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Journal of Solution Focused Practices

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Abstract available in: Armenian, Chinese, German, Italian, and Norwegian

Evaluating the Solution Focused Wellness for HIV Intervention for Women: A Pilot Study – Helen T. Yates and Orion Mowbray

Theory

Steve De Shazer's Theory Development – Harry J. Korman, Peter De Jong, and Sara Smock Jordan
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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**A Broad Overview of Solution Focused Severe Trauma & Stress Recovery Work, with the Introduction of Two Additional SF Instruments to Promote Thriverhood**

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Abstract

The purpose of this paper is to show how the author's solution focused (SF) work with both adult survivors of child abuse and neglect; and, adult trauma survivors, has developed from Yvonne Dolan's severe trauma recovery work (Dolan, 1998). Dolan's major contribution to this way of working is acknowledged; and, her three-stage Victim – Survivor –Thriver continuum detailed, with an emphasis on the Thriver stage. Other contemporary practitioners' work is described, in brief, also. From the author's clinical work with survivors of trauma, over some 25 years, it has become clear that clients need to understand more fully what thriverhood is about, in order to move towards it more effectively. Psychoeducation in the form of in-session verbal information and typed sheets to take away, has proved to be helpful in most cases. Some recent neuroscientific research, with specific reference to neuroplasticity is referred to, to demonstrate how clients improve through this specialist SF application. The handouts 'What Thriving is Like' (Figure 1) and 'The Thriver Progress Questionnaire' (Figure 2) are more advanced materials to help clients have a better understanding of both what is possible and how to be thriving more fully. It is the author's intention also, to encourage more practitioners, equipped with the additional tools referred to, to take up the challenge of those important and rewarding work.

Keywords: Thriving; Solution focused; Trauma; Survivor; Victim; Thriver; Neuroscience; Neuroplasticity

Introduction

Almost year on year, the number of specialist applications of the SF approach, expands. Since becoming an SF therapist in the early 1990s, I have sought to apply the principles, assumptions, tools and techniques of our wonderfully liberating approach to therapy, coaching and consultancy. Within the last 10 years, especially, I have concentrated on my two specialist mental health applications: Suicide Prevention and Severe Trauma Recovery. The second of these, developed out of my extensive training of military welfare workers, across the British armed forces, saw the publication of my first work: *Beating Combat Stress: 101 techniques for recovery* (Henden, 2011). This was both a reference book for welfare workers and a self-help book for military veterans and serving personnel, who may have experienced combat operational stress injury (COSI) or operational stress injury (OSI). (I avoid using the problem-focused term, PTSD, deliberately.)

Immediately after the book was published, there were requests from various quarters for a civilian version. This was published in Dec 2017 and is entitled, *what it takes to Thrive: techniques for severe trauma recovery* (Henden, 2017). Within this article, I will consider some aspects of my SF approach to severe trauma recovery, with a later focus on the recently designed above mentioned instruments.

In my psychotherapeutic work over some twenty plus years, with both adult survivors of childhood abuse and neglect; and, adult severe trauma experiences, I have found it helpful to provide clients with a degree of psychoeducation, to help them understand how what happened to them has caused their current symptoms and experiences; but more importantly, what they can do about them, to live full and satisfying lives. It is important for clients to be allowed to tell their story at the beginning of the therapy. "Being able to say to another human being...is a sign that healing can begin" (Van der Kolk, 2014).

Background

I owe a deep debt of gratitude to Yvonne Dolan (1998), who developed her notion of Victim-Survivor-living the authentic life (Thriver). By way of providing some background, after many years of working with victims of trauma, Dolan noticed that although such clients could acknowledge they were survivors, being able to function better than hitherto, they were still prone to spells of very low mood. Her belief was that there must be a third stage that clients could both aspire to – and reach. This she described as ‘The authentic self-identity’ or ‘Living the life you truly want and deserve’. (The term Thriver was suggested to me some fifteen years ago by Roger Meeson (2006), an SF colleague and private psychotherapist practicing in the South West of England.) In her book, *Beyond Survival: Living well is the best revenge*, Dolan outlined many novel and powerful tools and techniques for clients to try out, as and when appropriate.

Before looking at Dolan’s 3-stages of recovery, it may be helpful to say a little about the approaches of other SF practitioners in the severe trauma recovery field.

Contemporary SF Trauma Recovery Specialists

Jackie von Cziffra-Bergs

Being based and practicing mainly in Johannesburg, South Africa, von Cziffra-Bergs (Froerer et al., 2018) finds that much of her trauma recovery work comprises of car jackings and home invasions, often involving firearms. She makes the point, strongly, that she has made the shift from a ‘victimologist’ to a ‘resilientologist’, in that she asks survivors, questions of resilience: “How did you cope?” and “How did you respond at the time?” It is well known that people do incredible things in a traumatic situation, so it is most helpful to ask questions about it. In keeping with this SF emphasis on resilience, instead of debriefing such clients, she focuses on a re-briefing of client strengths. Presuppositional questions about client resilience and those leading to recovery are a cornerstone to von Cziffra-Bergs’ work.

Steve Flatt

Being one of the more experienced SF severe trauma recovery therapists I have met, Flatt (personal communication, 2020), having seen over 2,000 clients within the past twenty years, including survivors of the cruise ship *Costa Concordia*, which capsized in shallow waters off Italy, in 2012, uses a strength-based approach comprised, typically, of a 4 – 6 session episode over some 10 weeks. Being fully aware of the work of neuroscientist Joseph LeDoux (2011), he is a firm believer in the idea that therapists do not change clients’ brains for the better: clients change their brain for themselves. Flatt (personal communication 2020) believes that clients know within the first milliseconds of the first meeting whether or not they are going to get on with their potential therapist. Within this first meeting, he talks in a strengths-based way about what happened to them and about how they managed to cope at the time. Like so many of us, resilience is a key part of Flatt’s work. He has an elegant way of introducing the notion of clients’ best hopes for the work, at the beginning of the first session: “Supposing that you could work with me; and, supposing we did some work together that was useful to you, standing at the end of the line of this work, what would you notice about yourself that would tell you that this has been helpful?”

Frederike Bannink

A clinical psychologist based in Amsterdam, the Netherlands, Bannink (2014) wrote her first book on trauma, in which the theory and practice of positive psychology and solution-focused brief therapy are combined with traditional approaches. Her concept veers away from a focus on clients’ pathology and how to repair the worst to a focus on what is right with them and how to create the best. In her book, *Posttraumatic Success* (Bannink, 2014) she lists the 3 R’s of posttraumatic success as:

1. Recovery
2. Resilience

3. Enrichment (posttraumatic growth)

Bannink (2014) labors the point that it is time to turn the tide on treating trauma by shifting the focus from reducing distress and merely surviving, to building success and positively thriving.

Ben Furman

Being one of a growing number of psychiatrists who question the consequences of the biomedical approach, Furman (2020) both pioneered and promoted SF practice, in a variety of settings.

Regarding trauma recovery work, he invites the client to choose their own preferred term to refer to the adverse event, thus avoiding the medical term, 'trauma' (Furman, 2020). Also, he assumes a not-knowing position with clients, asking whether past traumatic events have a bearing on current problems. Other key aspects of Furman's approach are to ensure the client defines the goal of therapy; to facilitate the client's natural recovery process; to invite clients to appreciate possible positive consequences of the adverse life events; and, to regard these adverse life events as memories that can change. A light-hearted part of Furman's work is to allow the client to share one or more amusing details related to the adverse event.

The 3 Stages of Recovery

Victim Stage

"Trauma make people feel either like somebody else or like nobody" (Van der Kolk, 2014. p247).

Acknowledgement of the Victim stage is the most important first step of healing: it is important for the person/client/ survivor, to face the reality of the bad or unfortunate thing/s that happened to them; or that they experienced. Accurate naming is important, without minimizing or putting any sort of gloss on it. An example of a past client of my own, was their marked shift from, "My childhood was not particularly rosy" to "I was a victim of severe and enduring childhood emotional and physical abuse from care givers."

Finding the courage to disclose to someone else what happened, breaks down the isolation and is crucial. Over the past twenty-five years, I have had numerous cases where, usually, the incident disclosed was between ten to fifty-one years previously. One memorable case, often which I cite on 2-day workshops, is of a 70-year old woman who had been imprisoned within a compound by soldiers in a war zone, when she was age 19. A young mother there, was worried about the distressed cries of her hungry baby. That night, under the cover of darkness, my client crept out, across the compound to a cattle shed where she milked one of the cows. The baby's mother was very grateful for her act of kindness in supplying the urgently required milk. Unfortunately, in the morning, the guards found out what she had done and killed the baby, as punishment. She had told no-one about this incident after the war and carried the false guilt about the baby's death throughout the intervening fifty-one years. Knowing what we know now about 'depression' resulting from either unexpressed negative emotion; and/or undisclosed or unresolved secrets from the past (Griffin & Terrell, 2000), this client fitted both of these categories; and consequently, had many occasions when, to the mystification and distress of her family, she was extremely low in mood.

A typical question at this stage, is as referred to above: "What happened to you?" (Langdon, 2013) This is a vitally important question as it allows the client to name, in their own words, what they experienced. It replaces the medical model's "What is wrong with you?" of yesteryear.

Naming the event/ abuse/ experience accurately, is an especially important part of the Victim stage; and, it is not necessary, unless the client wishes, for them to go into detail. Other useful questions to ask at this stage are:

- "What remaining negative feelings about the event/
- abuse/ experience, do you need to discharge
- safely?"; and,
- "What have you done so far, that has been helpful?"

For clients, feeling listened to and understood, changes their physiology. "Being able to articulate a complex feeling; and, having our feelings recognized, lights up our limbic brain and creates an "Aha" moment." (Van der Kolk, 2014) The simple SF techniques of acknowledgement and validation, facilitate this process.

Once full acknowledgement of victimhood has taken place, any negative emotions that might be around, can be expressed safely in several ways. These negative emotions most commonly are: grief, frustration, anger, guilt, shame, disappointment, hopelessness and helplessness. Expressing them safely, is a vital part of healing within the Victim stage.

Often, a challenge for the therapist is their helping the client to appreciate that what happened was not their fault. Survivors of child abuse often feel, that in some way, they were to blame for what happened to them. Many perpetrators are particularly skilled at imputing this belief into their victims. Any harm which comes to children is the responsibility of the responsible adults (parents or other care givers, teachers, etc.) around at the time, who were supposed to be ensuring they came to no harm. A helpful psychoeducational statement here, is: "From what we know from doing this work, it is never the child's fault."

Many survivors of traumatic events in adulthood feel, too, that they are either wholly or partly responsible for what happened, or, what they witnessed. For over twenty years, personally, I carried the guilt of a road traffic crash I witnessed at the age of 18, where a helmet-less motorcyclist crashed into the front of a lorry. The impact speed was approximately 50mph, the motorcyclist landing on the road head-first, after being propelled through the air for some distance, like a rocket. He bled out from a serious head wound within three minutes, creating a pool of blood two feet in diameter. I had been awarded a top-level first aid certificate only two weeks previously and did nothing to help, simply looking on, in shock. My therapist explained that, most probably, he was dead on impact with the oncoming lorry and was certainly dead on impact with the road. There was nothing I could have done; and, what I was experiencing was some sort of 'survivor guilt': quite a normal response. After that, I was able to let the guilt go.

There are some cases with adult traumatic experiences where some of the guilt may be owned, justifiably, by the survivor. However, it is rarely "100%", as often expressed by survivors. Such clients, through a process of apportioning percentages to other factors, and individuals, can enable the correct proportion of blame to be carried. Appropriate SF techniques can then be used to deal with this remaining guilt, in constructive ways. Deep sorrow and repentance and forgiveness from either the victim in person, or via the healing letters exercise (Dolan, 1998), can lead to a freeing up. Other valuable SF questions and statements for helping clients through this stage are:

- "How would you like to use these sessions?";
- "How much of the detail, if any, do you need to tell me, in order for me to be most helpful to you?"; and,
- "I am getting some level of understanding of how awful this was for you at the time and your reactions to it which are unsurprising."

Once the Victim stage has been understood and acknowledged, the client can then move on to the next stage – Survivor.

Survivor Stage

This begins when the traumatized person understands they have lived beyond the traumatic or highly stressful experience that occurred. The Survivor stage reinforces the fact that this/these experiences happened in the past. There is then a wonderful opportunity for the therapist to ask the following SF questions:

- "How did you survive it?"
- "How did you do that?"
- "How did you know how to do that?"
- "What strengths, abilities and personal resources did you bring into play, at the time?"
- "What got you through it?"

Acknowledgement of survivorhood also involves developing an inventory of internal strengths and positive personality characteristics. The list may include some of the following: creativity; curiosity; determination; honesty; having clear values; and, resourceful. This is important, because victims of whichever type of trauma can experience both low self-esteem and low self-confidence, as a result of what happened to them. Often, I have found severe trauma clients to be hard-pressed to list any positive characteristics. Using third parties, (e.g. best friend, mother, head teacher) can often build this much-needed list through the well-known Gestalt technique of the empty chair: "Just suppose, in that chair over there, is sitting your best friend. What would they say are your positive characteristics?"

Furthermore, clients can be asked to elaborate on other internal strengths and qualities such as hidden knowledge, courage, spirituality, personal beliefs and other positive aspects of self that have got them this far on their journey. There is a powerful process at work here, as through this line of SF questioning, clients realize that things are not all

bad; and, that through answering, positive emotions can be elicited. This is an important aspect of solution-building. (Kim & Franklin, 2015).

It is worth enquiring about external resources that were available to the client, too, around the time or shortly after the abuse or trauma was experienced. These might comprise of a grandparent or neighbor (in the case of child abuse or neglect); mates; a minister or welfare worker.

Questions then may be asked such as:

- “Who was most helpful?”
- “What was it they said or did that was most helpful?”
- “How did you know how to access their help at the time?”
- “Looking back, how could you have enlisted their help even more than you did at the time?”

At this stage, Survivors begin to regain better functioning in their everyday lives: both in terms of family and social life; and at work. Increased assertiveness and a determination not to be pushed around, bullied or abused, is often evident as clients embrace survivorhood, more fully. One client once remarked; “I’ve decided I’m not going to be taken advantage anymore, by some of my so-called friends!” There is a greater willingness to engage in household tasks, meet up with friends and be involved in community activities. Once survivorhood is fully acknowledged, with all skills, resources, strengths and qualities appreciated, they are ready then, to move on to Thriving. Psychoeducation in the form of a simple explanation about how what happened, has had an effect both on how the person feels about themselves now; and about how they have been living, can be both informative, liberating and empowering. Backing it up with written information can be helpful, too.

In addition to feeling better informed about the results of what happened to them, clients can learn some practical steps they can take to promote recovery in the form of useful tools and techniques, thus feeling more empowered and in control of their own recovery process. Victims of trauma have 6 fields of concern: Triggers; Flashbacks; Intrusive thoughts, ‘The Lows’; Sleep disturbance; and, Living life to the full (Henden, 2017). A simple, yet highly effective technique for dealing with triggers is: “Let it go...Let it go...Let it go...”

Clients are taught to repeat it in the session to ensure they are saying it slowly and deliberately for future occasions when they experience the trigger. It seems that no survivor is too old to change their brain’s response to take the sting out of a trigger, by this technique, so long as they are motivated to do so. There has been a great deal of research into this area of neuroscience, over the past two decades or so. “Investigators of neuroplasticity, demonstrated that the adult brain can continue to form novel neural connections in response to training...” (Garland & Howard, 2009) During the early years, SF practitioners knew that something amazing was happening to clients’ brains, from what seemed on the face of it, carefully crafted SF questions and some simple techniques. The newer neuroscientific research can be declared the theory behind what is happening here with and explains how the SF approach sees clients recover from trauma over time. Another neuroscientist, Joseph LeDoux (2011), talks in terms of “traumatic learning” and “memory reconsolidation”, suggesting that the synapses in the brain get stuck around the traumatic memory, thus explaining the amygdala response to triggers (LeDoux, 2011).

By using an SF technique “Let it go...Let it go...Let it go...” what seems to happen here, is that these synapses are made fluid again through re-imaging the trauma as the trigger occurs and then via the application of the technique, reset in a healthier way, such that the client responds differently for future triggers. Clinical experience suggests that practicing it for some 30 – 40 occasions, achieves the desired result.

Now, to consider the all-important Thriver stage, within Dolan’s Victim-Survivor-Thriver continuum.

Thriver Stage

In my early years of working with both adult survivors of child abuse and neglect; and, with clients experiencing trauma in their adult lives, I produced a single-sided handout, summarizing Dolan’s key points at each stage, entitled ‘The three stages of survival’.

Helpful questions at this stage are:

- When this incident/ traumatic time is but a fading memory, what will you be doing differently?
- “How will you be spending your time?”
- “As you continue healing even more, what will your (significant other) be noticing?”

Whilst being helpful to many, as far as it went, to explain the process, I observed some clients still struggled to grasp the importance of understanding and appreciating each step. Hence the need for something more detailed in the form of the three-pager: 'What Thriving is Like' (Figure 1), which was developed in the light of practical experience, with my clients over many years.

Within it, there is mention of acknowledgement of survival skills; rejecting the 'damaged goods' label; improved interpersonal relationships; personal skills, attributes, strengths and abilities; the many and varied techniques available for recovery; and, experience of real joy and fulfilment once the third stage, Thriving, is reached. Victimhood and survivorhood, it seems, are easier for clients to grasp, but it is this most important Thriver stage which needs that fuller appreciation and understanding. Interestingly, I have found for many clients, in the early stages of the work, neither do they believe it is possible, nor do they feel they deserve to thrive! Once clients have had explained this three-pager, re-read it as a between-session task, and inwardly digested it, the 'Questionnaire for Measuring Thriver Progress' (Figure 2) follows on naturally. This, also, was developed in the light of practical experience, with a wide range of clients. Within the ten-point Likert scale (below) for each of the questionnaire's thirty-three questions, even the smallest steps of progress are measurable, as the client's scoring range is between 33 – 330 points. To assist with understanding and appreciating the power of this measuring tool, I will examine a few of the questions.

Firstly, Question 2 deals with the issue of assertiveness which, invariably, is an issue for adult survivors of childhood abuse and neglect, who may have been blamed and shamed; and, also experienced assaults on their self-esteem. Passivity, (non-assertiveness), can result in their being taken for granted, bullied and/or abused by others. Once clients have a full understanding of the three main interpersonal communication styles (passivity – aggression – assertiveness) they can be encouraged to develop and practice their assertiveness skills with family, friends and in their interactions generally, with others. (Clients can choose to be self-rating and/or the therapist can complete the questionnaire, collaboratively, with the client in the session.) At an early stage in therapy, a score of 1 or 2 on this 1 – 10 scale, would be unsurprising; this increasing, typically, to 7 or 8, at the conclusion of the work. Question 13 measures willingness to take risks, to promote personal growth and life satisfaction. Clients in the Victim stage, generally, move within an exceedingly small world, often shunning change and valuing the security of the familiar. As these clients move into the Survivor stage, they are more likely to push the boundaries of their comfort zone, by taking risks. Thrivers want more fulfilment and therefore are more willing to challenge themselves. It is not uncommon for Thrivers to score 8 or 9 on this question by the end.

Improving sleep quantity and quality, is an important barometer of progress towards thriverhood. Question 17 addresses this. Once establishing client's usual sleep patterns at the first session, I will ask again how it is, in the third or fourth session. Evidence of improved sleep is understandable in the sense that, through the SF severe trauma recovery process, the client starts to process and sorts things out in their conscious mind, obviating the need for dreamwork, during REM sleep, to attempt to resolve waking life conflicts. Some typical client responses during the third or fourth sessions are: "Since I saw you last; I have had three nights when I have slept for four and a half hours straight. That's not happened for months!"; and, "I am waking up less often in a cold sweat, in the middle of the night, than before I started this work."

The last question (No 33) is about one of the key aspects of thriverhood: that of moments of great joy and exhilaration. Victimhood is characterized by chronic low mood; survivorhood has great fluctuations in highs and lows; and thriverhood provides these benefits of a life lived to the full. These great joy and/or exhilaration moments may be fleeting and periodic, but they are very noticeable by clients in thriverhood and are indications that they are beginning to live life well.

Clients may be encouraged to complete the questionnaire between sessions and bring it to the next session. If photocopying facilities are unavailable, the scores for the 33 questions can be recorded within the worker's case notes. A new blank copy can be provided to the client, as appropriate, at future sessions. Increasing total scores over time can be both affirming and a great encouragement to clients as they continue their journey towards thriverhood. Naturally, this questionnaire would be given to clients only as and when appropriate. Another important point to mention, from a research point of view, is that this questionnaire has not yet been standardized, in terms of reliability and validity. Each one simply tracks the progress of each client over time, during their episode of therapy. It may be that in future studies, this questionnaire could be subjected to statistical validation.

Returning to the concept of resilience, which is a strong feature of other specialists in the field, and mentioned in an earlier part of this paper, the Thriver Questionnaire highlights client strengths, qualities and abilities; and shows how even more resilient they are now despite their awful past experience/s.

By the very action of completing this instrument, clients are further transforming their feelings, thoughts, attitude and behaviors, thus accelerating and encouraging them along their Thriver journey. Just a few more points added to their total score, since the last time they completed one, is very reinforcing. Again, this can be corroborated by the research evidence referred to above

Conclusions

In conclusion, this valuable severe trauma recovery work is both challenging and rewarding. Traumatized people who receive no help or ineffective help from some practitioners, are destined for a lowly existence which often involves poor physical and mental health and limiting life choices. Being in receipt of prescribed medication and/or self-medication to reduce their pain, they will live significantly shorter lives. Achieving thriverhood, despite whatever awful thing/s have happened, Thrivers are likelier to access healthcare systems less frequently; be in employment and consequently be net providers to the national exchequer through income taxes. Furthermore, they will enjoy better quality personal relationships; and, live more meaningful and purposeful lives. In the light of the practice-based evidence of more than twenty years of this particular specialist application of SF, the majority of the most severely harmed clients achieve thriverhood within approximately 7 to 9 sessions over 8 to 10 months.

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Figure 1**SEVERE TRAUMA & STRESS RECOVERY****WHAT THRIVING IS LIKE**

You have acknowledged and accepted now that you have been a victim of whatever it was that happened to you; or, what one or others did to you. More importantly, you have acknowledged now that you survived it, using whatever strengths, abilities, and personal resources you tapped into at the time. Also, you acknowledged many external resources that you used at that time. However, on its own, being a 'survivor' is not enough. You owe it to yourself to move into the third stage: *THRIVING*.

What is it like to be a 'Thrivers'?

Millions of others who have experienced the same, or similar dreadful things that happened to you, have powerful personal testimonies/stories about their journey; and what their life is like now. They will never forget what happened to them (although memory fades with time) but no longer, are they pulling around the 'ball and chain' of the incident or their traumatic past.

A good illustration of what the Thrivers' life is like, is the Japanese art of Kintsugi:

This is where the hand-built and hand-painted ceramic bowl broken during the firing process was repaired by Kintsugi. Kintsugi ("golden joinery"), also known as Kintsukuroi ("golden repair"), is the Japanese art of repairing broken pottery with lacquer dusted or mixed with powdered gold, silver, or platinum. As a philosophy, it treats breakage and repair as part of the history of an object, rather than something to disguise it.

