a rare and valuable example of encouraging a fruitful dialogue amongst the therapeutic gardeners, who are all-too-often to be found hiding behind their fences, defending their models or holding them to be superior to other ways of caring for growth.

In a nutshell, if someone shares the fruit of a long experience, there is a lot to be learned.

The reviewer

Matthias Schwab is a psychologist and conceptual artist. SF therapist, coach, trainer and supervisor in private practice in Germany. He is co-creating “social sculptures” in working within the Free International University and the Solution-Focused Collective.

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BOOK REVIEW**Connective Clarity: When Horses Invite You to Take Up Authentic, Solution Focused Leadership**

Wendy Van Den Bulk

Wendy Van Den Bulk, 2019, 92 pages, ISBN-13: 978-9463883856, € 20,99 paperback (e-book available at €8,99)

Review by Karen De Waele

 Clinical Psychologist and Solution Focused Business Professional

If horses could write, they would have written Wendy Van Den Bulk's book. She does a really good job at explaining the behavior of horses and how it can be useful for leaders. It makes *Connective Clarity* an interesting read about communication, connection, and leadership, and all of it thoroughly linked with the Solution Focus mindset. It's wonderful to notice how Solution Focus really is omnipresent in nature and how it seems to be the basic mindset horses have. Wendy promises the reader great insights in leadership communication and wants the book to help leaders take up their role in a (more) resilient way.

The book is built around the *Connective Clarity* model. The first part covers how to communicate a clear message and being understood as you intend to. It's an invitation to slow down and reflect on what you really want to say and to prepare yourself to communicate clearly.

The second part dives into the receiving end of communication and helps you to attune to the other and focus on the inter-action rather than the action or the re-action. The five core elements of the model are carefully explained, using examples from the horse world, and linking them with leadership. Part two was a bit tough to swallow because a lot of new concepts are introduced to build the *Connective Clarity* model. Luckily Wendy uses repetition and clear illustrations which helps to make the concepts stick. She also uses the metaphor of a tumble clown (a toy) to connect all the concepts she used throughout the book. It's a lot of information to put in one part of this book. It seems to me she has all the information and stories in place to write another book to elaborate even more on these core elements.

In the third part she really shows the model in action linked to some core communication concepts such as receiving feedback, encounter confrontations or team dynamics. This third part is full of practical examples and really invites you to explore the themes you need at any given moment. It's the part of the book you can grab whenever you want a practical guide in leadership communication.

What I took away from this book and even have passed on to others is the constant alertness horses have, combined with the basic mindset of 'Interesting!' to connect with their surroundings and developing situations. It's a truly solution focused mindset that helps to be unbiased and to slow down and explore or accept a situation with intent.

This means Wendy succeeds in communicating her message. In the introduction she writes that she hopes readers will adopt the typical mindset horses have ("Interesting!") and feel challenged to actually take small steps to establish *Connective Clarity*. Knowing Wendy personally it is sometimes as if I hear her say the words that are written. This is authentically Wendy. Her love of horses and Solution Focus really drips from the pages and she managed to naturally link those in this book.

It's really a book that invites the reader to take up authentic, solution focused leadership. When you're part of the Solution Focused community you'll realize that the book is filled with Solution Focus. Wendy states Solution Focus is omnipresent in nature. After reading this book you'll know that's true, certainly when it comes to horses! When you are rather new to the Solution Focus approach, this book invites you to adopt the mindset of horses, which is really Solution Focused in its core.

I would recommend this book to leaders all over the world - even if you're not into horses or don't believe you can learn from their behavior as a leader. This book introduces a few ideas and concepts every leader can use in day-to-day conversations and communication with others.

Personally, I'm rather new to leadership and this book has helped me to be unbiased towards my team and colleagues and slowdown in my conversations and interactions with them.

If you see this book, I hope the cover and or the title trigger you, so you think "Interesting!" and start reading!

The reviewer

Karen De Waele is a clinical psychologist and a solution focused business professional, currently working as CEO for Sint-Lievenspoort, a social non-profit in Belgium that offers education, therapy, counseling, and other help for people with hearing disabilities, speech disorder and/or autism spectrum disorder.