Many survivors view themselves as 'damaged goods' but this does not need to be so. The trauma part is only one part of your life. As you move into the Thrivers stage, you can now regard yourself as a Kintsugi bowl!

"Our wounds are often the opening into the best and most beautiful part of us" – David Richo

When further along into Thrivers, you will notice that your mood generally is better for much of the time. There will be blips along the way, but you will feel now you have the resources to deal with them, as they occur. Also, you are more able to visualise a future which is both realistic and achievable.

Your relationships with others will have improved/are improving. You are wanting to spend more time with friends and family members who are more nurturing and encouraging; who value and respect you. You feel more comfortable being assertive now, in a variety of personal/family/social/professional situations.

As a Thrivers, (or being well established on your Thrivers journey), you feel your life has more meaning and purpose than at the earlier stages. You feel more fulfilled, more often and feel a greater sense of freedom now. There are times when you reflect on your beliefs and values, acknowledging and giving expression to the spiritual (small s or big S) side of your life.

You notice, too, there are times when you feel more relaxed, calmer and more centred. You are more inspired and have a wish to strive for meaning, rooted in your values and principles. If you find it helpful to consider the Thrivers stage as being comprised of 'chapters', you have an optimistic outlook as to how these future chapters will be written. (Some Thrivers find it helpful to think in terms of 5-year or 10-year chapters, taking them up to age 80, 90 or even 100!).

Hopes and dreams for the future, help you to hold some ideas in your mind for these future chapters. Many have found it helpful to jot down these ideas in a personal diary or journal.

"Once you have chosen hope, anything is possible" – Christopher Reeve

Personal skills, abilities, strengths and attributes

In the Thrivers stage, it is important to remind yourself about your journey from Victim, through Survivor, to Thrivers. This has brought into play your many personal abilities, strengths, skills, attributes and resources. Also, along the way, you have found helpful, the resources and strengths of others. There is a good number/range of these abilities,

strengths, skills, attributes and resources that are of great value in Thriving. Ensure you value, cherish and honour these.

Tools and Techniques

During the Survivor stage, particularly, you will have learned many useful tools and techniques to master or get control over triggers, flashbacks and intrusive thoughts, connected to the trauma/neglect/abuse/tragedy/incident that you experienced. You will have learned even more useful tools and techniques for strengthening you for the Thriver stage, to enable you to thrive more fully, still. Many of these tools and techniques you will use, as and when appropriate, for the rest of your life. You will be able to encourage others, too, to learn and practise these tools and techniques, to help them along their own Thriver journeys.

You will have noticed your sleep is now much improved than during earlier stages, in that you sleep for longer periods; are more rested by the morning; and, your dream content is better. You use effective psychological and practical techniques which promote sleep.

Your Journey

Now that you are Thriving, or moving further along your Thriver journey, you feel that earlier restrictions on your life are now a thing of the past. You feel you can take more risks now with new interests, pursuits or hobbies that will expand your horizons. You experience now a greater sense of freedom to make choices; to do the things you want; and, to fulfil your hopes and dreams for the future.

As part of moving out of your comfort zone, you may be thinking of doing things, which previously, you would have considered outrageous. You are more creative now in both your thinking and actions.

Your life nowadays is a life being lived and enjoyed; one that you feel you richly deserve. You will be doing more things, taking up new hobbies, interests and other pursuits.

Generally, life now involves a sense of wonder, personal creativity, wider interests and immediacy. Life in the present is more vivid and compelling than your past; and, you can now look the world in the face.

Regarding how you are with others, not only will you now be more nurturing and loving towards yourself; but also, you will be more loving and nurturing towards others close to you. You will feel more comfortable about initiating contact with friends and loved ones; valuing mutually supportive and intimate relationships.

Other key parts of Thriving are that you will have moments of intense joy about your life as it is now. You may notice that your sense of humour is more present than it was. A whole range of emotions, both pleasant and unpleasant, can be experienced fully now; and, you will appreciate that these are vital parts of being human. The challenges, hardships and disappointments of life come your way as usual, but you feel more equipped both to face and deal with them.

Now, you are more likely to enjoy the simple things of everyday life; and, are able to be grateful for all the good things happening in your life as a whole.

Above all else, after all that has happened, *YOU DESERVE TO THRIVE!*

(This paper is the result of both personal and professional experience in the field of severe trauma and stress recovery over the past 25 years. I am forever indebted to Yvonne Dolan and all that she has taught me over the years, especially through the tools and techniques she has developed for use with Survivors and Thrivers.)

Figure 2

**SEVERE TRAUMA & STRESS RECOVERY
QUESTIONNAIRE FOR MEASURING 'THRIVER' PROGRESS**

In the questions below, please tick the box which, currently, applies to you.

1. I have genuine relationships in which I can share deep thoughts and feelings

Strongly disagree									Strongly agree

2. Generally, I am pleased about my assertiveness skills, in my interactions with others.

Strongly disagree									Strongly agree

3. I feel my life is now as fulfilled as I want it to be; and, I am living my life well.

Strongly disagree									Strongly agree

4. My life is both meaningful and purposeful.

Strongly disagree									Strongly agree

5. I apply my personal strengths, skills and abilities to my life.

Strongly disagree									Strongly agree

6. I have at least one good friend or relative, who would help me out psychologically, in most situations.

Strongly disagree									Strongly agree

7. Although I remember what happened to me, the incident/s is/are no longer a 'ball and chain' I drag around.

Strongly disagree									Strongly agree

8. I use tools and techniques that I have learned, to deal successfully with any triggers, flashbacks, intrusive thoughts or sleep problems I may have.

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Strongly disagree Strongly agree

9. Within the last month, I can identify at least one instance of emotional calm.

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Strongly disagree Strongly agree

10. I am realising, fully, my hopes and dreams for the future.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

11. My low moods are largely a thing of the past.

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Strongly disagree Strongly agree

12. I am having ideas and thoughts about new things I could put into this present chapter of my life.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

13. Nowadays I am able to challenge myself to do things out of my comfort zone.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

14. Despite all that has happened, I am now living the life I richly deserve.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

15. Over this past year, I have taken on new interests, hobbies or pursuits.

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Strongly disagree Strongly agree

16. I have a greater sense of freedom now that I can make choices; do things I want; fulfil my dreams; etc, than ever before.

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Strongly disagree Strongly agree

17. My sleep is now more restful, for longer periods; and, my dream content is better.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

18. Generally, I am now experiencing most of the qualities of thriving (freedom, joy, personal creativity, meaning & purpose in life, immediacy, wonder, etc), for most of the time.

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Strongly disagree Strongly agree

19. Nowadays, I look at the world fully in the face.

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Strongly disagree Strongly agree

20. I am now more hopeful for the future.

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Strongly disagree Strongly agree

21. I am now living my life well; and to the full, despite any physical limitations I may have.

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Strongly disagree Strongly agree

22. Nowadays I am more relaxed, calm and centred.

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Strongly disagree Strongly agree

23. Now, I am living my life according to what I believe and value.

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Strongly disagree Strongly agree

24. I find I am better now at problem-solving and finding solutions.

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Strongly disagree Strongly agree

25. My sense of humour is better than it was.

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Strongly disagree Strongly agree

26. I am pleased with my achievements over the past few months.

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Strongly disagree Strongly agree

27. I experience a wide range of emotions, both pleasant and unpleasant; and, I accept this is a normal part of life.

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Strongly disagree Strongly agree

28. I seem more able to accept praise well, thanking the person giving the praise.

--	--	--	--	--	--	--	--	--	--

Strongly disagree Strongly agree

29. I am now more able to love and nurture others, as well as myself.

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Strongly disagree Strongly agree

30. Nowadays, I manage better the challenges, disappointments and hardships of life, that come my way.

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Strongly disagree Strongly agree

31. I initiate contact with friends and loved ones.

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Strongly disagree Strongly agree

32. I am relating in more positive and constructive ways now with my family, friends, work colleagues and to others within my social networks.

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Strongly disagree Strongly agree

33. I have moments of great joy or exhilaration, at least once a month.

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Strongly disagree Strongly agree

Other comments you would like to add:

(This questionnaire is with acknowledgement to Yvonne Dolan for her massive contribution to SF severe trauma recovery work; and, was inspired both by her publications and workshops.)

*ARTICLE***The Psychometric of the Adult Resilience Doughnut Model, a Solution Focused, Ecological Model of Resilience**

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Abstract

The Resilience Doughnut is an ecological and Solution Focused model showing the interaction of resources that build resilience during a person's lifetime. In order to statistically validate the model, a 44-item scale (RDA) was developed and tested with 859 adults. Reliability was explored showing a very good fit $\alpha = 0.92$ and a good representation of the research constructs. All seven resource strengths of the RDA showed negative correlation with each of the subscales of the Depression, Anxiety, and Stress scale (DASS). While those in the moderate to severe depression symptoms range reported less than three resource strengths, those with mild to no depressive symptoms reported over three resource strengths scoring above the mean. The findings support strength-based interventions which focus on developing contextual and relational strengths as a way of impacting mental health outcomes.

Introduction

Resilience is seen as the ability to respond to adversity and stressful or traumatic situations in a healthy and productive way (Reivich & Shatte, 2002). Research into resilience has focused on individuals who have coped well despite adversity, exploring the emerging skills, strengths and protective factors in the process of developing a resilient mindset. Ecological approaches to resilience, focus on the contexts where skills and strengths are formed believing that a person's development was affected by everything in their surrounding environment.

The Solution Focused (SF) approach is guided by a series of assumptions similar to the ecological approaches. Some of these assumptions are: (a) the client is nested in a system which supports or maintains functional behaviour, (b) changing something can lead to further change, (c) resources are in relationships, contexts and bigger systems, (d) there are strengths one learns within the system that helps them to function within the system.

The Resilience Doughnut model emerged from these assumptions, linking the extensive ecological research on resilience and the solution focused assumptions. The model, similar to the Bronfenbrenner's (2005) series of concentric circles, has the individual in the centre, being influenced by seven micro systems. The individual develops within each system and adapts their behaviour which influences further system's as they emerge.

The reliability and validity of the model has previously been confirmed in a large sample of children aged 8–16 years (Anyan et al., 2016; Worsley & Hjemdal, 2017). It has also been shown to be a useful tool for explaining the many ways to promote resilience in adults, helping to manage and even overcome the detrimental effects of trauma and adversity (Worsley, 2014).

The purpose of the present study is to test the validity and reliability of the model when applied to adults. The importance of validating the model cannot be understated, since wellbeing and resilience has become a catch phrase for our decade. Validating the model will give a strength and SF contribution to the pool of evidence base research on resilience, which is more problem centric and heavily focused on reducing risk and adversity (Abela et al., 2008; Eisman et al., 2015).

Furthermore, having an empirically valid SF model of resilience informs policy makers and social change makers as well as provides a foundation for further research with diverse populations. The validity of the model will show that resilience is a process of navigating and negotiating with social ecologies and that relationships and contexts matter when working with individuals who want to change. Furthermore, by linking the strength and SF approach with the dynamic of activating helpful resources to build resilience, will give credence to interventions that focus on what works and who is working.

Defining Resilience

Resilience has been defined as the ability to navigate and negotiate one's social ecology (Bellis et al., 2017; Ungar et al., 2008). It appears that over their life span, adults continue to navigate and negotiate with those around them, thereby building their personal competencies. This may be through caring for a family, sustaining a marriage, negotiating within the workplace, maintaining friendships, developing new skills or being part of a community (Bellis et al., 2017; Besser et al., 2014; Worsley, 2015).

In considering an ecological approach to development through the lifespan, Bronfenbrenner (2005) divided the person's environment into five different levels: the microsystem, the mesosystem, the exo-system, the macrosystem, and the chronosystem. Following on from Bronfenbrenner's work, the work by Rutter (2006), Ungar (2008) and Masten and Wright (2010), noted the interactional nature of the systems that help the developing person to navigate with the world around them.

The solution focused approach originated in a systems framework, branching out to include more dynamic questioning to help a person, group or organisation to move towards their preferred future (Durant, 2016). The starting point of all solution focused work is the preferred future. Moving towards this preferred future draws on the client's relationships, experiences and cultural understandings to inform the process. Finding what works, becomes a process of eliciting helpful responses within the meso, micro and macro systems that may be useful in the journey towards that preferred future. The outstanding benefit of using the solution focused approach is the knowledge that the process of change can change the process and the systems themselves (Bolton et al., 2017). Being client focused and respectful that the client is the only one who understands the system fully, places the therapist as a curious observer on the client's journey.

Extensive research has shown that there are three dynamics involved in the process of resilience (Benard, 2004; Grotberg, 1995; McGraw et al., 2008; Rutter, 2006; Ungar et al., 2008): internal or personal characteristics that help individuals overcome adversity (Benard, 2004; Friberg et al., 2003; Grotberg, 1995; Hjemdal et al., 2006; Lin et al., 2017); external or environmental influences that contribute to the building of internal assets or personal competencies (Friberg et al., 2003; Fuller et al., 1998; Hjemdal et al., 2006; Paulsen & Thomas, 2018; Ungar, 2008; Ungar & Lerner, 2008; Werner & Smith, 2001); and the interactions between internal characteristics and external resources, which may either hinder or enhance resilience, ultimately affecting an individual's response to adversity (Grigorenko et al., 2012; Hjemdal et al., 2006; G. McDonald et al., 2013; S. McDonald & Mair, 2010; Rutter, 2008).

Using these three dynamics involved in resilience, resilience is therefore defined as the process of continual development of personal competence while negotiating one's available resources in the face of adversity (Worsley & Hjemdal, 2017).

A Framework for Resilience: The Resilience Doughnut

The Resilience Doughnut model is based on the three above mentioned dynamics involved in resilience. The model is illustrated using a simple diagram of two circles. The inner circle represents an individual's internal characteristics (personal competencies), while the outer circle represents seven external factors that may contribute to building personal competencies. The interactions between an individual's internal and external worlds is visually represented by the inner circle situated within the outer circle (see Figure 1).

Figure 1*The Resilience Doughnut Model****Internal Characteristics of Psychological Resilience***

The inner circle of the model represents three categories of personal competence:

- I have—awareness of social resources (Fuller-Iglesias et al., 2008).
- I am—self-awareness and esteem (Bauer & Park, 2010; Gergen & Gerngen, 2010).
- I can—experiences of self-efficacy (Fry & Debats, 2010b; Fry & Keyes, 2010).

External Structure of the Resilience Doughnut of Adults

The outer circle of the framework is divided into seven sections (Fry & Debats, 2010a; Gilgun et al., 2000; Windle & Woods, 2004), which represent the relationships and environmental factors contributing to the development of personal and social competencies during adulthood. These seven factors are: partner, skills, family, education, friends, community and work. The characteristics of each factor and the studies from which they have been derived are shown in Table 1 (Worsley, 2011).

Table 1*Characteristics of Each Factor in the Resilience Doughnut*

Factor	Characteristics	Studies
Partner	Attachment, positive experiences, personal growth, autonomy, cooperation and collaboration	Atwool (2006); Moen et al. (2010)
Skills	Control and mastery, self-efficacy, goal setting and planning, challenges	Gillman et al. (2015); Vos et al. (2015)
Family	Connections with the wider family, transitions through life stages, good role models, successful role changes	Gottman et al. (2011)
Education	Positive experience of prior learning, enjoyment of learning, involvement in an educational institution, informal education, research	Arnup and Bowles (2016); Lin et al. (2017)
Friends	Networks of friends, ability to make friends, lifelong friendships, friendships of support	Domínguez and Arford (2010); Grandbois and Sanders (2009); Sanders et al. (2017)
Community	Valued contribution, spiritual connections, meaning and purpose, role models, supportive networks	Carr et al. (2017)
Work	Status of vocation, social support, relationships in work, role is valued, zest, satisfaction	Benadé et al. (2017); Holcomb (2009)

The change process in SF approach is one of transformation in which clients rediscover and utilize existing skills, strengths, and protective factors to solve current challenges and are transformed through the SF process with regard to the ways in which they understand themselves, their relationships, the world they experience, and their future possibilities.

This interactive process is similarly observed in the process of resilience, and the protective factors associated with resilience outcomes are uncovered and cultivated during SF conversations and interventions (Bolton et. al. 2017).

The key characteristics of an SF approach include using miracle questions to help clients envisage their preferred future, scaling questions, assessing client's pre-existing strengths and assigning homework to activate these strengths (De Shazer et al., 2007; Durrant, 2016).

As a strength-based ecological model, the Resilience Doughnut for Adults (RDA) uses an SF approach to show how an individual's existing resource strengths can assist them towards their preferred future. It may also be used as a dynamic conversational model to prompt questions that may help individuals envisage their preferred future and identify their resource strengths. Moreover, the model can be used to compliment individuals on their progression (Worsley, 2011; 2012). An individual's resources may be observed in their everyday ordinary relationships at any given point in time and be activated by combining the strengths in homework activities.

In order to empirically validate the model, a measure, based on the research into each of the representative systems, will undergo an item and confirmatory factor analysis to establish the best fit for the model, and to ascertain the items represent the research. This will establish the statistical validation of each of the seven factors which form the model. The measure will then be validated against a reputable measure of resilience to establish reliability. Further to this, the relationship of the model with measures associated with low resilience will be explored.

Scaled Development Process

The items in the Resilience Doughnut model were initially generated from research constructs gathered from studies of individuals who have shown resilience in the face of adversity (see Table 1). These items contributed to the development of the preliminary Resilience Doughnut tool. The outer circle was divided into seven subtests, with 10 items for each subtest. Items were represented by simple statements beginning with I have, I am, or I can, with a dichotomous response, Yes or No (Worsley, 2011).

To review the items, a questionnaire was developed and distributed to 30 adults in various settings in Sydney, Australia. The sample comprised five psychologists attending Resilience Doughnut training for children and adolescents, 10 adults attending a community music festival, six community members attending a local seminar and nine consulting psychologists in Epping, Sydney. Signed permission was sought from each participant to allow their comments and results to be used for future research. Each participant was asked to complete the questionnaire and provide feedback to the researchers regarding the wording of the questions and relevance to their life circumstances. The psychologists were asked to consider the responses with respect to their current clients' needs. Their feedback led to the removal of ambiguous and negatively worded items, which were replaced with positively worded items. Based on the feedback from the adults, the dichotomous response format was changed to a 6-point Likert scale (0 = never; 1 = almost never; 2 = not really; 3 = sort of; 4 = sometimes; 5 = always).

The questionnaire was then developed into an online format, allowing the responses to be visible when hovering the cursor over the question. The number allocated to each response was not visible to participants, allowing for a wider range of responses and stimulating further discussion with subsequent representative samples. The scores were collated for each item and divided by five, giving a total score out of 10 for each subtest. Total scores were visible to the participants.

Study Aims

In order to empirically validate the Resilience Doughnut model, the present study explores the psychometric properties of the RDA scale. Given that exploratory and confirmatory factor analysis (CFA) of the Resilience Doughnut for adolescents demonstrated its validity and strong theoretical foundation (Worsley & Hjemdal, 2017), CFA was conducted on the adult model to examine each of the subtests separately, establish the best fit and reduce the number of items.

It was hypothesised that the RDA subtest scores would be positively correlated with the subtest scores of another measure of resilience, the Resilience Scale for Adults (RSA) (Friborg et al., 2003; Hjemdal, 2007) and negatively correlated with the scores from the Depression, Anxiety, and Stress Scale (DASS) (Crawford et al., 2011). The RSA is a reputable measure of resilience which shows high validity and reliability. Originally drawn from Norwegian samples the RSA has been validated with samples across Europe and Australia and shows good reliability with other measures of wellbeing. It is positively worded and seeks to draw out the personal and social competencies an individual may experience when they are coping well (Hjemdal et al., 2012). The DASS is a common measure used for depression, anxiety, and stress by clinicians in Australia and the UK. It has high reliability and validity and is a useful measure to establish a preliminary clinical diagnosis of depression and anxiety (Crawford et al., 2011).

Exploration of the RDA model involved considering the external factors associated with a high level of personal competency and a low level of mental health concerns. To do so, we considered the number of RDA subtests scoring above the mean in relation to RSA-based competency scores and DASS-based mental health scores.

To determine a hierarchy of the RDA subtests with high scores, groups were formed based on the number of subtests scoring above the mean. For example, Group 0 was comprised of individuals with no subtest scoring above the mean, Group 1 was comprised of individuals with one subtest scoring above the mean, while Group 2 was comprised of individuals with two subtests scoring above the mean, and so on until eight groups were formed. The following questions were then explored:

1. What is the relationship between the number of RDA resource strengths scoring above the mean and DASS scores for depression, anxiety, and stress?
2. What is the relationship between the number of RDA resource strengths scoring above the mean and RSA scores for perception of self, planned future, social competence, structured style, family coherence and social resources?

Methods

Participants

Participants were a non-clinical sample drawn from professional development (PD) courses conducted by the researchers in schools and organisational settings in Australia and the UK from 2015 to 2017. Approximately 1500 teachers and employees attended the PD courses, arranged by their organisation aimed at building resilience, with a total of 859 adults (570 females and 289 males) aged 25–60 years voluntarily participating in the research. Being from Australia and UK, participants were of varied ethnological and religious backgrounds and cultures although all were English speaking.

Measures

Resilience Scale for Adults

The RSA measures protective factors associated with resilience and includes 33 items covering six dimensions: perception of self ($\alpha = .81$), planned future ($\alpha = .78$), social competence ($\alpha = .75$), family cohesion ($\alpha = .79$), social resources ($\alpha = .77$) and structured style ($\alpha = .67$) (Friborg et al., 2003; Hjemdal, 2007; Hjemdal et al., 2012; Hjemdal et al., 2006). Higher scores indicate higher levels of resilience. Previous studies have shown that higher RSA scores are negatively correlated with symptoms of depression and general/social anxiety, while lower scores have the ability to predict symptoms of depression when controlling for age, gender, stressful life events and severity of anxiety symptoms. The validity of the RSA has been supported by previous research (Anyan et al., 2020; Friborg et al., 2003; Hjemdal et al., 2012; Hjemdal et al., 2006; Morote, Hjemdal, Krysinska, et al., 2017; Morote, Hjemdal, Uribe, et al., 2017).

Depression, Anxiety, and Stress Scale

DASS (Crawford et al., 2011; Lovibond & Lovibond, 1995) includes 21 items covering three dimensions: depression, anxiety, and stress. The depression scale ($\alpha = .90$) assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The anxiety scale ($\alpha = .76$) assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experiences of anxiety. The stress scale ($\alpha = .89$) measures chronic non-specific arousal such as difficulty relaxing, nervous arousal, impatience and being easily upset, agitated, irritable or over-reactive. Respondents rate the extent to which they have experienced each state over the past week using a 4-point severity/frequency scale. Scores for depression, anxiety, and stress are calculated by summing the scores for the relevant items (Crawford et al., 2011). The scores range on a continuum according to severity of symptoms, with arbitrary cutoff points of 9 and 13 for severe and extremely severe, respectively.

In developing DASS-21, normative data from samples of the general Australian adult population were used to determine the percentile norms and clinical cutoff points along three axes: depression, anxiety, and stress. While in reality the severity of depression and anxiety symptoms exists on a continuum, for clinical purposes, cut-off points are applied in each DASS scale to assess symptoms as mild, moderate, severe or extremely severe (Crawford et al., 2011; Lovibond & Lovibond, 1995).

Resilience Doughnut Tool

The Resilience Doughnut tool (Worsley, 2012, 2014) includes 70 items covering seven subtests: partner, skills, family, education, friends, community and work. Each item is represented by a positive statement related to its associated context, with responses based on a 6-point Likert scale. Sub-totals are collated to give an overall mean for each subtest.

Procedure

Participants responded using a computer program specifically designed to administer the three questionnaires and collect individual results. The estimated time required for participation was 30 minutes, with participants using their own devices in their own time. As part of the incentive, participants were given access to their RDA and RSA results, which highlighted their three strongest resources. Comments were entered into the open question section and participants were encouraged to discuss the results with their colleagues. The online format ensured consistency of instructions and delivery of the measures and improved the potential for honest responses. The de-identified data from each participant was immediately made available to researchers for statistical analysis.

Statistical Analysis

A Confirmatory Factor Analysis (CFA) was performed using Mplus 7.4 (Muthén & Muthén, 2012). First, each subtest was examined for goodness of fit using modification indices, followed by actual modifications involving deletion of items. Goodness of fit was determined using the following indices: root mean square error of approximation (RMSEA) of less than .08 (for 90% CI close to or < .08) and comparative fit index (CFI) and non-normed fit index (Tucker–Lewis index) values of greater than .95 (Hu & Bentler, 1999). Basic correlation analyses and three analyses of variance (ANOVAs) using stress, anxiety, and depressive symptoms as dependent variables were performed using SPSS version 25.

Results

A total of 859 participants were included in the analysis. The psychometric properties of the RDA were tested for reliability and validity, with each external factor treated as an independent subtest.

Confirmatory Factor Analysis

The final results of CFA are presented in Table 2. Initially, each of the seven subtests contained 10 items. A separate CFA was conducted for each subtest using a previously published procedure (Hjemdal et al., 2006). Fit and modification indices guided the selection of items for each subtest. Reliability of each subtest was tested using Cronbach's alpha, which showed that all subtests achieved acceptable reliability after 26 of the 70 items were removed to achieve best fit. Analysis was then carried out on the entire model, with the modifications resulting in 44 items showing a very good fit ($\alpha = .92$), and the remaining items showing a good fit to the research constructs (see Table 2).

Table 2

Resilience Doughnut Subtest Confirmatory Factor Analysis Results

Subtest	No. items	Alpha	Chi-square	CFI	TLI	RMSEA
Partner	9	0.98	109.984*	.984	.978	.062
Skills	5	0.81	16.991*	.986	.971	.054
Family	6	0.85	29.982*	.980	.967	.036
Education	8	0.84	70.563*	.919	.896	.024
Friends	6	0.91	25.959*	.988	.981	.052
Community	5	0.87	15.088*	.993	.985	.045
Work	5	0.83	15.652*	.990	.979	.041
Entire model	44	0.92	1,873.115*	.950	.946	1.000

Note. N = 859; CFI: comparative fit index; TLI: Tucker–Lewis index; RMSEA: root mean square error of approximation.

* $p < .001$

Exploration of Construct Validity

Pearson's correlation coefficient was used to measure the correlations between each of the seven modified RDA subtests with the RSA constructs (Friborg et al., 2003). All RDA subtests were weakly to moderately positively correlated ($p < .01$) with RSA constructs. However, the correlation between partner and structured style was not significant, and the correlation between partner and social competence was moderately significant ($p < .05$). All RDA subtests showed a moderate correlation with total RSA score (see Table 3).

Table 3

Correlations Between RDA and RSA

RDA subtests	RSA constructs						
	Perception of self	Planned future	Social competence	Structured style	Family cohesion	Social resources	Total score
Partner	.157**	.200**	.095*	.029	.289**	.227**	.242**
Skill	.528**	.507**	.226**	.365**	.280**	.393**	.526**
Family	.327**	.312**	.272**	.160**	.626**	.509**	.532**
Education	.423**	.452**	.272**	.278**	.230**	.378**	.467**
Friends	.296**	.289**	.453**	.076*	.300**	.574**	.481**
Community	.197**	.228**	.283**	.094*	.192**	.224**	.290**
Work	.456**	.475**	.195**	.257**	.277**	.340**	.462**

Note: N = 818; RDA: Resilience Doughnut for Adults; RSA: Resilience Scale for Adults

* $p < .05$, ** $p < .01$

Using Pearson's correlation coefficient, a further test of validity was conducted for each of the seven modified subtests from the RDA with respect to DASS (Crawford et al., 2011; Lovibond & Lovibond, 1995). All RDA subtests were weakly to moderately negatively correlated ($p < .01$) with each of the DASS subscales. However, the correlation between community and stress was negligible ($p < .05$) (see Table 4).

Table 4

Correlations between RDA and DASS

RDA factors	DASS scales		
	Depression	Anxiety	Stress
Partner	-.106**	-.155**	-.111**
Skills	-.232**	-.257**	-.144**
Family	-.249**	-.262**	-.197**
Education	-.206**	-.221**	-.142**
Friends	-.222**	-.260**	-.147**
Community	-.130**	-.149**	-.091*
Work	-.261**	-.298**	-.196**

Note. N = 818; RDA: Resilience Doughnut for Adults; DASS: Depression, Anxiety, and Stress Scale.

* $p < .05$, ** $p < .01$

Exploration of the Model

Categories of Strengths

To explore the number of strengths needed to reduce depression, anxiety, and stress, mean scores were estimated for each of the seven RDA subtests. Scores above the mean were classified as high and those below the mean as low. Based on this, eight groups of participants were developed. Group 0 represented those with no strengths above the mean, Group 1 represented those with one subtest scoring above the mean, Group 2 represented those with two subtests scoring above the mean, and so on. To explore whether the number of subtests with scores above the mean had implications for reported symptoms, three separate ANOVAs using stress, anxiety, and depression as dependent variables were conducted. The results indicated significant results for stress ($F(7, 673) = 8.39$; $p < .001$), anxiety ($F(7, 673) = 16.44$; $p < .001$) and depression ($F(7, 673) = 14.80$; $p < .001$) (see Table 5).

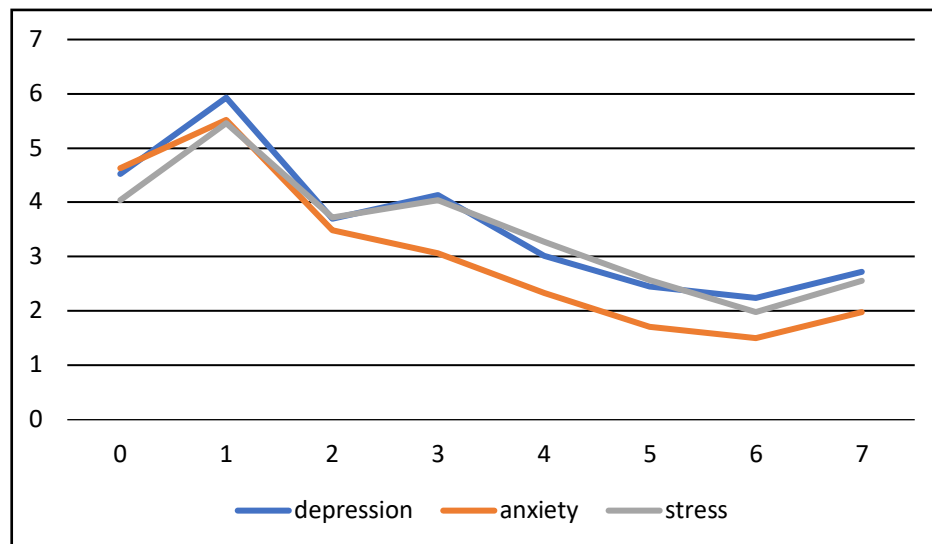
Table 5

DASS Subscale Scores According to the Number of RD Strengths Above the Mean

	Number of subtests above the mean							
	0	1	2	3	4	5	6	7
Depression	4.52	5.93	3.70	4.13	3.02	2.45	2.24	2.72
Anxiety	4.63	5.52	3.49	3.06	2.33	1.71	1.50	1.98
Stress	4.04	5.46	3.72	4.04	3.27	2.57	1.98	2.56

Figure 2

Symptoms According to Number of Strengths above the Mean



To establish the number of participants achieving a clinical score for depression in DASS, proportion scoring within severity ranges was explored. The established severity labels are used to describe the range of scores in the population (Crawford et al., 2011). For example, mild indicates that the score is above the population mean but the depression is likely to be less severe than that of an individual seeking professional help. In the present study, only 10.3% of the

sample reported moderate to severe symptoms of depression, with the remaining reporting mild to no symptoms of depression, again highlighting the nonclinical sample. Due to a small sample of participants in the extremely severe group (7), scoring for this group may be unreliable. However, when grouping those with moderate to severe depression there were fewer than three resource strengths as indicated by the RDA subtests scoring above the mean (moderate = 2.26, severe = 1.88, extremely severe = 2.14), while those with mild to no depressive symptoms reported more than three resource strengths scoring above the mean (mild = 3.19, normal = 3.95) (see Table 6).

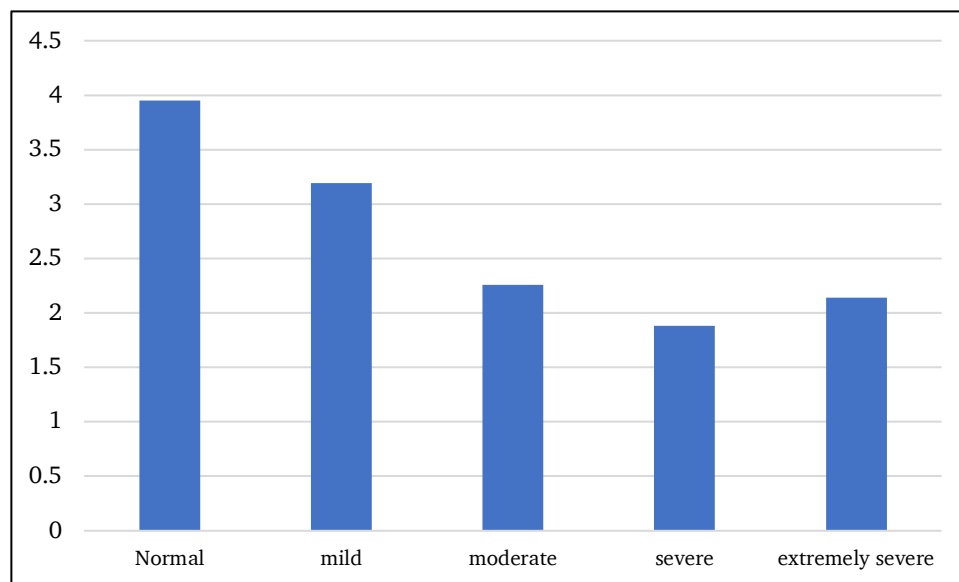
Table 6

Number of Strengths According to Clinical Depression Symptoms

	Normal	Mild	Moderate	Severe	Extremely severe
Number of strengths	3.95	3.19	2.26	1.88	2.14
Number of participants	479	116	61	17	7

Figure 3

Number of Strengths According to Categories of Depressive Symptoms



Further exploration of the model considered the relationship between the number of RDA subtests scoring above the mean and signs of resilience and personal competency established by the RSA. A moderate to strong correlation ($p < .000$) was found between all RSA subscales and the sum of RDA strengths above the mean. This suggests that stronger connection and support are associated with higher perceptions of self, planned future, social competence, structured style and family cohesion. Each of these subscales contributes to resilience as determined by the total RSA score, which showed a high correlation with the RDA sum of strengths ($p < .000$) (see Table 7).

Table 7*Correlations Between RSA Subscales and RDA Sum of Strengths Above the Mean*

	RSA subscales					
	Perception of self	Planned future	Social competence	Structured style	Family cohesion	RSA Total
RDA	.520***	.508***	.370***	.263***	.458***	.634***
<i>n</i>	736	746	736	737	736	737

* $p < .001$

Discussion

Adulthood is frequently associated with adversity, grief, critical incidents and trauma across the life stages. When these occur, a range of reactions can occur. As noted in the literature, individuals with stronger support networks appear to have healthier coping mechanisms (Cacioppo et al., 2011; Hobfoll et al., 2011; McKinley et al., 2019). Drawing on constructs identified in the literature, the RDA includes seven contexts in which support may be found and suggests that a certain number of strong supports (referred to as strengths) can lead to the successful navigation through adversity.

Psychometric Qualities of the Resilience Doughnut Model

Using CFA, goodness of fit was established for the model, resulting in a reduction of items based on fit and modification indices. This process yielded 44 items that appeared reliable and valid according to the research constructs. The seven contextual supports were treated as subtests. Each showed a positive correlation with the subscales of the RSA, which measures both personal and social competencies as well as social resources, both within and external to the individual's family (Hjemdal et al., 2006). Further, a strong negative correlation was found with the DASS subscales, which measure depression, anxiety, and stress. The results support the research findings that individuals with healthier coping styles (high competency and low depression, anxiety, and stress) appear to have strong and supportive networks of friends, family and community, as indicated by the RDA.

Does the Number of Resilience Resources Influence Stress, Anxiety, and Depression?

The model exploration considered the relationship between depression, anxiety, and stress and the number of resource strengths (established by the RDA subtest scores above the mean). Respondents scoring zero, one and two resource strengths above the mean showed a graduated decline in reported depression and stress scores, with a significant difference for those scoring five, six, and seven strengths above the mean. Similarly, a gradual decline in anxiety symptoms was found for up to five strengths above the mean.

To further explore the number of strengths necessary to reduce depression, anxiety, and stress, participants were grouped according to their DASS scores for depression. The number of strengths for each level of symptom severity was then established. Participants with mild to no depressive symptoms reported having three or more strengths over the mean, while those with moderate to severe depression reported less than three strengths over the mean. Those with extreme severe depression scores, however, reported slightly more strengths than those with severe depression. While the score is still below three strengths, it is important to note that due to the non-clinical sample, and with only seven subjects in this group the results for this group may be unreliable. Despite the smaller extremely severe group, however, these results support the hypothesis that there is a strong negative correlation between resource strengths and depression, anxiety, and stress symptoms. Further, the results suggest that the presence of three or more strengths may influence the severity of depression symptoms. In order to draw further conclusions, it would be helpful to consider a

clinical sample in future research, where a larger representative group may occur in the clinical range of depression scores.

Conversely the group scoring mild to no depressive symptoms reported 3.19 and 3.95, strengths above the mean, highlighting there were not 4 or higher strengths as may be expected. It is important to note that each of these strengths indicate significant social capital or social systems in which a person is nested. That is, in each of the strengths there exists a network of relationships and systems that establish the degree of strength. Having more than four strengths may be unusual for the adults in this sample, given the nature of work and family involvement as all of the participants were workers. Furthermore, when work is a dominant factor there may be only time for two-three other significant factors above the mean. However, it is notable that there was a significant decrease in anxiety and depression scores (regardless of the clinical range) with those scoring five through six and seven strengths above the mean.

Again, further research is needed to assess groups of adults who are rich in strengths, to consider their scores of resilience and depressive and anxiety symptoms and to establish the number of strengths needed to tip the balance towards more resilient outcomes.

Access to Resources as a Predictor of Resilience

The RDA model shows that there is a number of resources or relational strengths needed to build resilience. Relationships change throughout adulthood, and transitions through the life cycle affect the strength of relationships over time. It has been suggested that support and access to social resources contribute to the personal skills needed to cope with life difficulties (Flores et al., 2018; Foster et al., 2019).

Indications of Validity

The strong positive correlations found between each RSA subscale and the sum of RDA strengths above the mean indicate that higher scores in the social resource category are associated with higher levels of competence and resilience as well as lower levels of depressive symptoms. While the strong correlations between the RSA and RDA indicate support for construct validity given that both are measures of resilience, each measure has a focus on different aspects of resilience. The RSA focuses on competencies in several social domains, while the RDA focuses on the relative strength of resources. Therefore, considering the strong correlations, the more resources a person has, the higher their levels of social and personal competencies; that is, the more resource strengths, the better the outcomes.

Implications

The findings suggest that people who have strong connections with resources from a number of different contexts have higher levels of resilience and better mental health. The implications being that a focus on developing contextual and relational strengths may be a more effective way to improve wellbeing and resilience.

Strength-based interventions that have been shown to be successful in helping people develop resilience tend to focus on what is working and identify the positive experiences that are already thriving (Brehm & Doll, 2009; Domínguez & Arford, 2010; Pinkerton & Dolan, 2007). Traditional mental health interventions, however, have focused on reducing the symptoms of mental health disorders such as depression, anxiety and stress. Rather, it may be simpler, and perhaps more in line with current research, to focus on and provide support for an individual's existing strengths. Building on existing strengths will lead to a positive flow-on effect to other areas of an individual's life, helping to reduce the negative effects that can threaten to undermine self-esteem. Focusing and building on existing resource strengths will enable the development of social and personal competencies, potentially promoting resilience features such as adaptability, hopefulness, readiness for change, future thinking and an enhanced sense of purpose and meaning (Mannix, 2010).

Many successful resilience interventions are underpinned by connections between positive intentional relationships in various contexts. Several case studies have noted the resilience responses of individuals as they negotiate life's challenges (Mooney-Somers et al., 2010; Sampson, 2005). Positive turning points for many of these individuals arise from the effects of external factors (Araneta, 2010; Shaffer et al., 2007). Additionally, some case studies have demonstrated 'tipping points' (negative changes) arising from the loss or disengagement from one's external resources

(Doherty et al., 2009; Hou et al., 2010). The present research suggests that three or more supportive resources are needed to prevent a decline into depression and anxiety, and the strongest available resources significantly contribute to personal resilience. This is supported by previous studies using a strength framework (Donnon & Hammond, 2007).

Another possible clinical implication may be linked to therapy. Using an SF approach in therapy necessitates curiosity on the part of the therapist. The aim of the SF therapist is to focus clients away from their pervasive problems and towards their strengths, feelings of hope and the solutions that may already exist. A number of assumptions guide SF therapists, including maintaining client agency, remaining a curious observer and the belief there are exceptions to the problem. Most SF therapy is conversational, using everyday language and carefully worded questions. Using the RD model as a conversational tool, SF therapists can explore the relative strengths of each contextual factor and the resources in everyday relationships that may help their clients' to successfully progress through the difficulties they are facing. Simply having a conversation about what is working in each area can uncover the competencies experienced in the past and shared through relationships. Thus, the RDA may be a useful tool in identifying the strengths on which to focus during conversations.

If resilience can be found in the ordinary everyday magic of people's lives, communities, families and connections (Masten, 2001), the RDA may be a tool to guide the conversation in uncovering the ordinary everyday magic that occurs in the lives of clients through their interactions with those around them.

The aim of this research was to validate the whole RDA model including the seven contextual strengths. The non-clinical sample allowed the researchers to establish validity and reliability of the RDA measure and test the assumptions that strong resources lead to more personal and social competence, and thereby lower levels of stress, depression and anxiety.

To test the model further, future research, using a clinical sample to explore the number of resource strengths with those with mental illness, would be of interest. Similarly, research with a sample of people going through a change in their life stages, such as first-time parents or retirees, could explore the effects of changes in RDA strengths on wellbeing. Furthermore, research into people who are disconnected from their strongest and most helpful resources during disasters, pandemics or as a result of trauma could inform recovery and intervention strategies for the future. From this research so far, it would seem that strategies that focus on increasing the connections, and resource strengths, rather than the symptoms of mental illness will be most effective.

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*ARTICLE***Evaluating the Solution Focused Wellness for HIV Intervention for Women: A Pilot Study**

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Abstract

Women living with HIV experience a gender gap in wellness outcomes in the U.S., and women of color are particularly vulnerable to this gap. To address this, the Solution Focused Wellness for HIV (SFWH) intervention for women was created. In this paper, we report the quantitative results of the most recent SFWH pilot study. The seven-session, group intervention was provided to (N=14) women living with HIV to evaluate it for effectiveness. Results showed the intervention was associated with significant multidimensional wellness improvements between baseline and five-week follow up. Participants' CD4 and Viral Load counts did not change significantly. To improve access to the intervention and increase retention in HIV care in the community, further adaptations of the SFWH are planned.

Keywords: HIV; Women; Solution Focused; Wellness, Intervention Research

Background

Wellness can be conceptualized as a multidimensional construct that includes not only physical, but also cognitive, emotional, spiritual and social well-being (Myers et al., 2004). In HIV research, this multidimensional conceptualization of wellness allows for a broader focus than the traditional medical model of narrowly examining morbidity, mortality and biomarkers. A multidimensional approach to wellness also allows researchers to better evaluate behavioral health interventions from the perspective of the person who is living with HIV. This provides a more individualized approach that is tailored to the unique life circumstances of wellness for participants. It is in keeping with the Solution Focused Brief Therapy (SFBT) mindset of taking a “stance of not knowing” and viewing the client as the expert in the helping relationship (DeJong & Berg, 2002).

Multiple wellness interventions exist for women living with HIV. However, the operationalization of wellness varies. For example, the WILLOW group focuses on prevention of HIV transmission and reducing parenting stress (Dale, et al., 2017), and the Making our Moms Stronger (MOMS) program also focuses on parenting as well as disease self-management skills (Johnson et al., 2015). Other interventions tailored for women living with HIV are aimed at addressing mental health and substance abuse issues because those factors are associated with poor HIV wellness outcomes (Mitrani et al., 2011). Given that not all women living with HIV are parents or experiencing substance abuse and mental health issues, the development of an intervention that takes a broader and more inclusive wellness perspective for women is needed.

It has been established that overall health and longevity in living with HIV depends on Antiretroviral Therapy (ART) (Aschengrau & Seage, 2014), but there are other factors that affect women's use of ART medication that would be beneficial for an intervention to address in community-based settings. Those include childcare, food security, transportation, as well as some of the above-mentioned factors including parenting, mental health and substances abuse (Yates, 2019). The existing wellness programs for women living with HIV focus primarily on preventing transmission to others including sexual partners and children. This narrow focus of existing wellness programs, from a Foucauldian perspective, can be seen as a process of disciplining women rather than helping them, and may contribute to the negative stigma associated with living with HIV (Foucault, 2004).

Solution Focused Brief Therapy was chosen as the main component of the current intervention due to its ability to broadly incorporate the needs of women without expert imposition of wellness conceptualization by practitioners. This allows the unique factors affecting the wellness of each woman receiving the intervention to be addressed by her, as she defines her own wellness needs, and creates specific goals to reach the best solution. Interventions that are promoted as improving wellness for women living with HIV should focus on broad, client-centered conceptualizations of wellness. Due to its social constructionism roots (Gergen, 2009), the SFBT intervention is uniquely able to do this.