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BOOK REVIEW**Jump Now! Lead Solution Focus Collaboration to Accelerate Sustainable Results**

John Brooker

Book Printing UK, 2020, 250 pp, ISBN 978-1838539443, £17.94 paperback (Kindle edition available)

Review by Matthew L. Schwartz

Adjunct Instructor & Doctor of Social Work Student (US)

In John Brooker's book *Jump Now! Lead Solution Focused Collaboration to Accelerate Sustainable Results* you will find a well laid out, easy to understand, and exciting to explore roadmap of Solution Focused practice for those who work in, or with organizations. He provides numerous examples of how Solution Focused practice can be utilized from strategic planning to civil engineering projects, and then provides the necessary framework to accomplish these tasks, drawing on a rich framework of metaphors starting with DNA (and continuing forward into each of the DNA's subsequent parts).

John then provides a new translation of Haesun Moon's Dialogic Orientation Quadrant transmuting it into the Solution Focused Compass (Canadian Centre for Brief Coaching, 2018). In this way, John provides us with a basis for looking at what energizes, or de-energizes collaborations and teams in a way that business leaders and SF practitioners both can readily understand.

In his translation of the compass, John moves to look at how questions are asked, rather than how questions are answered, providing SF leaders with a new metaphorical way of framing our work. Keenly aware of his words, and his word choices. John works to explain the 'whys' of how questions are asked and designed throughout the text to make the reader more aware of their own lexicon and mindset.

While this book may raise the hackles of some Solution Focused traditionalists in its embrace of Problem Focused talk as being part-and-parcel of the change process, John presents this as a continuum to understand our own internal biases, and to map where we are in finding solutions when collaborating with others, and when exploring paths forward. He doesn't treat Problem Focused language as something to be eschewed, but rather something to be aware of, and to consider its use with the deepest intention.

John answers the one criticism I had of his book in Chapter 6 on using Solution Focused Questions. While I would have liked to see, perhaps, more examples of questions that can be asked in an organizational/macro practice/business work, John rightly points readers in the direction where such a list can be found (along with a wonderful diagram in his "A Guide to Create SF Questions, page 122), while cautioning readers against 'memorizing questions' to the point where we're a) not thinking of our own questions and b) trying to remember the 'right' question to the detriment of listening to those who are with us in the room. John builds on this in Chapter 7 when he discusses question patterns and provides further resources for readers to explore that will no doubt lead both novice (as well as experienced) SF practitioners in the right direction to facilitate change in their organizations.

While some may consider the chapters on space and pacing simplistic, they are anything but (especially for those of us who have ever been stuck in uncomfortable, unimaginative, unproductive board rooms, lecture halls, and other spaces). John remembers the important details, and – again, through his use of DNA metaphor – entreats us to remember them as an important part of the change process as well. Just like those who are therapists will have carefully thought out their counseling spaces, so too does John ask us to think about our corporate spaces in which we encourage change and solution finding.

The author neatly takes his metaphors and expertly brings them together in part two of his book, where, through a series of 'Jumps' he affords the reader the space, and the examples, to apply the first section in their work through the

metaphor of FreeRunning or Parkour, including many activities that can be used individually and in groups, both online and offline.

While this book is oriented for those who have a basic understanding of SF, novices and experts alike will find it a useful addition to their bookshelf. Perhaps most appealing for the corporate consultant, this book may be equally appealing for the therapist or counselor seeking to make change at their agency, or social work students who are learning about institutional and organizational change. I look forward to adopting it, and many of the activities, for a class that I teach on social media and social movements where my students must collaborate to create social change.

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The reviewer

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BOOK REVIEW**The Resilience Doughnut: The Secret of Strong Kids - Bringing Resilience into the Common Language of Families**

Lyn Worsley

The Resilience Doughnut Pty Ltd, Kindle edition, 2015. 130 pages, ISBN 978-0-646-55255-2. £11.22

Review by Tara Gretton

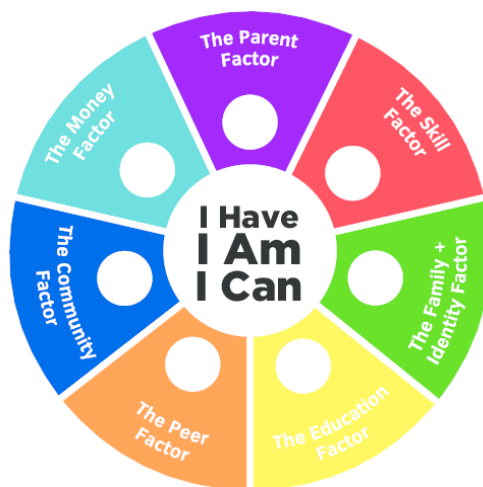
Social worker, solution focused practitioner and trainer (UK)