Evidence-based interventions need to be created and tested for efficacy in real world settings with sustained results over time. More clinical trials should be performed in combination with qualitative input from participants to improve uptake of effective programs. Furthermore, these programs should be listed on evidence-based registries so doctors, social workers, nurses and case managers can locate them. Training should also be provided to improve implementation in the community. From a policy perspective, funding must continue to support the research and programs that are aimed at improving outcomes for women living with HIV.

SFBT

Solution Focused Brief Therapy (SFBT) is a talk therapy treatment model that is delivered in individual, family and group formats, as well through case management processes. The SFBT method is comprised of three mindset components (future focus, strengths orientation, client as expert) and eight therapeutic techniques (scaling questions, goal setting, miracle question, finding exceptions to the problem, therapeutic breaks, genuine compliments, relationship questions and asking about the client's best hopes; Trepper et al., 2012).

A recent meta-analysis of randomized controlled trials involving SFBT in healthcare settings indicated it is a promising approach for addressing behavioral outcomes (Zhang et al., 2017). The therapeutic methods were originally developed by Insoo Kim Berg, Steve de Shazer, and their colleagues at the Brief Family Therapy Center in Milwaukee, Wisconsin in the 1980s. They developed SFBT as a strengths-based, rather than problem-oriented approach, that is future-focused, goal-oriented, and primarily driven by the client's individualized experiences rather than expert imposition by the professional (De Jong & Berg, 2002). Privileging the experiences of clients and trusting in their inherent ability to develop their own knowledge about how to best address their problems has made the approach amenable to client-centered research methods (Froerer et al., 2009; Szlyk, 2018).

SFBT is a popular case management and counseling method that has been embraced by the fields of social work, marriage and family therapy, counseling, and public health due to its emergent base of outcome studies (Kim, 2008; Kim et al., 2019). SFBT takes a culturally competent approach that values the unique experiences and backgrounds of diverse individuals and communities (Kim, 2013).

Applying SFBT to the lives of persons living with HIV involves helping clients explore their own ideas for how to overcome social and psychological problems experienced in their environment. Therefore, it is plausible that the method

could have a positive effect on factors associated with HIV wellness. Those needs may include substance use, mental health, housing and food security and parenting needs (Blashill et al., 2015). SFBT enables practitioners to partner with clients to co-construct meaningful and lasting change (Blundo & Simon, 2015). The significance of this co-construction process within SFBT was highlighted as one of the most important keys to the success of SFBT outlined by Franklin et al. (2017) in their meta-analysis of SFBT change process research.

Current Intervention-SFWH

To more comprehensively address the wellness needs of women living with HIV, the Solution Focused Wellness for HIV (SFWH) intervention for women was created. This intervention was developed by adapting the current treatment manual for SFBT and SFBT wellness intervention research by Beauchemin (2018). After combining those elements, the intervention was written as a session-by-session group counseling manual and adapted to meet the needs of women living with HIV according to previous literature. During the initial phase of the intervention development, the researcher sought feedback from SFBT and HIV experts and this work is outlined in the publication of the qualitative findings used in the manual adaptation process (Yates et al., 2019). The SFBT expert who provided feedback has published several meta-analyses of solution focused methods as well as multiple large-scale clinical trials related to substance abuse and child welfare. The HIV expert who provided feedback has published intervention studies related to women who are living with HIV and other social service programs. Both are Associate Professors and Program Directors of schools of social work in the United States. After incorporating their feedback into the manual, the researcher delivered the intervention to a small group of women (n=4) living with HIV (Yates et al., 2019). Those women participated in a focus group to provide expert client feedback in keeping with the SFBT mindset of honoring the client as the expert, (Blundo & Simon, 2015). This manualized SFBT intervention, which is named Solution Focused Wellness for HIV (SFWH), was implemented and evaluated in the current study.

The purpose of this study is to (a) determine whether the SFWH Intervention for Women significantly improves the wellness of women living with HIV, (b) to determine if the intervention is safe and well-tolerated by participants and (c) to aid in the continued development of the treatment manual. The results from the qualitative components of the study will be detailed in a separate paper. This paper reports the quantitative results of the study only.

Methods

Research Design

During this pilot study, participants were compared at baseline and a 5-week post-intervention follow-up time. All participants received the intervention and an intent to treat approach was used for data analysis. Pilot studies “are typically small prospective studies that evaluate a treatment’s potential and may or may not be randomized (Cook & DeMets, 2008, p. 76).” The goal of clinical trial phases is to assess safety and feasibility and to determine if further study is warranted. The desired outcome of early phase studies is that most participants improve (Cook & DeMets, 2008).

The dependent variable in this study was wellness; a multidimensional construct that may include spiritual, physical, cognitive/emotional and relational/social well-being (Myers et al., 2004). A multidimensional approach to wellness also allows researchers to evaluate health interventions from the perspective of the person who is living with HIV, rather than narrowly focusing on CD4 and Viral Load counts alone. The multidimensional approach leads to an individualized intervention that is tailored to the unique lifestyle of each participant.

In an effort to strengthen the research design, wellness was also assessed using biomarkers that are typically associated with HIV disease progression. This allowed for a triangulation of data collection and measured the effect the intervention had on HIV wellness from a disease progression standpoint. We used data from existing case management records as a less invasive approach in contrast to asking participants to undergo additional testing procedures.

The independent variable was the SFWH intervention for women, a group wellness counseling intervention that has been adapted for women living with HIV. The intervention has been manualized with session-by-session instructions and handouts that incorporate the SFBT mindset components and techniques to improve treatment fidelity. Seven

sessions are included in the manual with five sessions focusing on specific areas of wellness and an introductory and wrap-up session at the beginning and end of the intervention.

Setting

The study was conducted at a non-profit organization which provides case management services to people living with HIV in North Georgia. The organization provides housing and food security services, and may assist with transportation, medical care coordination, medication adherence counseling, and parenting support. The clients served by the agency were located in 10 counties that covered urban, rural, and suburban communities.

Study Participants

A total of (N=14) women participated in the study, and the participants' characteristics are displayed in Table 1. To be included in the study, participants had to (1) identify as female, (2) be living with HIV, and (3) be over the age of 18. Intent to treat was used to determine whether participants who only participated in some sessions of the intervention should be included or excluded from the analysis. Therefore, all participants were included in the analysis regardless of their level of participation. Some attrition occurred and the number of sessions received was inconsistent among participants. The mean number of sessions received was three (out of the seven recommended sessions) with a standard deviation of (SD=2.60). Participant flow is shown in Figure 1.

Procedures

Recruitment was conducted at the research site through the case managers of the participants via a flyer. Three existing support groups for women living with HIV were being conducted in the community, and participants shared the study information with each other, which resulted in a convenience sample. The group was offered at all three locations operated by the study site, but only two were used for groups due to small recruitment numbers at the third location. Informed consent was obtained prior to data collection and the start of the first session.

Fidelity

Fidelity to SFBT was encouraged and monitored in several ways during the study. The training of the facilitator in SFBT, the development of a session by session treatment manual, a fidelity checklist and a rigorous study design were the fidelity improvement, and monitoring techniques that were used. A fidelity checklist was completed by the group facilitator to monitor a randomly chosen session for adherence to the SFBT components and measured the extent to which each SFBT component was used by the facilitator. The checklist helps to monitor the amount of the intervention that is received by participants.

The use of a treatment manual was intended to improve treatment fidelity. All the components identified by SFBT researchers in the treatment manual published by the Solution Focused Brief Therapy Association (Trepper et al., 2012) were incorporated into scripts and instructions in the session-by-session manual. The use of a manual has been recommended by behavioral intervention researchers to improve fidelity (Gitlin & Czaja, 2015).

Ethical Considerations

The Institutional Review Board of the Human Subjects Office at the University of Georgia Human Research Protection Program approved the study. Permission to conduct research with the clients at the agency was obtained from the Executive Director prior to IRB submission. Participants received \$20 grocery gift cards to encourage participation and transportation vouchers, refreshments, and childcare vouchers to improve access to the intervention. No names or other identifying information were associated with the participant data. Participant numbers were used to maintain privacy during data analysis.

Measuring Multidimensional Wellness

To measure multidimensional wellness, the Five Factor Wellness Inventory or 5F-Wel was used. The instrument is a 92-item scale that is valid and reliable with a Chronbach's alpha score of ($\alpha=0.89$) (Myers et al., 2004). There are 74 scored items which include questions like "I am satisfied with how I cope with stress," and "I eat a healthy amount of fruits, vegetables and fiber each day." Confirmatory factor analysis indicated that the five wellness factors addressed in the instrument include physical, spiritual, cognitive/intellectual, emotional and social/relational wellness. The instrument consists of self-reported Likert-type scale responses ranging from 1=strongly agree to 5=strongly disagree. Higher scores reflect greater wellness. Chronbach's alpha scores for the SFWH study were acceptable ($\alpha = .67$), indicating reliability in measuring participants' multidimensional wellness.

Measuring HIV-related Wellness

HIV related wellness was measured using biomarkers typically obtained from the medical care providers of people living with HIV. They include the viral load (HIV-RNA) and CD4 T-Cell Lymphocyte counts. These biomarkers indicate the presence of HIV in the body (viral replication) as well as the body's immune response to the virus. They also indirectly measure use of Antiretroviral therapy. The viral load can range from 0 (undetectable) to millions, with lower counts being associated with better HIV wellness. CD4 counts determine the immune system's response to the virus. Higher CD4 counts are associated with wellness as these cells are used to fight off opportunistic and secondary infections (Aschengrau & Seage, 2014). A CD4 count below 200 indicates progression to the final stage of HIV-AIDS.

Data Analysis

To analyze the quantitative results, SPSS Version 25.0 (IBM, 2017) and R Software were used to perform paired samples T-Tests and Chi-Square tests. Effect sizes were calculated using Cohen's d. Due to the exploratory nature of this pilot study which was performed in the early phases of the research pipeline, we used a p value of <0.10 to determine statistical significance. Because an improvement in wellness was hypothesized, a one-tailed test was used. The research questions included:

1. Does the SFWH Intervention for women (IV) significantly improve wellness as measured by the *Five Factor Wellness Inventory* among participants between baseline and five weeks after the intervention is provided?
2. Does SFWH significantly increase *CD4 counts* of women living with HIV between baseline and follow up?
3. Does SFWH significantly decrease HIV-RNA *viral loads* of women living with HIV between baseline and follow up?

To answer research questions one and two, the Five Factor Wellness Inventory scores, CD4 counts and viral loads of participants were analyzed using a paired samples t-test. This test was used to check for differences between the baseline and follow up scores of participants. According to Randolph and Myers (2013), the t-test is used to "determine if there is a statistically significant difference between the scores from two samples in which the individual values or cases in the sample are paired with each other for some reason related to the research question (p.89)." In this instance, one sample of participants was measured at two different time points (before the intervention took place, and at a 5 week follow up time).

To answer question three, the data was first cleaned to account for viral load lab results reporting "less than 20 or "less than 40." Viral loads less than 20 or 40 are considered "undetectable." This is a clinically important cut off point because it indicates uptake of antiretroviral therapy as well as lack of HIV disease progression (Panel on Antiretroviral Guidelines for Adults and Adolescents, 2018). These categories are typically used in HIV medical care to determine disease progression based on the number of copies of HIV RNA present in the person's system. The categories range from 0-40 (undetectable) to 41 and above (detectable). A chi-square test was used to detect differences between participants' categorical viral load values at baseline and follow-up. The chi-square is a non-parametric test that measures the difference between observed and expected results (McHugh, 2013).

Results

Participants

The baseline demographic and clinical characteristics of the women who participated in the study are displayed in Table 1. The mean age of the women was 48.21 years old ($SD=11.86$, range 21-63). In terms of race and ethnicity, all participants identified as African American and one participant identified with multiple races. Depression was indicated among 53.33% of participants and anxiety was endorsed by 60% of participants. No participants reported substance abuse issues at the time of the study. About 87% of the women in the study reported some form of care responsibility including children under the age of 18 or another adult.

The scores on the wellness outcomes at baseline are displayed in Table 2. The results of the data analysis indicated that the intervention favorably increased the participants' mean CD4 Counts and Five Factor Wellness Inventory Scores between baseline and five-week follow-up. However, the mean Viral Load increased, which is not a desired or positive outcome.

To answer research question number one: *Does the SFWH Intervention for women (IV) significantly improve wellness (DV) as measured by the Five Factor Wellness Inventory among participants between baseline and five weeks after the intervention is provided?* an additional t-test was performed. Five Factor Wellness Inventory scores were obtained before the intervention began and at a five-week follow-up time. They were analyzed using a paired samples t-test. The test result was $t = -1.56$ ($df=13$) indicating that scores obtained at the follow-up time ($M=63.03$, $SD=5.75$) were higher than those obtained before the intervention ($M=60.84$, $SD=6.71$). The test results were statistically significant at the $p<.10$ level ($p=0.07$). Consistent with Cohen's interpretation of effect sizes (Cohen, 1992) the effect size was medium ($d=.42$). Figure 2 displays the mean changes in scores over time.

To consider the effect that the dose (measured by number of sessions attended) had on wellness measured by the Five Factor Wellness Inventory scores, a regression analysis was performed. Pre-test scores and dose were used as independent variables with post-test scores as dependent variables. The results indicated that the number of SFBT sessions or dose was not a significant predictor of multidimensional wellness for this sample ($\beta=.061$, $p=.82$). The overall model fit was $R^2=.14$, indicating that 14% of the variance of multidimensional wellness scores were explained by the predictors.

To answer research question number two, *Does SFWH significantly increase CD4 counts of women living with HIV between baseline and follow up?* a paired-samples t-test was performed. CD4 counts were obtained before the intervention began and at a five-week follow-up time. The test revealed that scores obtained at the follow-up time ($M=739.13$, $SD=579.19$) were higher than those obtained before the intervention ($M=684.25$, $SD=411.24$). This is a favorable increase. However, the results were not significant at the predetermined level of $p<.10$.

To answer research question number three *Does SFWH significantly decrease HIV-RNA viral loads of women living with HIV between baseline and follow up?* a chi-square test was indicated. The mean Viral Load levels of participants collected at follow-up ($M=81616.46$, $SD=183258.1$) were higher than the pre-intervention levels ($M=794.8$, $SD=1889$). A Pearson Chi-square was used to identify whether there was a difference between the baseline and follow up groups of data in the sample according to Viral Load detectability. Results showed a significant difference between the groups ($X^2(1,13) = 4.8$, $p<.10$). At follow-up, 50% of participants had undetectable HIV, versus at baseline, 62.5% of participants had undetectable HIV. Significance was derived from Fisher's Exact Test ($p=0.07$).

Fidelity

To address intervention fidelity, the SFWH intervention for women manual was used as instructed for each session, and each session in the manual was delivered as written. Participants were offered each session outlined in the manual. However, some participants did not attend each session. The range of sessions attended was from 0 (no sessions) to 7 (all sessions). The average number of sessions received by participants was 3.07 ($SD=2.60$).

In addition to number of sessions, fidelity was monitored by an SFBT checklist that detailed the techniques and mindsets of SFBT. The score was 70% SFBT fidelity for one randomly monitored session. This is considered adequate SFBT fidelity given the flexible nature of this counseling method (not all techniques are delivered in each session). The

Miracle Question and Therapeutic Break techniques were not used in the scored session. Fidelity was also addressed through SFBT training. The intervention was delivered by a licensed therapist who attended three multi-day trainings before delivering the intervention.

Discussion

A gender disparity in HIV wellness outcomes exists in the U.S. according to a CDC review that indicated women living with HIV have more difficulty engaging in HIV care (Beer & Skarbinski, 2014). In a 2008 article, Eyakuze, Jones, Starrs, and Sorkin implored HIV care providers to shift their focus from prevention to the direct needs of women living with HIV to correct this disparity. However, behavioral interventions aimed at assisting women living with HIV with their wellness efforts have continued to focus primarily on prevention of the spread of the disease to others, particularly for mothers (Yates, 2019).

The current SFWH intervention was developed to address the gender disparity in HIV wellness outcomes using a culturally competent behavioral intervention that capitalizes on the strengths and skills of the women (Yates et al., 2019). Using Solution Focused Brief Therapy allowed the group leader to employ a client-centered approach and take a stance of not knowing where the women are the experts in their HIV wellness. The wellness component of the intervention is based on Myers et al. (2004) research about a multidimensional approach to wellness that takes into account the physical, spiritual, cognitive/emotional and social/relational factors from the individual's perspective. Solution focused wellness was initially developed for college students with positive effects (Beauchemin, 2018) and is being applied to people living with HIV for the first time in this intervention.

In the current study, we provided the SFWH intervention for women to (N=14) African American participants who agreed to complete the seven-session, strengths-oriented counseling program. This article addressed the variables, procedures, measures, analysis plan and fidelity measurement plan for evaluating the SFWH Intervention for Women. Participants' experiences of the intervention as well as changes in solution building skills were also recorded in the study but are reported in a separate paper.

Wellness was measured with a valid psychometric instrument as well as two traditional HIV biomarkers taken from case management records. Quantitative methods including a t-test and chi-square were used to analyze a psychometric multidimensional wellness measure and HIV disease biomarkers. Intervention fidelity was also measured and reported as favorable. In sum, the intervention was effective at increasing the multidimensional wellness of participants according to the t-test results from the Five Factor Wellness Inventory ($p < .10$). However, the t-test of the CD4 counts showed no significant results. Though the results of the Viral Load analysis showed significant results, the analysis should be interpreted with extreme caution due to missing data. Because the data was taken from existing records, 50% of participants did not have reportable Viral Load test results at the time of the five-week follow-up data collection.

Limitations

The intervention was not delivered entirely as intended because the participants did not receive all the sessions due to difficulties of accessing the intervention. Despite efforts to engage participants by including incentives and supports for transportation and childcare, recruitment was limited. More research is needed to address recruitment and retention issues during research in community-based settings serving women living with HIV. This is addressed in the qualitative findings of the study, which will be presented in a separate paper. The issues around recruitment and retention contributed to the major limitation of this study, which is sample size. Missing data was also a limitation that affected the sample size of the study. Data collection issues were related to the choice of using existing case management records for HIV biomarker data rather than collecting that data, which would have been too invasive and burdensome for participants.

Implications

Behavioral interventions developed in community-based agencies serving women with HIV may improve wellness outcomes for women living with the disease. However, the burden to participants must be considered if a study is to be feasible in this setting. Though attempts were made to improve engagement in the study, including conducting it in a community-based setting, offering incentives and providing childcare and transportation, more efforts are needed.

Adjustments that make it easier to engage and retain African American women in this and other HIV care interventions are also necessary if the needs of this vulnerable population are to be met in their communities. This is important to note since though it was not a criterion for inclusion in the study, all the women identified as African American. While this was due to the recruitment issues in the study that led to a convenience sample, it also reflects the population of women living with HIV in the United States. Like many other chronic illnesses that affect women, HIV unfortunately makes African Americans vulnerable to health disparities (Beer & Skarbinsky, 2014).

The women in this study had caregiving responsibilities and transportation issues that may have interfered with their attempts to address their wellness. This result is consistent with other studies addressing women's HIV wellness outcomes (Yates, 2019). Further adaptation of the SFWH Intervention for Women is needed to address care responsibilities and transportation more specifically. Though these factors were addressed in the funding of the intervention to improve recruitment, they were not specifically addressed in the counseling manual. Future studies involving the SFWH intervention for women will continue to focus on improving access to services to improve not only retention and recruitment, but overall HIV and multidimensional wellness for women.

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Table 1*Participants' Baseline Demographic and Clinical Characteristics*

Demographics	Frequency	Percentage
Gender		
Biological female	14	93.33
Transgender female	1	6.67
Race		
White	0	0
African American	15	93.33
Multiple Races	1	0.67
Providing care to children under 18		
Yes	9	60
No	6	40
Providing care to adults		
Yes	4	26.67
No	11	73.33
Current Homelessness		
Yes	1	6.67
No	14	93.33
Current depression		
Yes	8	53.33
No	7	46.67
Current anxiety		
Yes	9	60
No	6	40
Current other mental health issue	3	20
Yes	3	20
No	12	80
Current substance abuse issue	0	0
Yes	0	0
No	15	100
Time since HIV diagnosis in years (categorical)		
<1 year	0	0
1-5 years	3	20
6-10 years	3	20
11-15 years	3	20
16-20 years	1	6.67
21 or more years	3	20
Missing	2	13.33
Time since most recent HIV medical care visit (categorical)		
0-3 months	7	46.67

4-6 months	3	20
7-10 months	2	13.33
11 or more months	0	0
Missing	3	20

Table 2*Paired Samples t-test Results for Wellness Measures over Time*

Measure	Baseline Mean (SD)	Follow-up Mean (SD)	Test Statistic	Effect Size	Sig (1-tailed)
CD4 Count	684.25 (411.24)	739.13 (579.19)	-.066	0.23	0.53
5FWel Score	60.84 (6.71)	63.03 (5.75)	-1.56	-.42	0.071

ARTICLE

Steve de Shazer's Theory Development

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Abstract

This paper traces developments in Steve de Shazer's theoretical thinking from 1969 until his passing in 2005. After reviewing his definition of "theory," we organize developments in his theorizing into 4 phases, distilling from each the axioms he continued to hold until his death. For each axiom, we indicate how it is foundational to an understanding of SFBT and, therefore, contributes to distinguishing SFBT from other talk therapies. We stay close to de Shazer's writings by frequently quoting from his many articles and 6 books. We conclude with a summary of what we believe are the 6 enduring axioms of his theory of SFBT, the striking features of how he developed his theories over the years and the new lens he left us for viewing therapy interactions, and one example of research that promises to expand his theoretical legacy.

Introduction

It is common, both inside and outside the solution focused community, to hear the assertion that solution focused brief therapy (SFBT) has no theory but is simply an approach of useful practice techniques. Steve de Shazer himself contributed to this belief because he often stated in workshops and meetings that "solution focused brief therapy has no theory". His style of teaching also made discussing the topic of theory difficult. He followed Wittgenstein's advice "Anything your reader can do for himself leave to him" (Wittgenstein, 1984. p. 77), which was often unsettling if not bizarre to his audiences. For example, a workshop participant in a workshop in Germany where Kirsten Dierolf was translating asked the simple question: "What do you do with depression?" and de Shazer answered: "I don't understand that question?" (Dierolf, 2015, pp. 38-39) His response aligns with the assertion that if one answers a question, one has accepted the presupposition(s) within that question. The question, "what do you do with depression," presupposes that a therapist does something with depression, which does not fit a SFBT framework. His response "I don't understand the question" would often lead to participants asking about his theory on depression, mental illness, or whatever. De Shazer would then respond that SFBT has no theory about those things. This and similar responses may have contributed to the belief that SFBT has no theory.

If one thoroughly reviews the historical development of SFBT, especially de Shazer's writings, it is clear that he and his colleagues talked about theory on a daily basis. De Shazer wrote 6 books and about 75 papers and at least one-third of that content is about theory. Eve Lipchik, an important early contributor to the development of SFBT, wrote about the evolution of SFBT in its first ten years: "the team [at the Brief Family Therapy Center in Milwaukee (BFTC)] always tried to use theory to guide practice and to further test theory-driven practices with clients" (Lipchik et al., 2013, p. 6). Given this close relationship of theory and practice at BFTC, the authors believe it is essential to closely examine de Shazer's "theory" in his writings to more fully understand the development of SFBT.

This paper is the result of study and reflection which began several years ago with the International Microanalysis Associates (IMA). Together with our IMA colleague Janet Bavelas,¹ we were struck by how often practitioners at conferences asserted that SFBT has no theory. So, we decided to review de Shazer's writings from beginning to end, focusing on theory development and distilling axioms of the theory Shazer developed. "An axiom is a statement accepted as true as the basis for argument or inference." (Merriam-Webster.com Dictionary, Merriam Webster, <https://www.merriam-webster.com/dictionary/axiom>. Accessed 28 Sep. 2020). Synonyms for axioms include postulates, principles, or tenets. As with its synonyms, axioms are foundational statements upon which theory is built. Over the years we have presented these axioms at conferences (Bavelas, De Jong, & Smock Jordan, 2014; Bavelas & Korman, 2014; De Jong & Smock Jordan, 2014; Korman, 2018) and we now offer our thoughts and conclusions in article form.

First, we address how de Shazer defined theory, attempting to clear up the confusion around his statement that "solution focused brief therapy has no theory". Next, we trace the development of de Shazer's theory through four successive phases. After summarizing and quoting from de Shazer's writings for each phase, we conclude with a statement of the axiom(s) we believe he developed during each phase. The paper concludes with a discussion of the axioms that have endured and were in place at his passing in 2005. In our conclusion, we propose the significance of de Shazer's theoretical viewpoint for practitioners in the fields of therapy and coaching.

What Did De Shazer Mean by "Theory"?

As noted earlier, about one-third of de Shazer's writing explicitly discuss theory. In order to understand his research and theory development, it is important to understand the distinction he drew between Theory (theory with a capital T) and theory (theory with lowercase T). De Shazer expressly did not attempt to explain human behavior or mental illness. Instead, his theory was deliberately and explicitly limited:

Certainly, I did not intend to develop nor have I developed a Theory or Grand Design, a Theory that attempts to explain everything or can be used as if it were designed to explain everything. (de Shazer, 1994, p. 274).

Rather, he stated:

Ever since I began practicing brief therapy in the early 1970's, my "research" question was "What do therapists do that is useful?" In the 1980s, we changed this to "What do clients and therapists do together that is useful?" (de Shazer & Berg, 1997, p. 122).

Steve de Shazer was rigorous. Two points remained constant in his research and theory construction projects. One addressed the phenomena he and his colleagues studied and the other the scope-conditions of their research. Said differently, the former was about what de Shazer and his colleagues were looking at and the second identified under what conditions their theories were valid and useful. One of his many statements about what he attempted to achieve was made in 1991:

Theory Construction.

In order to construct a useful theory of doing (brief) therapy, we need to identify what is observable and repeatable about therapy sessions. We need to describe the consistencies from session to session and case to case based on what therapists and clients actually do during therapy sessions. Therefore, theory development needs to be based on the disciplined observation of therapy being done within a specific context. From this process, a description of what is done in therapy sessions can be built and then rules can be created that will enable other people to do therapy "in the same way" (Gingerich & de Shazer, 1991, pp. 241-242).

De Shazer also clearly defined what he meant by "theory":

Theory, as I use the term, is not meant as an "explanation," [i.e. inferences] but rather as a coherent "description" of specific sequences of events within a specific context [i.e., a description of the therapist interacting with the client in the therapy setting] (de Shazer, 1988, p. xiv).

He also clearly defined what his theory was not about:

The theory [of SFBT] has nothing whatsoever to say about "problems complaints, difficulties" etc. In fact, the theory explicitly neither includes nor excludes ideas about causation and neither includes nor excludes the various ideas about problem maintenance: it only deals with doing therapy (de Shazer, 1988, p. xix.).

¹ This paper owes much to Dr. Janet Beavin Bavelas. Without her creative input this paper would not have been written.

Initially, de Shazer focused on descriptions of what the therapist does in the therapy room and later moved to focusing on what the therapist and client do together, that is, their interactions. In subscribing to an interactional view, he refused to theorize about behaviors or problems outside of the therapist/client interactions in which these behaviors or problems were described. He further limited his theory to the visible and audible interactions² in the therapy room at BFTC, saying that these were the scope-conditions for his theory. He did add, however, that the theory would be useless if it could not be applied in other settings (de Shazer, 1988, p. 67).

De Shazer's theory construction project stands apart from other theory development in the psychotherapy field. Usually, theory construction in the field starts with a set of interrelated propositions about the nature and cause of a problem. De Shazer's theory construction, by contrast, started out with trying to conceptualize the rules Milton Erickson used when he designed his unusual interventions (Erickson, 1980). De Shazer then moved on to describe what the therapist did and, thereafter, to what clients and therapists did together. All along, he kept developing theoretical descriptions of how change happens in therapy.

De Shazer's developing theory of SFBT as "... a coherent description of a sequence of events within a specific context" (1988, p. 63) can be likened to Einstein's theory of gravity. In both cases, scholars can describe what is observably happening, but they admit they do not know precisely how or why the phenomena occur that way. For example, Einstein stated that gravity bends space, but that does not say much about how or why gravity works that way. Still, with Einstein's sophisticated mathematical descriptions, scientists and engineers have been able to send people to the moon and back. Similarly, the coherent descriptions that de Shazer developed over the years about what is happening in SFBT therapist/client interactions do not depict how or why the interactions work. Nonetheless, drawing on his descriptions, many SFBT therapists aid clients in living more satisfying lives.

Historical Development or Steve de Shazer's "Phases"

Based on our reading and understanding of de Shazer's work (or perhaps one should say mis-reading and mis-understanding³ as de Shazer preferred to call it), one can roughly divide his theory project into four different and somewhat overlapping phases: the young de Shazer, 1969-1978; early BFTC, 1978-1982; de Shazer at BFTC, 1982-1989; and the late de Shazer, 1989-2005. We encountered challenges when presenting these phases because of understandable time lapses; namely, (a) the time that elapsed between changes in practice and related theory construction, (b) the time it took de Shazer to write about these changes, and (c) the time it took for these changes to be published. These time lapses make the post-hoc reconstruction attempted in this paper challenging and somewhat arbitrary. So, this paper is our version or understanding of de Shazer's theory development project and stakes no claim of being the right or only version.

Phase 1: The Young de Shazer, 1969-1978

De Shazer was 29 years old when he started imitating what he believed Milton Erickson did with his clients. He learned Erickson's methods from reading his cases (H. Korman, personal communication, September 2002) and discovered later that he thoroughly misunderstood how Erickson worked.⁴

We find very little theory development in de Shazer's early writings. His first 4 papers are, first, about his understanding of Erickson's principles and procedures and, second, give his descriptions of his own innovative hypnotherapy techniques and strategies (de Shazer, 1974; 1975a; 1975b; 1977).

In the 4 papers that followed (de Shazer, 1978a; 1978b; 1979a; 1979b), he used other peoples' theories as lenses through which he looked at Erickson's and his own work. For example, in 1978 de Shazer wrote about his variation of

² De Shazer described this focus as "staying on the surface" and trying to avoid making inferences about anything going on below or underneath. We address this focus in more detail in the section of this paper called "The Late de Shazer and Wittgenstein, 1989-2005."

³ More on this rather confusing idea further down.

⁴ Many years later when de Shazer saw Milton Erickson on videotape for the first time, his spontaneous reaction was: "Gee, he's doing it all wrong" (McKergow & Korman, 2009, p. 44).

Milton Erickson's crystal ball technique⁵ using "Expectation States Theory" (Webster & Sobieszek, 1974) to look at his own work:

...The crystal ball technique as described in the two case examples is not, in any formal sense, an application of Expectation States Theory, nor is the case material offered as further proof of the theory. Simply, this theory will be used to look at the therapy from a different point of view (de Shazer, 1978a, p. 204; our emphasis added).

Between 1971-1976, de Shazer worked with Jerry Talley and Joseph Berger from Stanford University's sociology department applying Heider's balance theory (Heider, 1946). They were trying to understand the rules Erickson used in his therapy sessions and, because de Shazer was imitating Erickson, also trying to understand what de Shazer was doing in his sessions.

As with other theories de Shazer examined over the years, he used Heider's balance theory as a lens through which to look at and describe what happens in the therapy room. It was as if he was trying to answer the question: How does what I did in this session fit or make sense within this theory?

The young de Shazer seemed to be searching for a theory that could be used to describe and, perhaps, explain his work. In a retrospective unpublished paper originally taken from the BFTC-website, de Shazer wrote about the work with Berger and described two research projects:

[writing about the first project] ...we would try to bring sociological knowledge to bear upon each of the cases. Eventually we narrowed it down to describing the situation using Fritz Heider's Balance Theory. The second [project] was to try to develop a theory based on the work of Milton H. Erickson or, perhaps, discover Erickson's theory which is implicit in the papers (de Shazer, 1999, p. 7).

De Shazer's work using Heider's balance theory in therapy and theory development is explored and described in great detail in his first book (de Shazer, 1982a). We do not see that balance theory had a lasting impact on SFBT theory.

Precursors of what will come. We found the first inkling of what will emerge later in de Shazer's theory construction projects when he described his disagreement with Berger in 1972 as they were mapping cases using Heider's balance theoretical model. The disagreement was about including the therapist in the balance-theoretical maps they were working on together. Berger wanted to stay with mapping the family while Steve wanted to map the whole system in the therapy-room which, as he saw it, included the therapist: "This eventually led to our agreeing to disagree when I started to take an 'outside-observer' position including the therapist on the map" (de Shazer, 1999, p. 7).

When de Shazer wrote "Beginnings" in 1999, it is clear that he felt that, already in 1972, he was starting to entertain the idea of investigating "therapy-as-a-system" (de Shazer 1981, p. 56) rather than looking at "the family-as-a-system" (de Shazer 1981, p. 56), even if this crucial distinction was not fully clear to himself at the time.⁶ This shift is noteworthy for at least two reasons. First, de Shazer's method of investigation was observing therapy sessions and then trying to describe what he observed. Second, the disagreement with Berger may well have been the beginning of de Shazer's shift from primarily observing and describing the client's problematic system and what the therapist did with that, to focusing instead on the interaction between the client and therapist. "Including the therapist on the map" (de Shazer 1999, p. 7) became a fundamental principle in everything that emerged later at BFTC. We have conceptualized this principle of de Shazer's developing theory in our first two axioms:

- **Axiom 1: Therapy is an observable interactional process, that is, a conversation.**

Axiom 1 captures how de Shazer, so early in his theorizing, moves toward focusing on what is observably happening in the therapy room, namely, clients and therapists are interacting in the sense of having a conversation together. Thus, he 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.

⁵ In 1987 he had come to see the crystal ball technique as "... an early attempt to systematically focus the client on solutions rather than on problems" (Molnar & de Shazer 1987, p. 350).

⁶ In a paper published in the late 1970's de Shazer still talked about "resistance" and "homeostasis" not yet questioning these concepts or metaphors (de Shazer, 1979b, pp. 83-95). It is noteworthy, as we explain later, that the concepts homeostasis and resistance disappeared (or stopped being useful) once the distinction between family-therapy-as-a-system and family-as-a-system became clearly articulated.

- **Axiom 2: The minimum unit of analysis is the therapist interacting with the client in the therapy setting. This unit cannot be subdivided further.**

With this axiom a clear boundary was set towards basically all other theories in the field. If you cannot subdivide “the unit of therapist interacting with the client in the therapy setting” you can no longer theorize or speculate about what’s going on with the client, inside the client or in the client’s family. In order to describe pathology or dysfunction in the client or in the family system you have to subdivide the unit into its components. Steve de Shazer’s theory is a theory about therapy – it’s not a theory about the people that are in therapy.

Before proceeding, we want to note that it soon became apparent to us in our study of de Shazer’s writings that it is not possible to pinpoint exactly when and in which manuscript de Shazer’s different ideas appeared. Some of his ideas were hinted at in early writings but then only fully described 10 to 20 years later. For example, consider the concept of exceptions. Harry Korman once asked de Shazer where his “weird” (Harry’s word) way of listening came from. De Shazer answered that he had “always heard the holes” in the story. When he started to do therapy, he said people would tell him about their problems, but what always stood out for him were the holes. Holes were the parts of the client’s story that did not fit with the complaint. De Shazer said that these holes were always there and had always interested him most. He also said that he had always worked the same way (personal communication, mid-90’s). Traces of this are in the papers he wrote. In 1975a, he published a paper where one can see that he was actively searching for what was later named exceptions:⁷

I tried to get exact data about the pattern of the boy's accidents. It happened at home, at his friend's, at kindergarten, morning or afternoon. Nor could they (the family) discover any behavior pattern common to the days when there were no messes. (de Shazer, 1975a, p. 86 emphasis added).

Phase 2: Early BFTC, 1978-1982

In 1978, de Shazer and a group of colleagues with different orientations to therapy from the agency, Family Services of Milwaukee, started the Brief Family Therapy Center (BFTC). Their expressed intent was to try to make therapy briefer and more effective. One of their main goals was to address an omission in the MRI-model (Mental Research Institute of Palo Alto):

Nowhere does the group [MRI] explicitly deal with the brief therapy approach used with people who have mutually exclusive goals or with people who have vague, ill-formed goals that they are unable to articulate (de Shazer, 1982a, p. 29).

Attempting to solve the puzzles posed by these families,⁸ while merging the different ideas at BFTC led to the development of the “ecosystemic brief family therapy” model (de Shazer, 1982a).⁹

It was during these years that de Shazer articulated the distinction between the study of the family-as-a-system and the study of family-therapy-as-a-system. He argued that studying the family-as-a-system in the context of therapy sessions makes little sense because in therapy there is also a therapist and sometimes a team with all these sub-systems working together with either the explicit or, at least, implicit goal of change (de Shazer, 1982a, pp. 1-3, 5-6). He began to write about what he called fundamental flaws in the theories about family therapy. He exposed the “muddles” (de Shazer, 1982a, p. 3; de Shazer 1982b) created by concepts like “homeostasis,” “resistance,” “linear versus circular thinking,” and “continuous versus discontinuous change”. He also questioned the usefulness of other popular concepts like “paradox” and “power” (de Shazer, 1981; 1982a, pp. 15-18; 1982b). He concluded that these concepts are not useful if one wants to understand how family therapy works as a “change-promoting” system. The concepts resistance and homeostasis were being used to make sense of what caused and/or maintained problems in the family-as-a-system. In order to understand the change process, one must make use of other concepts. Motivating de Shazer’s conceptual conclusions during this period was what he and his colleagues saw happening in the therapy rooms at BFTC. Rather

⁷ An exception is “what happens when the complaint does not happen” (de Shazer et al., 1986, p. 215).

⁸ Actually, de Shazer had already published a paper in 1975 (de Shazer, 1975b) where he suggested one way to work with families having conflicting goals.

⁹ In August 1980, de Shazer wrote that he was putting the “final touches” on his first book *Patterns of Brief Family Therapy: An Ecosystemic Approach* (Underground Railroad, Vol • 1 • No. 2, p. 2). So, there was a two-year lag between the final touches and the book’s publication. By that time (1982), with therapy innovations at BFTC developing so rapidly, de Shazer and his colleagues were no longer working as described in this book (H. Korman, personal communication, 1988).

than families and couples showing homeostatic reactions or resistance, the team observed families and therapists collaborating to produce client change (de Shazer, 1982a, pp. 9-15). The challenge for de Shazer became describing this collaborative process in more useful ways.

The importance of the shift from describing the family-as-a-system to describing family-therapy-as-a-system cannot be overemphasized. Taking an interactional view among the family therapy sub-systems opened up a whole new world of theoretical description, clinical practice, and investigation (research). With the new focus of family-therapy-as-a-system, de Shazer and the team at BFTC removed the artificial conceptual barrier between the therapist and the family. Among other conceptual shifts, they replaced homeostasis with "morphogenesis." Homeostasis is a concept that leads to a relatively closed-system, static description of the client system (i.e., the couple or family). Employing the concept of morphogenesis, on the other hand, leads to a more open-system, "ecosystemic" description of the client system as a sub-system in interaction with other sub-systems (i.e. the therapist and consulting team) in the therapy context. Therefore, morphogenesis can be used to more clearly and accurately describe client system change (de Shazer, 1982a, pp. 3-5).

The team at BFTC also replaced the concept of client resistance with "clients as cooperating". The study of family-as-a-system, and the notions of homeostasis, and client systems being resistant to change all went hand in hand. As de Shazer wrote in his ground-breaking paper, "The Death of Resistance":

The idea [of client resistance] was that the family-as-a-system seemed to maintain the status quo through deviation-counteracting processes. The changes in the family-as-a-system were seen as mutual, causal, negative feedback loops that kept the changes within certain limits and constraints.... Systemic changes that go beyond the homeostatic plateau either destroy the system or restructure it (de Shazer, 1984, p. 12).

And, a bit further on he continues:

The concept of resistance locks many family-systems-based therapies into the prevailing epistemology of linear causation, "force", or "power", because it implies a separation between the therapist and the family system. When homeostasis is used as the organizing concept on this more complex level, the "resistance" is seen as located in the family and is described as something the family is doing. It is not seen as a product of therapist-family interaction. (de Shazer, 1984, p. 13)

Later, in the same paper, he explained that adopting a view of the family-therapy-as-a-system with its ecosystemic view of sub-systems (i.e. family, therapist, and team) in interaction within an open supra-system (i.e., the therapy context) puts the concept of client resistance to "death"¹⁰ (de Shazer, 1984). In its place, he turned to the notion of clients cooperating and wrote the following about the clinical significance of re-describing the therapy system with different metaphors:

*If these distinctions [family therapy-as-a-system versus family-as-a-system and morphogenesis versus homeostasis] are to be useful clinically, then behavior that is commonly labelled "resistance" can be usefully re-described. One way of doing so is to conceptualize or think in terms of "cooperating": [and then quoting from his earlier book *Patterns of Brief Family Therapy*]*

'Each family (individual or couple) shows a unique way of attempting to cooperate, and the therapist's job becomes, first, to describe that particular manner to himself that the family shows and, then, to cooperate with the family's way and, thus to promote change (de Shazer, 1982a, pp. 9-10)'

(The term "cooperating" is used in an attempt to avoid reification, because the "ing" helps to keep the therapist thinking in terms of processes of continuing interaction between the subsystems, rather than the condition that

¹⁰ De Shazer's paper on "The Death of Resistance" was not published until 1984. However, as he explained later in a 1989 paper entitled "Resistance Revisited," the paper had been conceptualized and essentially written several years earlier. He wrote in that later paper: "In 1978, after sitting behind the mirror and seeing our team ... work with clients advertised as 'highly resistant' by the referring therapists and seeing these clients cooperate readily with us, we decided that a little conceptual violence was called for and thus we murdered resistance" (p. 227). Soon after, in 1979, de Shazer submitted the paper for the first time. He recounts it took 6 revisions without changing the title or thesis of the paper and 17 rejections before the paper was accepted and published in 1984. Apparently, resistance can be very difficult to overcome.

There is a story in SFBT circles that in July 1979, after the team at BFTC had killed resistance, they buried it and built a shrine. Some say the burial was at BFTC, others say it took place at de Shazer and Berg's home. While widely circulated, this story has never been confirmed and, as of yet, we have never heard anyone say that they saw the shrine. Perhaps the burial was metaphorical as was the "murdering".

The paper was accepted for publication on the 3'd May 1984. This date was chosen as the Solution Focused world day in honour of what some people see as one of de Shazer's most groundbreaking publications.

might be implied by the use of cooperation, which might describe a principle rather than a process. 'Cooperation' tends to disconnect a 'something' from its ground and makes it 'thing like': a likely process given the dominance of the old epistemology.) (de Shazer, 1984, p. 13)

While we do not know which came first, the change in metaphors for therapy or the way the BFTC team was working with clients (probably it was different on different days until their re-descriptions crystallized), we do know that these conceptual shifts meant a very different way of thinking about therapy interactions and responding to what clients were saying. For example, if a family or client now showed "resistance," this no longer meant that they were resisting change – the old concept. Instead, the apparent resistance was now understood as a collaborating attempt from the family or client trying to let the therapist know that he or she had expressed a less than useful idea (knowingly or un-knowingly), about what the problem was, or what the therapist thought would be good for the family, or what the family should do to solve the problem. By labelling this “collaborating,” the behavior was now understood – and responded to – as a communicative signal from the family indicating that the therapist was off track in his work and that the therapist needed to change his behavior, that is, to continue responding to the family in the direction of finding a way to cooperate with the family. The apparent resistance, therefore, was no longer seen as a sign of pathology in a family needing to preserve the problem and the status quo.

Once the therapists at BFTC began discarding homeostasis and resistance as useful ways to understand and decide on what to do in therapy and, instead, saw the family's responses as attempts at cooperating, this change in viewpoint reinforced changing therapists' behaviors toward clients and, therefore, changed the interactional patterns in the therapy ecosystem (i.e. family-therapy-as-a-system). So, practice at BFTC had now changed: new patterns of interactions had emerged that required new concepts and theories for the new interactional patterns to be described more accurately. This, in turn, influenced the design of new research projects that, in turn, influenced ongoing theory and practice. This was how practice, theory, and research were recursively related in the theory development project at BFTC.

It was also during this period that de Shazer developed his binocular theory of change in the therapy ecosystem which drew directly on Maruyama's (1963, p. 166) concept of morphogenesis in interacting systems. Maruyama defined morphogenesis this way:

Once a system is kicked in a right direction and with sufficient initial push, the deviation-amplifying mutual positive feedbacks take over the process, and the resulting development will be disproportionately large as compared with the initial kick (as quoted in De Shazer, 1982a, p. 96).

De Shazer theorized that the therapist and the team at BFTC were initiating change in client systems by harnessing morphogenesis through the design and delivery of the "intervention" at the end of the therapy session (de Shazer, 1982a, pp. 7-15). The idea was that the family had one view of “the problem” and of what happens in the family. The therapist and team would develop another view that was different, yet related enough to be in cooperation with the family's view. The team would then give their view in the feedback to the family at the end of the session. A bonus would emerge in the difference between the two views. This bonus, according to de Shazer, was the same kind of bonus that happens with the merging of the different visions of the world when the picture in the left eye is merged with the picture of the right eye; namely, depth appears. He called this the binocular theory of change.¹¹ For a long time, this was the main concept that organized the therapy sessions at BFTC. The therapist's or "conductor's" job was to interview the family and create a detailed description of what happened when the problem was present. The conductor and the team would then meet and create an intervention message for the family that was as close as possible to the family's description but with some differences. The goal was to create a “matching” description of the family's trouble, close enough and called “isomorphic” by de Shazer, to be recognized and accepted by the family as their own, and yet different enough to create a meaningful, change initiating difference when merged with the family's slightly different view. The concepts of “isomorphism” and “match” were the organizing principles in how to do the interviews and create these matching, isomorphic intervention messages. At the time, de Shazer's theory was that it was the intervention message with their incorporated tasks, and more specifically, the families' responses to the tasks that promoted change. The team at BFTC called these tasks “clues”. The clue could be anything from specific behavioral tasks and experiments to indirect

¹¹ De Shazer drew on Bateson's concept of “news of the difference” and the notion of “second order changes” in systems when explicating his concept of “bonus” in the binocular theory of change (1982a, pp. 7-9; 1984, p. 12).