Lyn Worsley is a clinical psychologist with a background in nursing, youth work and teaching. Lyn and her family are based in Sydney Australia. Lyn's extensive experience of working with children, young people and their families in a variety of settings; schools, street youth work, children's hospitals, prisons and local youth groups give her first-hand experience both of the complexities of life that children, young people and their families can experience in their everyday lives, and also of how these complexities can cause limitations for people within their communities and social environment.

Lyn's book and her model The Resilience Doughnut offers an ecological model to support children, young people and their families to see hope and possibilities in their future. The model is simple, fun and accessible, where the focus is on finding a coherent way to communicate what resources are available to people in their everyday lives, in everyday communities.

The Resilience Doughnut, like any good doughnut, has two parts: the hole in the middle and the outer circle. The hole in the middle represents the person; *'I have, I am, I can'* with a focus on what is working well already in the person's life. Lyn refers to some wonderful *'strength-based research and studies of individuals'* where it is usefully highlighted that *'people have survived and thrived despite the risk factors and adversity in their lives'*. She highlights that people have resilience and that it needs to be noticed and amplified.

The outer circle is made up of seven external factors as shown in the diagram of the Resilience Doughnut itself below. The Resilience Doughnut uses a scale to record the strengths of each external factor and together creative ways to strengthen each factor are born.



The Resilience Doughnut has elements of the solution focused assumptions infused within the model; with its belief in change and its focus on strengths. The resilience doughnut however in my view, with its focus on external factors to increase resilience, is more of a strengths-based model rather than a solution focused model. I am curious to see what

difference it would have made to the book if there was more reference made to the solution focused approach; whether it would have enabled more of a focus on the solution focused assumption that people are experts in their own lives with the strengths and capabilities to (in a co-constructive manner) create their own solutions related to the seven external factors.

However, an experienced solution focused practitioner would be able to use the resilience doughnut alongside the young person to elicit their hoped-for change and by inviting them to notice how they had coped with adversity in the past, and how the seven external factors (and individual characteristics) had contributed to how they had coped in the past. They would then be able to start to explore the small signs that would tell them they were building their resilience in the seven external factors and how others in their community could be a part of this change.

Lyn Worsley exudes knowledge, experience and passion throughout the book. It is evident in abundance that Lyn believes in children and young people and has written a book and created an accessible model that gives them every opportunity to thrive by focusing on their strengths and by drawing on the community where the young person *'receives messages that nurture inner self – the I HAVE, I AM and I CAN resources'* (p 19). This can only be of benefit to children, young people and their families and can truly invite a shift from problem and deficit focused models to a model of hope and possibility.

This book is written with the intention that anyone working with children and young people can pick it up and instantly have the Resilience Doughnut Model at their fingertips, ready to use. It's inspiring how the author's attention to detail answers those 'what if' scenario questions, ensuring that the reader can visualize the use of the model in every type of scenario and potential complex situation. I can see this book and *The Resilience Doughnut* being incredibly useful to workers in community settings; where they are interacting with young people and their families and where familial difficulties can be negatively affecting the potential life outcomes of the young person - where it can be hard to notice what's working well already and how this can be built upon.

Having trained as a social worker. I see this book being hugely useful to this field. This is a field where workers are often completely entrenched in work with children and families where there is pervasive adversity, where assessments, interactions, meetings are often focused on deficit, crisis intervention and analyzing the problems. I believe that *The Resilience Doughnut* would offer something more hopeful and pertain to the more traditional social work approaches where the community/external factors are drawn upon to enable a young person to thrive and reach their full potential. I also believe that in the context of social work and perhaps other fields where risk is being assessed; the framework offers more of a directive structured model that is robust to assess and manage potential risk factors.

The Resilience Doughnut is an accessible means to measure strengths and how to increase strengths in relation to external factors in a child and young person's life, no matter what adversity that they have experienced. The quote in relation to this book that springs to mind is the African Proverb, *'It takes a village to raise a Child'*. This book highlights what we can draw upon that is at our fingertips within our communities and it does it in a coherent accessible way; giving hope and possibility for all.