Ericksonian “interspersing techniques,” or simply telling a story about how other families with similar problems had solved their problems, or simply being pessimistic about the outcome of the therapy.¹²

We think it is important to emphasize that the model developed during these first four years at BFTC was a problem-solving model solidly built on systems thinking and interspersed with Ericksonian ideas. Detailed descriptions of the problem and the interactional patterns around the problem were thought to be necessary to create purposeful tasks that would change the problematic patterns of interaction in the families and solve their problems.

Even though there are hints earlier in de Shazer's writings, our belief is that a new axiom about change crystallized during this 1978-1982 phase and remained prominent ever after in de Shazer's work:

- **Axiom 3: Change is the purpose of the therapist and client meeting.**

Axiom 3 may seem simplistic and obvious to everyone. It's not. By emphasizing therapy as a change-promoting system, de Shazer is distinguishing his focus from all the therapies that focus on the nature and assessment of client difficulties as the precursor to treatment. As he himself put it:

What the early conceptualizers and therapists since then have failed to realize is that “the study of the family” and “the study of family therapy” are studies of different logical types. The former is a study of stability while the latter is a study of changing (de Shazer, 1982a, p.4).

This axiom also clarifies why solution focused therapists are not interested in the problem or the causes of the problem and the enormous differences this leads to in practice compared to almost everything else in the world of psychology and psychiatry.

- **Axiom 4: Client change via therapy occurs through observable interactions in which the therapist finds ways to cooperate with the client.**

As we described earlier in this section, de Shazer and his colleagues noticed that in the therapy rooms at BFTC -- instead of resisting -- clients seemed to be collaborating with their therapists in order to produce client change. This observation, coupled with his already developing interactional focus on the client-therapist system, led de Shazer to question and dismiss 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 both then and today.

Phase 3: de Shazer at BFTC 1982-1989: The Emergence of Solution Focused Brief Therapy

From problem resolution to solution development, How It Began. In 1982 a family with 27 problems came to therapy (as described in Hopwood & de Shazer, 1994). At the end of the session, when it was time to take a break and construct an intervention message, none of the problems had been described in enough detail for an isomorphic message to be constructed.

So, following de Shazer's and the BFTC's team understanding of Ericksonian principles,¹³ the therapist and team constructed a vague task later to be named the “formula first session task” (FFST)¹⁴ and delivered it to the family at the end of the session:

Between now and next time we meet, we [I] want you to observe, so that you can tell us (me) next time, what happens in your [pick one: family, life, marriage, relationship] that you want to continue to have happen (Hopwood & de Shazer, 1994, p. 558, quoting de Shazer, 1985, p. 137).

¹² The reader can find many examples of client cases and the related clues that the BFTC team designed during this period in de Shazer (1982a).

¹³ See Haley's (1967) description of these principles including that which says problems which are vaguely described should lead to vague end-of-session feedback and a vague homework task.

¹⁴ De Shazer had started developing standard (or formula) tasks as early as 1969 for use with cases involving similar problems (de Shazer, 1985, pp. 122-125). In 1985 he renamed them “skeleton keys” (de Shazer 1985, pp. 119-136). Many SFBT practitioners continue to use these tasks today.

Hopwood and de Shazer (1994) described what happened next:

Two weeks later when the family returned, my [de Shazer's] 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 (p. 558).

In the ensuing discussions at BFTC, someone remarked that this was a very interesting case because the family did the task and the task was useful; that is, change happened and most important and interesting was that the therapist and the team had no idea which one of the 27 problems had been addressed by the task. This fact would eventually lead to a radical new question: Is it possible to solve a problem without knowing what the problem is? Another very important and interesting thing was that this family with vague problems had reported concrete things happening.

This prompted us to start using the formula intervention with other cases in which the clients described vague goals and complaints. Case after case, concrete and specific changes in the week interval between the first and second session were reported. This prompted the development of a more organized study, (de Shazer 1985, p. 138).

In the more organized exploratory study that followed, the therapists at BFTC were instructed to give the FFST task to all the clients and families at the end of the first session regardless of what had happened in the interview, unless the therapist had a very good reason not to. If the therapist did not give the FFST, he or she had to describe why. Sixty-four percent of new cases got the task. Eighty-nine percent of these cases reported noticing something worthwhile happening in the interval between the first and second session and two-thirds said that things were better (de Shazer, 1985, p. 155).

The results of this research created a major theoretical problem. The binocular theory of change in the ecosystemic model of brief therapy (de Shazer, 1982a) required that the team produce an isomorphic description of the family's problem that matched the family's view. This was necessary in order to open the lock of the closed door of the problem and solve it. It was inconceivable that the FFST could match and be isomorphic with two-thirds of the clients' and families' descriptions of their problems and complaints. Identifying this as an anomaly, that is, an occurrence when the data do not fit the theory, de Shazer stated:

As Kuhn (1970) [in The Structure of Scientific Revolutions] pointed out, anomalies develop and either they need to be re-described within a current theory or the theory needs to change so that a description is possible (1988, p. xiv).

So, faced with a choice between re-describing the observations from the BFTC study of the FFST within their current ecosystemic theory of problem-solving, isomorphism, and match, versus needing to change the current theory, de Shazer chose the latter. He started doubting the theories he had developed for 15 years and began to develop new concepts and theoretical descriptions.

From isomorphism and match to fit. The shift that started in 1982 did not appear in print until 3 years later. It took until the 1985 publication of *Keys to Solution in Brief Therapy* for de Shazer to offer a very different description of what he now saw happening in the therapy rooms at BFTC:

As the BFTC team continued to work together and a distinct, unique philosophy developed, a shift occurred from our being interested in 'problems/complaints and how to solve them' to 'solutions and how they work'. We looked at what is on the other side of the locked doors and started to figure out how the clients and we got there (de Shazer, 1985, pp. 44-45).

The locked door metaphor was central in de Shazer's 1985 book. The client's problem was metaphorically described as a room with a number of locked doors, where all the doors might lead to a solution. Before the shift began in 1982, therapy focused on understanding the lock (the problem) in such a way that one of the doors could be opened. The therapist needed to create an isomorphic description of the problem, matching the one the family already had, but with small differences so that new possibilities might come out of the merging of the two (the binocular theory of change). With the results from the study on the FFST, the concepts of match and isomorphism had to be abandoned. Interventions no longer needed to be isomorphic and matching. They just needed to fit:

We had been looking at "Problems: Complaints and how to solve them," while the concept of fit suggests rather that we need to look at "solutions and how they work". And we do not need to know how a particular lock (complaint) is constructed in order to find a skeleton key-like intervention that fits in such a way that it opens the door to a "better," more satisfactory future for the client (Nunnally et al., 1986, p. 95).

Changing the interviewing process. Changing the theoretical focus from problems and how to solve them to solutions and how they work led to fundamental changes over time in the interviewing process and what kinds of information were sought and amplified in the interviews. This process had begun with the invention of the FFST because once this task was given at the end of a session, the team at BFTC followed up at the next session with questions about what clients had discovered that they wanted to continue to have happen in their lives. These questions were new. De Shazer wrote the following about this change:

As my colleagues and I at the Brief Family Therapy Center (BFTC) continue to study solution development, we have been forced by our analyses to look more and more at the process of the interview. We found it was no longer enough to use our (perhaps overly) simple idea that the interview led to the intervention strategy and therefore the task. Clearly, there are solution related things that the client and therapist do during the session. (de Shazer, 1988, p. xiii).

He continued a bit further on:

For several reasons, I did not (and still do not) like this shift in focus, but our investigation of solution development forced it on me. This is the second time that one of our investigations has forced a major shift in our approach (see de Shazer, 1985). Such shifts are normal parts of any exploration process: one follows where the data lead (De Shazer, 1988, p. xiv).

De Shazer was not explicit about what it was about the change of focus to "solution related things that the client and therapist do during the sessions" that he did not like. Perhaps he was still enamored of the elegant summaries and ingenious tasks that he had been offering families at the end of sessions. Perhaps he felt that it was a daunting task to make sense of the chaos and complexity that is the therapy session and take on describing and theorizing about how these "solution related things" actually happen in the interaction in the therapy room. Regardless, he decided to follow where the data led. Consequently, at BFTC, the team now started looking for patterns of interactions around successful solution development. As the team focused more on the interviewing process, they saw things happening that they had not noticed before. In addition to inventing and continuing to incorporate the FFST and its follow up interviewing, they invented interviewing for exceptions and pre-session change. These three phenomena shared being descriptions of better things happening in clients' lives. In other words, they were all descriptions of when seemingly locked doors of the problem were open or partially open. The simplest way to begin opening the locked doors and, therefore, to promote change became building on when things were already better, that is, finding out how clients made exceptions and pre-session change happen and suggesting that they do more of what they were already doing that was working for them.

Exceptions. De Shazer mentions "exceptions" for the first time in 1985:

Although the child is seen as always wetting the bed, there are probably some dry nights now and then - exceptions to the rule (an important concept developed jointly by the author, Wallace Gingerich and Michele Weiner-Davis to describe what the therapist is after during the first session). However, these exceptions frequently slip by unnoticed because these differences are not seen as differences that make any difference: The difference is too small or too slow.

These exceptions to the rules of the pattern are exactly the kind of information the therapist needs to know. It is important for the therapist, the child, and the parent(s) to know that the child in some (perhaps unconscious?) way knows how to have a dry bed (de Shazer 1985, p. 34).¹⁵

De Shazer later created the distinction between spontaneous and deliberate exceptions:

...many clients reported exceptions to the rule that the complaint always happens. Some of these exceptions the client described as spontaneous – "it just happened" – while others they described as the result of a deliberate shift in behavior. In either case, their description can be seen as including a difference that had not yet made a difference to them (de Shazer, 1988, p. 4).

¹⁵ One of the authors (PDJ) interviewed Insoo Kim Berg in 1996 about the development of solution focused brief therapy at BFTC and where, in particular, the concept of exceptions came from. She said she thought it came soon after and directly from the development of the FFST. Her view was that asking clients to pay attention for what they wanted to continue to have happen in their lives (i.e. FFST) was similar to asking them about what was happening in their lives when the problem times were not happening (i.e. exceptions). The interview with Berg is available on request from PDJ; if interested, email him for a copy at pdejongsf@gmail.com.

Creating descriptions of exceptions in the therapy interview, and being clear about whether they were spontaneous or deliberate, eventually came to be viewed by de Shazer and the BFTC team as one very useful way to promote solution development. Every exception was thought to be a difference in the client's life that potentially could be made into a difference that creates the more satisfying life desired by the client. For clients who could describe deliberate exceptions to their problems, de Shazer and his colleagues suggested that they do more of the exception behavior because they were already doing that and thus knew how to do it. For those clients who described spontaneous exceptions, the team recommended for clients to: (a) pay attention to when the exceptions happened, (b) how they might be contributing to them happening, and (c) report back to the therapist/team at the next session what they discovered.

Pre-session change. The shift from problem resolution to solution development began with the invention of the FFST. The team at BFTC used the FFST and other formula tasks¹⁶ as the primary interventions in client solution development and by the mid-1980's they had described these tasks in detail (de Shazer, 1985; de Shazer & Molnar, 1984). For a long time, de Shazer and his colleagues thought the end-of-session tasks were the key initiators of client change. However, ongoing careful observation of therapy sessions kept leading to new discoveries of how the interview itself might be promoting solution development.

Weiner-Davis, de Shazer, and Gingerich (1987) gave a detailed description of the chance event that led to the discovery and description of pre-session change:

She (the mother) postulated that her divorce of several years ago had had a lasting effect on him (the 12-year old son) and that perhaps he was experiencing a deeply rooted depression. Just as the therapist was about to consult with the team behind the mirror, the mother nonchalantly mentioned that for the 3 days prior to coming for therapy, her son "had been trying in school." The therapist stopped for a moment, expressed great surprise, and asked the boy why he decided to "turn over a new leaf."

At first the boy appeared perplexed by this idea but quickly affirmed that, indeed, he had turned over a new leaf because he was "tired of always getting into trouble." The remainder of the session was devoted to helping the boy determine what he needed to do to stick to his resolution. Therapy goals were accomplished within three sessions. (p. 359).

The team at BFTC then recalled other clients who had reported improvements between the call for an appointment and the first session. These findings once again led to a research project, this time at Weiner-Davis's clinic. In this study, 30 families were asked the following question by their therapists at the beginning of the session:

Many times people notice in between the time they make the appointment for therapy and the first session that things already seem different. What have you noticed about your situation? (Weiner-Davis et al., 1987, p. 360).

In 20 of the 30 cases, the parent present in the session answered that things had already started to be better in the direction of what they wanted to get out of therapy. Consequently, as with the discovery of exceptions in the first session, therapy in these cases turned to working on maintaining change instead of trying to start it. De Shazer and his colleagues wrote the following about when clients reported exceptions, pre-session change, or any useful changes in first sessions:

We noted that we then worked to keep these changes going and that this approach led to increased client satisfaction and fewer sessions per client (Nunnally et al., 1986, p. 90).

Noticing the presence of and then inventing the concepts of exceptions and pre-session change, changed how the interviews were conducted at BFTC. Therapists began exploring change in the form of exceptions and pre-session change earlier and earlier in the first session. Moreover, since this search could begin right away in the first session, it meant that:

... the therapist and client are constructing a therapeutic reality based on continuing transformation or change (as evidenced by any exceptions), rather than on initiating change. When exceptions are identified, the homework task will usually include the idea that the client should do more of what they are already doing rather than suggesting that they do something new (de Shazer, 1988, p. 5).

An interesting aside here that again reveals how revolutionary BFTC's developing ideas and practices were in the 1980's, is that already in 1978 Don Norum, who worked at Family Services in Milwaukee at the same time as de Shazer and Berg, wrote and presented a paper titled: "The Family has the Solution". The paper was about how pre-session

¹⁶ Several other formula tasks had their origins in the earlier work of mainly de Shazer and Erickson (de Shazer, 1985, pp. 119-136).

change can be used to create a sustainable solution. It was rejected as nonsense by the reviewers for the journal *Family Process* (Kiser 1995, pp. 263-264). The paper was finally published 22 years later (Norum, 2000).

The crystal ball technique and the miracle question. Like Milton Erickson, de Shazer believed that brief therapy should be organized around client goals. And, although de Shazer's concept of "goals" evolved along with his therapy practices and theoretical descriptions, he also believed client goals should be as specific, concrete, behavioral, and realistic as possible (de Shazer, 1985, p. 9; 1990, p. 97). However, as he wrote in 1985:

The reality is that clients often come with vague and/or mutually exclusive goals or goals which they cannot describe. In fact, the most difficult and confusing version of this is that some people do not know how they will know when their problem is solved. Without realistic goals, without a way to measure success, people can go around in this world mired in the muck of past mistakes and bad luck.

Erickson's crystal ball technique and BFTC's miracle question were therapy practices intended to help clients develop and describe more useful goals than they had at the outset of therapy.

The crystal ball technique was the precursor to the miracle question. Erickson described using the crystal ball technique with a variety of problems (Erickson, 1954, pp. 261-283). De Shazer started using his version of the crystal ball technique in the mid-1970's (de Shazer, 1978a) and his version involved having the client in a trance imagine and peer into several different crystal balls and describe what they were seeing (1985, pp. 81-83). Two of the balls were about memories of the past, "a pleasant memory that was forgotten long ago" and a memory of "a recent but surprisingly forgotten event". In both cases, the client was asked to (and thereby taught to) observe her or his own behavior and how others responded. Two other crystal balls were oriented to the future, one to the successful resolution of the client's problem and another to how the problem was solved. De Shazer summarized the significance of this technique:

The crystal ball technique is used to project the client into a future that is successful: The complaint is gone. I have found that simply having the client, while in a trance, view his or her future in a crystal ball or a series of crystal balls can be enough to prompt different behavior, thereby leading to a solution (de Shazer, 1978a). The ideas behind the technique can also be used in clinical situations that do not involve formal trance. Either way, the client constructs his own solution, which can then be used to guide therapy. As I see it, the principles behind this technique form the foundation for therapy based on solutions rather than problems (1985, p. 81).

Most notably, two of the crystal balls were brought forward into the new solution development interviews. They morphed into asking clients to remember "some success in life, particularly one that is an exception to the rules surrounding the complaint," and asking clients "what will things be like for you and others when the problem is solved?" (de Shazer, 1985, pp. 82-83).

In theoretically reflecting on how using the crystal ball technique in therapy sessions might be promoting client change, de Shazer drew on two different theories: 1) Berger's expectation states theory (Berger et al., 1977) and 2) Axelrod's theory of cooperation (1984). Both of these theories had the backing of experimental research. Regarding expectation states theory, de Shazer (1985, p. 74) wrote that it "is concerned with both how interactional situations develop and maintain patterns and also how the expectation-maintaining behaviors change". De Shazer stated that when clients come to therapy, they come because their attempts to solve their problems have failed and they have developed expectations for the future which say only more of the same "damn thing" is going to keep happening. He then noted that therapy can change these negative expectations:

Change in the structure of these [problem saturated] expectations will occur when the conditions change in some way, Feedback or evaluation from an authoritative source such as a therapist can undermine these expectations and thus promote changes in behavior, different outcomes, and the development of new expectations (Berger et al., 1977). Of course, these new expectations will also be self-maintaining and the clients stand a chance of a more satisfactory life (de Shazer, 1985, p. 75).

De Shazer, then, viewed the crystal ball technique as a way to get clients to describe new and different sets of expectations for the future, expectations of having successfully resolved the problems that brought them to therapy.

The usefulness of Axelrod's theory and research to de Shazer's project of describing how therapy more broadly and the crystal ball technique in particular seem to work, can best be appreciated by considering de Shazer's definition of therapy in the mid-1980's. At this time, he defined therapy in these words: "At BFTC, clinical practice defines therapy as cooperative, as oriented toward change and solutions, and as focused on the present and future" (de Shazer, 1985,

p. 79). At the same time, then, that de Shazer was describing therapy as an interactive process in which the therapy system of therapist, client, and team work collaboratively toward the client's goals, Axelrod was busy researching under which conditions cooperation among interacting participants was advantageous. As described earlier in phase 2, de Shazer had replaced the concept of client resistance with the idea of clients attempting to cooperate. Axelrod's experiments provided strong evidence that cooperation is the strategy that leads to the best outcomes in the long run, even in the competitive game situations he was researching. De Shazer (1985, 73), noting the relevance of Axelrod's findings to the therapy situation, quoted Axelrod who stated: "... mutual cooperation can be stable if the future is sufficiently important relative to the present" (Axelrod, 1984, p. 126). In the crystal ball technique, de Shazer saw the therapist and team cooperating with the client to construct a description and an experience of a desired future. The desired future, of course, was directly relevant and important to the client's problem-saturated present which the client presumably came to therapy to change.

The miracle question, similar in purpose to the crystal ball technique, was invented in 1984 by Insoo Kim Berg (De Jong & Berg, 2013, p. 90-91; Korman, personal communication with Steve de Shazer, 1990). Berg was trying to get a woman with many complex complaints to describe how she would know that she did not need therapy any longer. The client was working hard with the questions but could not find answers. About 20-25 minutes into the session, the woman sighed deeply and said, "My problems are so serious it would take a miracle to solve them." Berg, picking up the words the client had used, then asked: "So suppose this miracle happens, but it happens while you're sleeping, so you can't know it happened. How will you discover it happened after you wake up? What will be different?" The woman then went on to describe 16 behaviors that would be signs to her that the miracle had happened and, therefore, indications that she no longer needed therapy.¹⁷ Members of the team at BFTC felt that the miracle question was significant and all the therapists were asked to use it. Lipchik et al. (2012, p. 15), in reviewing how SFBT developed, wrote: "... soon it became evident that the miracle question added a new dimension to therapy: a future orientation and an opportunity for people to build on their hopes and dreams for solutions, not only past and present strengths and resources."

In summary, then, by the mid-1980's, de Shazer was describing the client's problem as a room with locked doors, and the role of the crystal ball technique (and by extension the miracle question) as a useful way out:

... the most useful way to decide which door can be opened to get a solution is by getting a description of what the client will be doing differently and/or what sorts of things will be happening that are different when the problem is solved, and thus, creating the expectation of beneficial change. The client's language while describing some alternative futures and the details of the differences after solution seem more important than the details about the locked room of the complaint. With possible alternative futures in mind, the client can join the therapist in constructing a viable set of solutions (1985, p. 46).

Again and again, when talking about goals, the crystal ball technique, and the miracle question, de Shazer came back to Berger's theories. He believed that it was the expectation of change happening that made change happen:

When a goal is defined, the expectation of a different, more satisfactory future starts to develop and behavior changes in the present become possible. The future is made salient to the present; thus, the goal and the consequences of its achievement can "determine" or shape what happens next (de Shazer, 1985, p. 94).

It is interesting to note that at the same time de Shazer was developing his thinking around the crystal ball technique and miracle question as a way for clients to construct and experience a desired (changed) future, he was also writing about homework tasks ("interventions") given at the end of a session as being a useful way to help clients experience change:

Our efforts to understand how the interventions described above worked [the authors had described "4 useful interventions" in their paper] revealed that they have one quality in common: each attempts, in some way, to help the clients experience changing (de Shazer & Molnar, 1984, p. 303).

So, according to de Shazer in the mid-1980's, therapy practices that allowed clients to experience changes seemed to contribute to solution development by changing the problem-saturated expectations they held at the beginning of therapy into expectations of more satisfying lives.

¹⁷ Another version of the invention of the miracle question has Jim Wilk, a resident at BFTC, observing Steve de Shazer using it for the first time in the mid 1980's (Lipchik et al., 2012).

Developing a theory about solution-developing interviews, the briefer maps. By 1988 and the publication of his third book, *Clues: Investigating Solutions in Brief Therapy*, de Shazer was continuing his shift of focus to the increased importance of the interviewing process itself in solution development. Based on ongoing observation of therapy sessions in the mid to later 1980's, he had realized even more persuasively that therapeutic change cannot all be put to the interventions in the end-of-session message. This realization complicated his theory development project. As he stated, "Let's face it, interviews are a mess and therefore studying them is equally messy" (1988, p. xiv). Nonetheless, he set about studying what the various team members shared in their solution development interviewing. He wrote: "Each member of the BFTC team has a different style and a different way of implementing the model. And yet each member of the team will say we are 'doing the same thing!'" (1988, pp. xiv-xv).

Consequently, de Shazer embarked on mapping the "same thing" the team members at BFTC were doing in their solution development interviews. He saw this project as a theory development project because: "Theory, as I use the term, is not meant as an 'explanation,' but rather as a coherent 'description' of specific sequences of events within a specific context" (1988, p. xiv). The sequences of events he wished to describe were "the various (interviewing) pathways from 'complaint' to 'goal achievement' and 'solution' that cases predictably tend to follow" (1988, p. xviii). De Shazer also realized he had to be rigorous in this effort: "Theory construction demands that the resulting map, have a high degree of rigor. It is not enough that one step logically follows another: these steps need to follow each other predictably" (1988, p. 15).

It was apparent upon observation that different therapists at BFTC were often making similar decisions. For instance, if a client described at the beginning of a session that things were already better, there was a high probability that the therapist would follow-up with questions about what was different, what the client had done to make the change happen, and what the client needed to do to maintain the progress. These types of decisions can be mapped:

IF: exception or pre-session change is described,

THEN: there exists a high probability that the therapist will ask: "How did you do that?"

Many cases were found to follow a similar pathway: Problem talk → Interviewing for Exceptions → Asking the Miracle Question → Asking about Pieces of the Client's Miracle Already Happening → Consultation Break → Feedback and often a Homework Task suggesting that the client(s) continue to do what they were doing, and/or observing further progress, and/or observing for what the client did to maintain the progress already made.

Other cases proceeded along different pathways. For example, one could be a session where the client would start by saying that there was no problem and, despite efforts by the therapist all through the session to get some sense of what the client wanted, nothing would emerge. In this pattern, it was highly predictable that the therapist would end the session with "compliments" only (de Shazer, 1988, pp. 87-88). It was also predictable that during this type of session the therapist would inquire if someone else had sent the client to therapy, who that was, and what that person wanted to see happen as a result of therapy.

The central map (i.e., the theory) changed as practice at BFTC changed. For example, once pre-session change had been discovered and described, it changed the pattern of first sessions because therapists now tended to start sessions searching for change that had already happened. The previous talking about the problem at the beginning of the session fell more into the background as the therapists at BFTC started trying to develop descriptions of progress and change already at the beginning of the session, and then working to keep the changes already happening going.

In reflecting on the "CENTRAL MAP," de Shazer wrote:

As a result, the structure or family tree that we have developed for looking at interviews has given us a tool for disciplined observation and description of the resemblances among interviews in spite of their apparent diversity. This has helped me in my theory construction project which, in turn, has helped us to understand what it is we do (1988, p. xvii).

As the clinical work at BFTC changed and became simpler, the central map and the accompanying computer program changed. The different iterations of the computer program were named "BRIEFER I" and "BRIEFER II" (de Shazer, 1988, pp. 14-19, 41-45). A third version Briefer III was never published and has survived only on a few peoples' computers that still run Windows XP. In Briefer III, between 80 and 90 per cent of de Shazer's task suggestions could be predicted by the program. The program itself contains only 16 rules (de Shazer, personal communication and demonstration of the program, Sept 1988). The version showed to Harry Korman was for research and demonstration purposes only. When Harry asked de Shazer if he had thought about commercializing the program,

de Shazer answered that it was too much hassle and that if the program was to be used clinically the questions about legal responsibility were unsolvable.

Theories about therapeutic change. What is change? This question looks simple enough until one tries to answer it. Is change just doing something in a different way? Or, is it thinking differently about a situation which then prompts different behavior? Or, is it being able to do something today that one could not do yesterday which then leads to feeling successful and telling someone about the success and then being able to do it again? Or, is change all of these things and possibly many more?

Nunnally et al. (1986), in an article about therapeutic change, described how they tried to apply different theoretical models of understanding to their observations of client change at BFTC. They considered: (a) the notions of first and second order change proposed by MRI (Watzlawick et al., 1974), (b) the continuous change/discontinuous change frame suggested by Prigogine et al. (1972) and by Dell & Goolishian (1979), (c) the distinction between homeostasis and morphogenesis (Maruyama 1963; Wilden, 1980), and d) the concepts of catastrophe theory (Thom, 1975). The BFTC authors indicated that none of these theories fit their experience or observations very well. Instead, they preferred to stay with the basic understanding that they had held for several years: "For us as brief therapists, influenced by Milton Erickson, it is perhaps easiest to think about 'change' as ... whatever happens that makes the client's life more satisfactory and to let it go at that" (Nunnally et al., 1986, p. 88). In addition, many of the therapists at BFTC long held a Buddhist view of change "...that change is constant and that stability is an illusion". This Buddhist view did fit their observations of clients reporting pre-session change, exceptions to problems, and progress between sessions. As they wrote: "we ... worked to keep these changes going and ... this approach led to increased client satisfaction and fewer sessions per client" (Nunnally et al., 1986, p. 90).

So, regardless of all the different theories about change; change is either satisfactory to the client or it is not. In the end, therefore, the BFTC authors concluded the following about change:

Any behavior that is seen as new or different can be used as part of the therapeutic construction of a solution. It does not need to be a bit of behavior that is seen as part of the complaint pattern. Even if the new behavior first occurred before the first therapy session, it can be labeled as the start of the solution. Thus, any difference can be developed into a difference that makes a difference as long as the new behavior (or newly perceived behavior) is „sacramental“, i.e., is perceived [by the client] as an "outward and visible sign of change."

Clearly, any theory of clinical change needs to include the influence of the observer, i.e., the Heisenberg hook. Although the process of change can be seen as constant, the therapist/observer's influence is part of what makes for the distinction between a) differences that make a difference and b) those differences which make no difference (Nunnally et al., 1986, p. 90).

How does brief therapy create change? Scanning de Shazer's writings for his answers to this question soon becomes confusing and overwhelming because he developed so many theories about the topic. In 1988 he wrote the following about his attempts to develop answers to how brief therapy creates change:

During the past 20 years of doing, studying, thinking about, and observing brief therapy, I have devised about 1,000 different descriptions [theories] of how brief therapy works. That is roughly one construction for every 10 cases. Along the way, I have found out that I never know what I think until I see what I write and how I write it. This has allowed me to throw away some of the more obviously stupid answers.

The answers that I thought held up best (the ones that more closely approximated a good answer!) I have used as material for articles, books, and more recently, expert systems (e.g., de Shazer, 1975a, 1978a, 1979a, 1985). But just when I have one that I think is the best, the clearest, the most comprehensive and most general, something happens that leads me in another direction. Therefore, today's answer is only for today; tomorrow it might change, or it might not (de Shazer 1990, p. 92).

While the above quotation is from a 1990 publication, that publication is a reprinting of an address given by de Shazer in 1988 at the Fourth International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy in San Francisco, California. It was in that address that he gave his most detailed description to date of how he thought brief therapy creates client change. He began this description by reviewing ideas he had introduced earlier in the 1980's,

namely, creating an expectation of change through BFTC's new interviewing techniques and having clients experience change through home-work tasks or experiments suggested in the end of session interventions. However, as he continued his description in the address, by 1988 he had expanded these ideas in ways that anticipated where he would take his theory development project in the 1990's and beyond.

As we described in our previous section on the crystal ball technique and miracle question, the complaints clients bring brief therapists seem to be constructed on a simple premise: whatever it is they are complaining about "always happens." By 1988, de Shazer was beginning to develop this point more fully by focusing on the language clients use when they describe their own and others' problems: Couples often will say "we always fight," or parents say "our children are always misbehaving," or the individual client so often uses language like "I am depressed," or "I am an anorexic," or "she is a schizophrenic." As de Shazer wrote: "Regardless, clients have had the bad luck of talking about things in a way that leads them into constructing the complaint as a situation involving a steady state. It is locked into the words they use, i.e., 'I am' and/or 'It is' and/or always" (1990, p. 94). Then, drawing on Wittgenstein (1958; 1968), he pointed out that this way of talking leads one to equate whatever follows the "I am" with "something immutable or unchangeable, such as, 'I am a male,' or 'I am a Swede. ... [and in using] analogous grammar in different sentences ['I am anorexic' and 'I am a Swede'], we (perhaps unconsciously) expect them to have analogous meanings" (pp. 94-95). In other words, the grammar clients regularly use plays a major role in rigidifying their perception of their problems.

De Shazer (1990) then made an argument for exceptions as poking a hole in the client's "it always happens" frame of reference:

As I see it, inventing exceptions pokes holes in the clients' frame ('I am this' or 'It always happens') so that they can see through it: The complaint rule is deconstructed so that its immutability is undecidable: The 'I am a flasher' rule changes into something else, perhaps: 'I sometimes expose myself.' The 'sometimes' in this sentence is very strong. It is difficult to even unconsciously hear the sentence as analogous to 'I am a male.' This deconstruction prompts clients to at least begin to doubt their 'it always happens' rule. Once doubt is developed, what is really going on becomes undecidable and a new reality can be constructed (de Shazer 1990, p. 96).

De Shazer by now (1988) was also stating that exceptions leading to client change are not objective phenomena: *It is important to remember that exceptions do not exist out there in the 'real world'; they are cooperatively invented or constructed by the therapist and client talking together. Before the therapist and client talk about exceptions, these times are simply seen as 'flukes' or differences that do not make a difference. It is the therapist's task to help clients make flukes into differences that make a difference. I am continually surprised by exceptions and frequently I let the client see this. Client stories about times when the complaint is unexpectedly absent frequently 'knock my socks off' (de Shazer 1988, p. 96).*

In the conclusion of this important paper de Shazer summarized his thinking this way:

Most simply put, therapy is a conversation between at least two people (minimally one therapist and one client) about reaching the client's goal. When as a result of this conversation clients begin to have doubts about their immutable framing of their troublesome situation, the door to change and solution has been opened. This is the essence of brief therapy (de Shazer 1990, p. 98).

Thus, de Shazer's theory in the late 1980's about how change happens in brief therapy was that the therapist gets the client to doubt the frame "it always happens" through the construction of exceptions that amount to differences that make a difference for clients.

In trying accurately to summarize phase three of de Shazer's theory development project, one cannot do much better than to point out that with the publication of *Keys to Solution in Brief Therapy* (1985), *Clues: Investigating Solutions in Brief Therapy* (1988), and some 25 articles between 1982 and 1989, de Shazer and his colleagues at BFTC had moved dramatically away from a problem-focused brief therapy based on ecosystemic thinking. In the latter's place, he had created a detailed theoretical description for how a solution-developing interview was conducted at BFTC. His publications included session maps for what to do in interviews and guidelines for how to use what had emerged during the session to develop end-of-session messages that included compliments, affirmations of the clients' goals, and standard interventions or tasks designed to prompt clients to look for and/or continue the changes they wanted more of in their lives. If one wanted to learn how to conduct SFBT with clients, one could not do much better than reading de Shazer's books and articles from this phase carefully and then working to put their content into practice.

These sources from the 1980's contain a theoretical description of client change through solution development and, thereby, incorporated one more groundbreaking axiom into de Shazer's theory development project:

- **Axiom 5: Brief therapy is about developing solutions with clients.**

This axiom is meant to capture solution development involving the therapist and client 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. It also involves inviting clients to expand and construct the details of their definitions of a more satisfying future. This axiom reaffirms de Shazer's interactional stance because solution development occurs through the client, therapist, and team (when present) acting as a single system focused on promoting client change. 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.

Phase 4: The Late de Shazer and Wittgenstein 1989-2005: Co-constructing Client Change through Language Interaction

The nymphomania case. Some would call this the period "after the nymphomania case" and some would call it the "post-structural phase of SFBT". By 1989, de Shazer and his colleagues had mapped how solution developing interviews were done. They had a clear view of how solution developing tasks were created and they had described the connections between the information created in the interview and the tasks they suggested to clients. BFTC was crowded with students and practitioners wanting to learn how to do this new form of brief therapy focused on developing solutions, not resolving or solving problems. De Shazer and Berg were getting more and more well-known and were teaching all over the world. Then, in 1989, a woman and her husband came to BFTC complaining about her being a "nymphomaniac". In the woman's view her condition – having an insatiable need for sex – was a symptom of an underlying, very serious problem rooted in her infancy that would require long-term "deep therapy" to solve. When she and her husband left the session, the problem was re-named "insomnia" which was resolved during the two weeks that followed the interview. De Shazer and his colleagues recognized that the change that had happened in the therapy session and the results reported by the clients could not be understood from inside the then current theory of SFBT; that is, the case could not be charted on the maps they had developed between 1982 and 1989. Once again, an "anomaly" had occurred and de Shazer turned to his "hobby" of philosophy and the sociology of knowledge to begin re-describing SFBT, this time through the lens of "post-structural" thinking.

Within a structuralist framework, "nymphomania" certainly cannot slip over into "insomnia." However, within the more recently developed post-structural view of language (Harland, 1987), this is exactly the way words are seen to work (de Shazer & Berg, 1992, p. 73).

And, in the same paper, de Shazer and Berg wrote:

While the predominant structuralist view sees meaning and truth as being behind or within a person, a system, or a structure, another view, called post-structuralism (see, e.g., Harland, 1987), stresses the interaction of people as an activity through which meaning is constructed. Basically, structuralism and post-structuralism involve discontinuous ways of thinking about words, concepts, and meaning (p. 73).

So, in what sense are these two views discontinuous? In the predominant structural view, meaning making is understood as a process happening in the mind of the person. How people interpret and understand what they perceive is an activity that happens in the brain. What people say and how they behave – the "surface" behaviors – are determined by what is going on beneath the surface, inside them. Understanding meaning making this way leads to research about what goes on inside the head of a person.

In the post-structural view – what today is more often known as "social constructionism" (Gergen, 2015) – meaning making is interactional; it happens in the communication between people. Meaning making is a visible process on the surface (i.e. visible and audible communicative actions) and it is going on continuously as people communicate with each other. Understanding meaning-making this way leads to research on the visible and audible interactions between people. Researchers here observe the micro-sequences of what happens in a conversation when people agree or disagree about what to do or think in a particular situation, or how to interpret and describe some experience. In other words, researchers here investigate the many ways the participants in the dialogue reciprocally influence one another.

These phenomena are thought to all play a role in how meaning emerges in the dialogue. De Shazer and Berg call these interactional phenomena the "negotiation" of meanings:

As an example of using language, the therapist-conversation-client unit can be approached in a broad way because whatever the conversation is going to mean to both therapist and client depends on their negotiations (1992, p. 77).

The couple in the nymphomania case, for example, described at the outset of therapy what they saw as their problem. The words they used carried certain meanings to them at the time. The wife said she had an insatiable sexual desire and she could not sleep without having had intercourse. To her, at that moment in the conversation, her desire and difficulties with sleep were signs of being a nymphomaniac. Further, in her view, nymphomania was a symptom of deep underlying problems rooted in her childhood which would require long-term therapy to resolve. The description on the surface; "an insatiable need for sex that prevents her from sleeping" was, to her, the sign on the surface of a deeper reality, namely, "nymphomania". As the session continued, however, an alternative description with its associated meanings emerged. De Shazer and Berg wrote:

The conversation about what is going on here switched to her husband who described her [the wife's] agony about the nymphomania and his tiredness. As he saw it, he was being robbed of the opportunity to be romantic toward her; rather than her lover, he had become just a stud, a sex machine.

Husband: "But for me, it's more of a sleep problem for both of us."

Therapist: "I wonder about that. Maybe we've been looking at this the wrong way."

Wife: "Do you have any cures for insomnia? I'm game."

Therapist: "I don't know. We've been looking at this as a sex disturbance, but it's beginning to look more like a sleep disturbance" (p. 75).

The husband suggested that it was more of a sleeping problem for the two of them. The therapist said that maybe we have been looking at this the wrong way and thus suggested that perhaps the husband was right. Perhaps the need for sex before sleeping was a way to deal with a sleeping disturbance. The wife then asked for a cure for insomnia. On the surface, that is, from how the three people in the therapy room were now talking, the meaning of the daily sexual activities before falling asleep had begun to shift from a clear-cut symptom of nymphomania to possibly being a symptom of a sleep disturbance, or simply a way to handle difficulty falling asleep.

De Shazer and Berg continued about the case:

Throughout the remainder of the session, the therapist kept the conversation strictly on a behavioral level and avoided any further discussion of thoughts, feelings, and meanings. The sleep-disturbance-complaint became solely a "behavioral" or "technical" difficulty around which a solution could be constructed through technical means (p. 77).

So, from this point in the session, the therapist and the couple talked about a problem of insomnia (not nymphomania) and, at the end of the session, the woman received technical advice from the team behind the see-through mirror on some things she might try to "cure" her insomnia.

After consulting with the team behind the see-through mirror, the therapist told the woman about two options:

- 1. Perhaps as an experiment, she could quit exercising for now. This idea was immediately rejected by the woman; or*
- 2. (a) if she found herself awake one hour after going to bed, she was to get up and do hateful household chores like oven cleaning; or (b) if she found herself awake one hour after going to bed, she was to continue to lie there but with her eyes wide open, concentrating on keeping her tongue from touching the roof of her mouth until she fell asleep.*

The second idea was accepted with good humor: Both the woman and her husband burst out laughing. In response, the team called in an additional element: After the evening meal, sometime before he went to bed, her husband was to toss a coin to decide which option she was to use on any particular night" (p. 77-78).

De Shazer and Berg, in reflecting on the case, commented:

What is going on here? The husband offered a different view, a different word/concept that was immediately accepted by his wife and the therapist. We thought we were on safe grounds; language seemed to be behaving itself quite well, but now the woman is saying that she is willing to consider calling her complaint by a different name (p. 76)!

De Shazer and Berg, of course, are joking when they say that “language seemed to be behaving itself quite well”. If language behaved well, which is the usual structuralist view, “nymphomania” cannot slip over to “insomnia”. Thus, the question remains: “What is going on here?”

Misunderstanding. In the same article about a post-structural revision of doing therapy, de Shazer and Berg offered this theoretical description of what happens in therapy sessions:

Clients describe their situation from their own particular, unique point of view. The therapist listens, always seeing things differently, always having different meanings for the words the clients use, and thus redescribes what the clients describe from a different point of view. The possibilities of new meanings open up from these two different descriptions, these two different meanings, when they are juxtaposed. (This is metaphorically similar to the process involved in depth perception (see, “Binocular theory of change” in de Shazer, 1982a). The result is not the clients’ views and meanings and it is not the therapist’s view and meaning but something different from both (p. 77).

In a related publication, de Shazer called this interactional process around client meanings and therapist attempts to understand, “creative misunderstanding” (de Shazer, 1991, pp. 68-69). He proposed that because the participants in a conversation, including clients and therapists, come from different backgrounds and experiences, they can, in a real sense, only misunderstand each other. It is through their language negotiations to reduce the misunderstandings that new meanings and related new pathways to solutions may emerge. So, again, in the “nymphomania case”, the husband misunderstood the wife’s “nymphomania” as a “sleep problem” and the therapist misunderstood the wife’s “sex disturbance” as a “sleep disturbance”. Then, as stated earlier, the therapist’s subsequent work with the couple in that initial session focused on the creative misunderstanding of them experiencing a sleep disturbance and how a solution to this technical difficulty could be constructed including giving a classic BFTC session-ending task. Thereafter, and extraordinarily:

Two weeks after this session, the woman sent a note thanking the therapist and team for seeing that her “insatiable need for sex” was but a “a symptom of my insomnia”. She wrote that “immediately my sleep patterns and my libido returned to normal”. She did not say whether she and her husband ever tried the intervention task (de Shazer & Berg, 1992, p. 78).

Ludwig Wittgenstein. From the early 1990’s until his death in 2005, de Shazer continued to think and write about how the meanings of words in therapy sessions are not fixed and the implications of these shifting meanings for client change. He drew on the work of several philosophers, most notably Ludwig Wittgenstein, to develop his own theoretical descriptions. De Shazer appreciated Wittgenstein’s view of how language works. Wittgenstein did not believe words have essential meanings; instead, de Shazer stated: “Wittgenstein ... points out that the meaning of words is determined by how they are used by the various participants within a specific context” (1991, p. 71). Closely associated to the contextual meaning of words is that meaning is established in interactive dialogue: “... language and speech originate and develop through use, through social interaction and communication” (de Shazer, 1994, p. 51). De Shazer expressed this contextual and interactive character of therapy sessions this way:

For instance, a therapist’s utterance during a particular session is related to all of his previous utterances (during that session), all of his future utterances (during that session), and all of the client’s utterances on a particular subject during that session as well – a situation ... Wittgenstein called a “language game” (de Shazer, 1994, p. 51).

By his use of the term “language game” Wittgenstein was proposing the view that language is better viewed as an interactive activity than an abstract set of essential meanings (de Shazer et al., 2007, p. 109). A bit further on in the same source, de Shazer writes: “What Wittgenstein calls ‘language-games’ can be simply described as slices of everyday life, the home base of words and concepts (p. 110). In the 1990’s and right up until the end of his life, de Shazer came to view and talk about solution-focused conversations as language games which are context specific and where the language interactions can open up new possibilities for clients to create more satisfying lives for themselves. After 1990, it is noteworthy that de Shazer and his colleagues did not add new solution focused techniques to the ones they had invented during the 1980’s. However, drawing especially on Wittgenstein and beginning with the “nymphomania” case, he came to describe what he saw happening through the use of solution focused techniques in a very different way. For example, de Shazer stated about the use of scaling in SFBT:

Unlike most scales used to measure something based on normative standards (i.e., a scale that measures and compares the client's functioning with that of the general population along the bell curve), our scales are designed primarily to facilitate treatment. Our scales are used not only to "measure" the client's own perception but also to motivate and encourage, and to elucidate goals, solutions, and anything else that is important to each individual client. ... Scales allow both therapist and client to use the way dialogue works naturally by developing an agreed upon term (i.e., "6") and a concept (i.e., on a scale where "10" stands for the solution and "0" for the starting point, "6" is clearly better than "5") that is obviously multiple and flexible. Since you cannot be absolutely certain what another person meant by his or her use of a word or concept, scaling questions allow both therapist and client to jointly construct a bridge, a way of talking about things that are hard to describe – including progress toward the client's solution (1994, p. 92).

Like scaling conversations, de Shazer theorized that conversations around the miracle question, what's better questions, exception questions, and coping questions similarly all draw on "the way dialogue works naturally". That is, these solution focused techniques invite clients to construct, in their own language, the alternative futures they want, what already is happening that is better relative to those preferred futures, times when more of what they want is already happening in their lives, and how they see themselves coping when they have all but lost hope of a better future. De Shazer called his theoretical description of solution focused sessions and the shifts in meaning that so often accompany solutions "interactional constructivism" (de Shazer, 1991, p. 48; 76-80). In addition to continuing the use of solution focused techniques invented in the 1980's, de Shazer's interactional constructivism continued to respect what clients said they wanted from therapy, not what the profession was saying clients needed. His interactional constructivism, with its focus on the shifting meaning of words through dialogic interaction, also made very clear the importance of attending to and working with client's everyday language. In this regard, de Shazer regularly reminded those who wanted to be SF therapists and coaches that, in their conversations with clients, they must "stay at the surface" of client words and not hypothesize about what might be going on inside clients' heads or their situations. Finally, his *interactional* constructivism continued the change already begun during the 1980's of viewing the content of the interview as more important in initiating client change than the end-of-session intervention or task. The focus of interactional constructivism is squarely on the language¹⁸ interactions of therapist and client in the sessions—on the solution-focused language game. Tasks, while still offered after 1990, receded into the background and functioned more as session ending summaries of what was interactionally constructed in the therapy session.