The reviewer

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BOOK REVIEW**The Solution Planner: How to Create the Life You Desire One Solution at a Time**

Erica Bowen

Independently published, 2020, 141 pages, ISBN-13 979-8626892710 (paperback) £9.99 (ebook available at Amazon £7.49)

Review by Matt Selman

 Senior Lecturer & Programme Lead for Evidence Based Psychological Practice

The *Solution Planner* is a self-help book based primarily upon solution focused brief therapy techniques. The back cover claims the solution focused nature makes this self-help book unique which I will dispute given existing publications such as O'Hanlon (1999) and Metcalf (2004). That aspect aside the format is different to many self-help books with it having two distinct sections, a workbook and a planner. The workbook consists of an introduction to solution focused brief therapy techniques, covering the core approach and core techniques such as the miracle question, scaling, and identifying exceptions. This is all accompanied by exercises and with space in the book to write the responses which encourages practice.

In addition to the solution focused practice there is also reference to the 24 Character Strengths identified in Positive Psychology. This is unfortunately lacking in its description and unclear in its relevance serving only as a list of the Strength names - no descriptions - that can be developed through practicing the journaling in the book. This is at odds with how Character Strengths are understood and conceptualised in the literature where a small number of signature strengths of the individual are identified and utilised rather than developing all 24 areas as the author suggests here (Niemiec, 2017).

Another area included is 'The 8 Domains of a Good Life' (Creativity, Healthy Living, Excellence in work and play, Independence, Relationships, Knowledge, Inner Peace, and Spirituality). The source is not referenced, with these placed into a 'Wheel of Life' diagram enabling a rating of 0-10 on enabling the reader to assess where they view themselves on meeting. This is used as a guide to areas of life where goals may be identified. There is a more explanation of the domains for this section. The benefits of including this are not clear given that people using SFBT have been able to identify what they want to change perfectly well without this. It could also have a prescriptive aspect in an implied optimal 10 for all these areas being the ideal - how better to identify your perceived short-comings across life which does not sit so well.

The second part of the book is the planner. This consists of a 12-week journal with set questions repeated to record progress and develop the techniques introduced in the workbook section. After the first week there is a helpful review section for any difficulties that might have been experienced. The following 11 weeks are a repeat of week one focusing the reader on the areas they have chosen to work on. In much the same way that mittens on a cord attached to a coat vary on the context of the person using them from fantastic for young kids who lose things to a contrasting more dangly embarrassment for the ambitious CEO - the inclusion of the planner could be equally great or frustrating.

A positive is for the more disorganised person there is no need to print sheets off or search out a pad and paper, it is easy to review previous weeks without sheets getting lost or put to one side and it is all there ready to flick back to the workbook for a quick check. For pure convenience we mightily eagerly await a second edition that comes with a pen attached by string so there is nothing getting in the way of completing or for the hopelessly disorganised a smartphone find my Planner App that can locate a misplaced copy.

The counter is a lot of the book is simply the pages repeated (there is a kindle edition so this will either be shorter or very frustrating to complete). There is also the experience of how much space is allocated to areas. Having worked with the planner I found there were areas where I did not have enough space and others where there was an entire page and I only had line or two needed; a plus for the pen and paper approach and no querying "Should have written more?"

A real strength is the deliberately interactive nature of the book inviting action and the opportunity to start experiencing change from the SFBT exercises through to the planner. This fits well with the SFBT approach in changing behaviour and finding what works. I am sure many self-help books are read and people feel better briefly imaging change, but nothing happens. Aimed as it is to the general reader another strength is the accessible writing style. There are multiple typos, not the best illustrations, lots of empty space around the side of pages and an unclear use of references (there are only five, but it is not clear why these and not others) which may be linked with the self-publishing as an editor and proof-reading service might have addressed.

Overall, I think someone looking for self-help for something relatively minor in their life would find benefits in engaging in the exercises in this book and get a sense of solution focused practice - particularly if that person was on the disorganised side but did have a pen. For those with some existing idea of solution focused practice or the therapist/coaches considering it as a supporting text I think it would not really offer much over a brief worksheet or personal journal and the inclusion of the non-SFBT areas might be distracting or require additional work so I could not recommend.

References

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The reviewer

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