Returning to our initial purpose of extracting the axioms in de Shazer's theory development project, we believe he added one more axiom in his 1989-2005 phase:

- **Axiom 6: Therapy is a visible interactional, dialogic process negotiating the meanings of the client's language.**

This axiom is meant to capture de Shazer's view that client change occurs through the negotiation of the meanings that clients bring to the client-therapist system. Words clients use are not essential or fixed in meaning, but negotiable through therapist-client conversations about what clients might want, positive client change already happening in clients' lives, and what additional progress toward more satisfying client lives might look like. 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 (i.e., depression, anxiety, nymphomania, sleeping problems etc.). That is, for most therapies in the field, client problems and their related treatments are largely thought to have a definable existence separate from clients and what clients might say about them.

This axiom is also consistent with the axioms identified with de Shazer's earlier theoretical phases. The negotiation of meanings is a visible process and continues his emphasis on describing the construction of solutions from what can be directly observed in the therapy room. Shifts in meaning occur in the language interactions of the therapist-client system as they cooperatively work to construct solutions around the client's goal(s) for a more satisfying life.

¹⁸ Language is not only words. Shrugging your shoulders, rolling your eyes, facial expressions etc. are all part of language.

Conclusion

We hope that this paper has challenged the myth that SFBT has no theory. If so, our purpose in writing it has been achieved. In reflecting on our attempt to condense de Shazer's writing we are amazed at the creativity and richness in his theory construction. He began by viewing Erickson's, and then later BFTC's, therapy sessions through the lens of several existing theories in the field. When these theories could no longer capture what he and his colleagues were observing in their therapy sessions, he set aside those conceptualizations and developed other theoretical descriptions. In the process, he deconstructed many entrenched theoretical constructs in the family therapy and broader psychotherapy field and several times reformulated his own descriptions of client change and what clients and therapists do together that is useful in promoting client change. At the time of his death in 2005, his descriptions were clearly postmodern, focusing on the language interactions between therapists and clients. In our view, he left a legacy of 6 enduring theoretical axioms of inviting client change through the practice of SFBT developed over more than 40 years of thinking and writing. In the time order in which they were developed, these axioms of SFBT are:

- **Axiom 1: Therapy is an observable interactional process, that is, a conversation.**
- **Axiom 2: The minimum unit of analysis is the therapist interacting with the client in the therapy setting. This unit cannot be subdivided further.**
- **Axiom 3: Change is the purpose of the therapist and client's meeting.**
- **Axiom 4: Client change via therapy occurs through observable interactions in which the therapist finds ways to cooperate with the client.**
- **Axiom 5: Brief therapy is about developing solutions with the client.**
- **Axiom 6: Therapy is a visible interactional, dialogic process negotiating the meanings of the client's language.**

In reflecting on what we have conceptualized as de Shazer's four phases of theory development, we are especially struck by two things. The first is his method of theory construction. We have written about his and the BFTC team's view of the recursive relationship between practice, research, and theory. It is obvious in his writings that de Shazer never strayed from this approach to knowledge development, and it is noteworthy that he privileged the direct observation of practice as the source of discoveries that led to the descriptions of the innovative and distinctive SFBT techniques of doing solution focused brief therapy that we have today. Time and again, throughout his four phases, it was a direct observation of something that happened in the therapy room between the therapist and the client that got the team thinking differently and developing a new research project to test the usefulness of the new discovery. The theory, then, followed from that.

The second thing about de Shazer's theory development project that jumps out for us is that he developed an interactional theory of what is happening between therapists and clients. In this regard, he is clearly in the minority among practitioners and theorists in the psychotherapy field. The field generally remains a problem solving one; that is, focused on assessing client problems and developing related interventions. Enormous energy and other resources are devoted to developing typologies of problems, clients, and families. These typologies are meant to give direction to therapists in their interviewing and development of interventions. It is striking that de Shazer's theory development project and the resulting SFBT have added no typologies or categories of clients or problems to the field. De Shazer did not even attempt to categorize client strengths or types of solutions. SFBT is solely focused on what is jointly constructed in the interactions of therapists and clients that is useful for client change. At the time of his death, he was continuing to theoretically describe what is happening in the language interactions of therapist and clients.

Since de Shazer's passing, new research in the microanalysis of therapy conversations is continuing de Shazer's interactional focus and expanding it to other aspects of therapist/client interactions (Bavelas, De Jong, and Smock Jordan et al., 2014; De Jong, Smock Jordan, Healing, & Gerwing, 2020; Korman et al., 2013; Smock Jordan et al., 2013). These studies which are based on direct observation of client/therapist interaction offer empirical support to de Shazer's interactional constructivism. They also indicate that the co-constructing of meaning is a feature of all therapies, not only post-modern ones. Although the meanings co-constructed by therapists using different models are different, all therapists employ the same, directly observable interactional processes to influence the direction of their sessions consistent with what they believe is most helpful to clients.

So, we believe de Shazer made significant theoretical contributions throughout his career. We also believe both his recursive method of developing theory and his interactional constructivism will endure. If we continue to follow the example he set in these regards, we believe our field will be the stronger for it.

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ARTICLE

Back to Basics: A Solution Focused Take on Using and Teaching Basic Communication Skills for Health Care Professionals

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Abstract

This project proposes that immediately teaching health care professionals basic communication skills in a Solution Focused way will provide therapeutic benefits for both client and care provider. Firstly, this article focuses on the development of a small set of core principles for Solution Focused work, easily explained to any audience. Secondly, it addresses the question “how can basic communication skills be applied immediately in a Solution Focused way?”

Keywords: Solution Focused therapy, basic communication skills, teaching, nursing, midwifery

Introduction

“The map is not the territory” (Korzybski, 1996).

Communicating effectively is far from simple. The complexity of communication is in the influence and balance of the words used, the way they are combined¹, the context they are used in, and how non-verbal signs and cues influence the overall meaning and interpretation of the recipient(s). When we try to shape our communication towards certain goals, e.g., in a professional relationship, it gets even harder to achieve that goal, despite our sharpened attention towards achieving good and clear communication.

Communication is a means towards achieving the most diverse ends.² Looking through a Solution Focused lens, communication is a tool used within a therapeutic relationship to work with our clients towards therapeutic goals they

¹ Eg. Wittgenstein’s concept ‘language-game’ (Wittgenstein, 1976) or Niklas Luhmann’s concept ‘semantic cluster’ (Commers, 2004).

² There is a Kantian remark to be made that within a Solution Focused vision on therapy communication, understood as the privilege to engage and be allowed to keep engaging in conversation with a client, is not a ‘means to an end’, but ‘a goal in itself’. Speaking from virtue ethics this imbues the activity of ‘conversing’ with immediate moral value (Gardner, 1999). Similar ideas were later on developed by, among others, Emanuel Levinas (Cohen, 1985) and many current time care-ethically inspired moral philosophers (see e.g. Vanlaere et al., 2012).

set. While the therapist³ manages the process of communication and the words they⁴ use to direct that process, the process is always directed by the goals of the client. The client is the expert of their own life, questions, and problems. The therapist is merely expert in the process of enabling the client to search for and realize what their actual needs are and enabling the client to discover the solutions inherent within them.

This kind of Solution Focused take on the therapeutic process allows the professional to help the client help themselves.

Realizing that communication is such a complex endeavor, we need to be sure that engaging with clients, session after session, is worth the trouble. Lambert (1992) made clear that 45% of what determines if therapy, or in essence ‘talking to clients,’ is actually effective and helpful is the quality of the therapeutic relationship. In other words, the quality of the connection established between client and therapist combined with the extent to which clients believe that ‘talking to the therapist will be helpful’ –placebo effect in communication – will determine the benefit from engaging in the process. To build a good therapeutic relationship, we have to navigate into the unclear waters of interpersonal communication.

Many models already exist that claim to effectively direct the process of therapeutic communication. The Bruges Model of psychotherapy (Isebaert, 1998; 2016), which is situated within a Solution Focused vision on professional communication, already provides some answers to how the therapist can direct the process. Most important, the Bruges Model provides an answer to questions regarding both timing and nature of interventions directed towards the client.

The Bruges Model offers guidance for making the right intervention at the appropriate time within the process of creating change through conversation. Good timing is achieved by constantly reflecting on the nature of the relationship between client and therapist. So called ‘non-engaged relationships,’ in which the client does not have any clear goals of their own, would ask for a different conversational strategy than ‘consulting’ relationships, where client and therapist are both working towards clearly defined and realistic goals (Isebaert, 2007).

Communication is more than a means to reaching the goals stipulated by the client. Any form of communication takes place within a relational context and influences the relationship between those communicating (Watzlawick et al., 2011; Struiving et al., 2017). Many health care professionals who come into contact with Solution Focused work for the first time have already acquired basic communication skills, often both in their preliminary training and through years of professional practice as nurses, midwives, psychologists, MDs, and more. Training, both at bachelor’s and master’s level that leads to a qualification as health care professionals, often starts with teaching basic communication skills such as active listening, summarizing, and reflecting on feelings. Often these basic communication skills are thought of as pure techniques and not explained by starting from a clear vision on how communication works in a therapeutic setting.

The gain for both client and therapist when the process of ‘talking to clients’ immediately starts from a Solution Focused vision has already been clearly documented in research (e.g., Duncan, 2010). As one of the founding fathers of Solution Focused therapy, de Shazer is often quoted as saying ‘If something works, do more of it’ (de Shazer, 1994). Building on this premise, this project hypothesized that immediately teaching health care professionals basic communication skills in a Solution Focused way could provide additional therapeutic gain for both client and therapist.

Aim

This paper has two main aims:

1. To generate additional therapeutic gain for both client and therapist, starting from the idea that focusing on creating a good therapeutic relationship helps generate additional therapeutic gain even in short-term or with single-contact interventions. A Solution Focused approach can help therapists achieve these additional gains.

Teaching a Solution Focused approach, applicable to any welfare and healthcare profession, gives rise to the question, what elements are the building blocks of professional conversations in these different settings? That common denominator is basic communication techniques. By applying these basic communication techniques in a Solution Focused way, any welfare and health professional can generate a therapeutic relationship with

³ For the purpose of this paper the concept ‘therapist’ is meant to encompass any health care professional entering into a professional relationship with a client/patient.

⁴ Therapists can be of all genders and can be gender non-conforming. The same is also true for clients. Throughout the course of this paper, for purposes of style and uniformity, we will refer to ‘the therapist’ and ‘the client’ as ‘he’.

the client more quickly, leading to additional therapeutic gain. This calls for the development of basic Solution Focused communication techniques.

2. How to teach these same techniques to such a diverse group of professionals and, in the end, reach the same added value? This paper therefore also aims to give an overview of how basic communication techniques can immediately be applied in a Solution Focused way. These theoretical and practical insights can then be combined to create a general template, a teaching tool aimed at introducing these new techniques both in higher education settings as well as in post-graduate professional trainings.

Developing Solution Focused Basic Communication Techniques

Developing a package of Solution Focused basic communication techniques comes down to asking if basic skills like summarizing, reflecting on feelings, can be done in a Solution Focused way? This in turn echoes the need for a simple and concise version of the core ideas of Solution Focused practice, matching the level of basic simplicity of the previously mentioned basic communication techniques.

Solution Focused Practice in a Nutshell

Always Start with the Client

In any situation or setting, the client always is the greatest expert of their own life. They are the expert with regards to both their strengths and successes concerning their problems. Starting with the client, activating them to tell their story, allows them to further connect to their current reality, helping to make the therapeutic process run smoother. 'Go fast by going slow' (de Shazer, 2002), and always engaging your client from a not knowing stance⁵ (de Shazer & Dolan, 2009).

De Jong and Kim Berg (2007) also point to a 'not knowing stance' as the most important mindset of any welfare or health professional. They start from the idea that the therapist can never know the meaning and contents of the experiences and actions of the client beforehand. Therefore, the therapist has to start from the story, vision and explanations of the client.

The Korzybski Institute's view on life sees our existence as a complex web of interwoven habits: big habits and small ones flowing over one another in a never-ending spiral towards inevitable change.⁶ Each habit in itself is viewed as a combination of four factors, namely:

- Logos - cognitions, semantic reality of the client
- Pathos - emotional reality of the habit
- Ethos - habitual' behavior
- Oikos Oikos habitual' context (Isebaert, 2007).⁷

These components define different aspects of the habit. The habit itself is experienced as a whole, as undivided. To effectively help our clients it is vital to have a very detailed understanding of all of these components of the habit, not in the least the Oikos, the context which simultaneously is both the space that co-constructs the habit itself and is the space in which the habit takes place. Start with the client. Only they know their habits inside out. By inviting the client to clarify all aspects of their habits the process of creating change through conversation is already set-in motion as this process often leads clients to a better and more differentiated understanding of their own habits.

⁵ The idea that starting from the premise of not knowing can help one to arrive faster at true knowledge stems from a Socratic stance in philosophy (Taylor, 2001). Within the Solution Focused vision on therapy the Socratic stance on 'true knowledge' can be replaced by the actual reality and habits of the client.

⁶ The idea that change is inevitable most likely stems from the pre-Socratic theories of Herakleitos (2014). His philosophical legacy is only known through citations and anecdotes, identifiable within the texts of others such as Plato, who attributes the known quote 'Panta Rhei', literally translated as 'everything flows' to him (2014).

⁷ This view on the structure of habitual behaviour has firm roots in cognitive behavioural therapy (eg Margraf 2003) and finds its origins in Aristotle's 'Retorica'.

In closing, starting with the client makes sure that the client will feel validated as being the expert in matters of their own life, placing them immediately on the same height as the therapist who is also an expert, albeit not with regard to the client's life but in regard to the process of communication as a way to direct the inevitable change occurring through conversation in such a way that is helpful for and/or desired by the client.

Make Room for All Positive Things

Solution Focused practice starts from the idea that every situation still contains aspects that can be viewed as positive by the client, when pointed out by the therapist. Often clients have become overwhelmed by the events in their life, making it hard or even impossible for them to not experience their current situation as solely made up of negatives. Positive aspects of their current situation no longer register on their radar. This however does not mean that there are no aspects of their day to day lives in which they show commitment to things not getting worse or even to things getting better in their lives. These could be called aspects of the client's life that are positive because they are oriented towards the client's own goals and wellbeing. Once the therapist deliberately directs their attention to these aspects and invites them to see these aspects of their lives in a positive light.

Solution Focused practice focuses on doing what works. What works in therapy is making a true connection, creating an alliance between client and therapist (Lambert, 1992; Duncan, 2010). Combining these two premises leads to a simple rule of thumb: when talking to clients, make room for the positive⁸. Making room for the positive aspects in the client's current situation, no matter how small, is always possible. Any, even the most traumatic situations, still contain positive aspects. A mother who gave birth to her stillborn child (mors in utero) just gave birth in impossible circumstances and still succeeded in showing perseverance and courage. The 16-year-old telling you that he stood there, yesterday with a box of pills in his hand ready to take them all at once, is today sitting there with you, telling you about it, having decided not to die.

Making room for the positive elements in the client's story of what has come to pass or is happening in their current life creates connection between therapist and the client. This can be the start of a process that changes the client's way of looking at their life at that point, re-orienting them from solely focusing on the problematic and enabling them to start to see the positive aspects once again. Connecting these positive elements to the client's own skills and resources is a first step towards installing a feeling that the client themselves has the ability to bring about positive change in their life.

Every Client Holds (the) Solution(s) for His/Her Problem

Life is a chain of choices, some made through conscious deliberation and reflection and others made unaware, on autopilot. So, any situation and any client still have a certain degree of free choice. Clients experiencing problems of any kind often lack the capacity to imagine the behavioral and/or cognitive options that enable making helpful choices which could lead to the client's desired change. Once the therapist assumes that any client walking through the door holds at the very least the basic building blocks for a possible solution to their current problematic situation, it means that it is no longer the therapist's responsibility to offer solutions for the current problem to the client. They view the client as the expert of their life as it now is, and their life as they desire it to be. The therapist is the expert of the process of 'getting from here to that desired future. This is one of the basic premises for The Bruges Model for Psychotherapy (Isebaert, 2016).

Offering solutions would be extremely difficult, especially if one realizes the client themselves, not the therapist, is the expert as far as their life, including their problems, are concerned. The sole responsibility of the therapist is to help give shape to the process of therapy through which it can become apparent to the client that they can make other choices, that they do have skills that they do not remember, or to develop new skills when necessary.

⁸ The concept 'the positive', used throughout the article is not merely the 'happy' elements of the client's life, but actually serves as a container term for those aspects of the client's desired future that already exist in the present, the client's motivation at this point in the process, resources the client has, etc. The concept 'the positive', used throughout the article is not merely the 'happy' elements of the client's life, but actually serves as a container term for those aspects of the client's desired future that already exist in the present, the client's motivation at this point in the process, resources the client has, etc.

Results

Basic Communication Skills (BCS)

What are the core communicative techniques that form any welfare and healthcare professional's basic communication skills? Which techniques form the basis of any 'helping' conversation?

A literature review was conducted, focusing on communication skills textbooks published in Dutch and describing themselves as covering basic communication skills. Most of these textbooks list what they see as basic communication skills and are in line with De Jong and Kim Berg (2007) who describe the following list of basic communication skills, immediately situated within the Solution Focused tradition:

1. Solution Focused listening - hearing the client's story and sticking to their lived experience of events rather than our interpretation of experiences
2. showing attention through non-verbal behavior of the therapist
3. echoing keywords in the client's story
4. asking open ended questions
5. summarizing thoughts, actions and feelings
6. paraphrasing
7. using silence
8. observing the client's non-verbal behavior
9. Self-reflection - the therapist introducing feelings, thoughts and behavior of the client into the conversation
10. building the process - building the process that the therapist and client will go through together and deciding which intervention is appropriate, and when
11. complimenting on personal qualities (strengths) and previous success (experiences)
12. confirming the client's perceptions
13. empathy - tuning in on the client's feelings, the underlying meaning to these feelings and responding in an appropriate way)
14. keeping the focus on the client
15. encouraging solution-talk (De Jong & Kim Berg, 2007).

Most of these basic skills are found in all of the general communication skills handbooks, while others are specifically part of a Solution Focused approach to communicating with clients. When we apply the core of Solution Focused practice as a filter to separate the general communication skills from the ones that are specific to a Solution Focused tradition, and one also takes into account several other manuals on communication skills in the healthcare sector (e.g., Brunklaus, 2015; Knipsel et al., 2015; Struiving et al., 2017), one finally comes to the following list of basic communication skills:

1. echoing,
2. summarizing/paraphrasing
3. reflecting feelings
4. eye contact
5. concretizing

These five communication techniques can be seen as absolute basic communication skills required. They form the basis of any helping conversation. ⁹These five techniques will be framed below within a solution focused framework. When thinking and applying these skills this way, these basic skills will immediately yield a gain in alliance between therapist and client.

A Solution Focused Take on Basic Communication Skills

The above described how communication skills are used to have sessions go as well as possible for both the client and the therapist. What follows is a description of how each of these basic communication skills can immediately be used in a Solution Focused way in any helping conversation.

⁹ For more background on basic communication skills see e.g., Bauer (2006), Goleman (2006), Knispel (2015), Hasson (2017), and Vogel et al. (2018).

The Parrot-Technique/Echoing

Seligman, the father of positive psychology, introduced the term ‘learned optimism’ (Seligman, 2002). Positive psychology emphasizes the strength of the client. Positive psychology starts from the assumption that feeling good is not the result of ‘the right genes’ or blind luck but rather the consequence of identifying and putting to use resources the client already has like kindness, humor, optimism, and openness. Erickson adds to this his vision of man as holding a vast well of wisdom. The craft of the therapist is to bring these strengths already present in the client to the surface so they can create desired change (Rossi, 1980).

Second, Erickson emphasized the competencies of the client. He deemed it necessary to look, together with the client, for opportunities to put the wheels of change into motion by themselves instead of tailoring the therapeutic process to diagnostic criteria (Rossi, 1980).

One of the many techniques the therapist can use in this regard is the parrot technique - repeating, in the same words, short statements made by the client (Isebaert, 2007). The parrot technique is in itself already Solution Focused because it fixes the client’s attention on the constant focus of the therapist on the client’s story. An extra dimension of Solution Focused gain can be achieved if the therapist does not echo client statements at random but instead deliberately repeats positive statements made by the client. The therapist can choose to parrot the positive elements within the often predominately negative story of the client. These positive elements could be anything ranging from strengths of the client, client successes, strengths in the client’s system or even broader context. This way of using the parrot technique fixes the client’s attention on the constant attention of the therapist to the client’s story and focusses the attention of both client and therapist on the client’s strengths and resources. By consciously parroting those elements the therapist deems useful for the therapeutic process, parroting both strengthens the alliance with the client – see the core of the Solution Focused vision and becomes a small extra step in the therapeutic process. It makes a start in changing the client’s outlook on their current situation, helping them realize that they can view their lived reality in a more positive light, and that they do hold various strengths within themselves that they can tap into during therapy to start making those changes they desire.

Summarizing/Paraphrasing

In the Solution Focused view on creating change the client is seen as expert of their life, problems and possible solutions, with the therapist focusing on competences, possibilities and strengths instead of limitations, shortages and weaknesses. Isebaert (2007) emphasizes that central to the Solution Focused view is creating a context of freedom of choice in every session, thus enhancing client-autonomy. It is about creating a repeated process of the client, making choices of their own, and on their own making more functional choices, more desired choices and by doing so regaining control of their life little by little. Ultimately, within a Solution Focused framework the client is seen as a motivated individual, wanting change and possibly needing help to find the desired direction for change (Evans, 2013).¹⁰

We start from the assumption that even when ‘just summarizing’ the therapist can create an additional layer of client autonomy and free decision-making¹⁰. We aim at creating as many opportunities as possible for the client to practice their autonomous decision-making within the therapeutic process. As Isebaert (2007) stated, the client is already free to choose whether they come into therapy by themselves or with significant others, which goals we will be setting in each session, and in which order they need to be addressed. We would take this one step further by incorporating the client making autonomous decisions on a micro level within the conversation. This can be done by asking the client’s permission to summarize what has just been shared. By presenting the client with the choices if it is ok or not to summarize, the therapist shows respect and appreciation towards the client and their constant contribution to the therapeutic process. When we incorporate client autonomous decision making on a micro level within the conversation itself, we as therapists instill the client’s decision-making competencies into the core of the therapeutic process. In this way the sessions themselves become a constant practice ground for the client to actively make decisions and experiences

¹⁰ Making the technique of summarizing solution focused within itself as is suggested in this paragraph can be seen as another approach towards the possible negative effect of summarizing voiced by clients who feel that therapists summarizing comes across as criticism. Instead of not summarizing at all the therapists makes sure that the summarisation does not have negative effects, moreover, it is used as one more way to install solution focussed gain throughout the session.

over and over. They are free to make choices and have their choices, once made, respected. It bolsters client autonomy when the therapist actively gives the client the choice to decide whether they feel it is a good time to summarize or not, or even if they feel like summarizing themselves? What would they want the therapist to see as the most important points thus far? This rise in client autonomy and choice-aptness bolstered on a micro level strengthens the alliance and offers clients small, simple practice chances in autonomous decision making with a maximum success rate.

Acknowledging Feelings

It is central to the Solution Focused way of looking at the client's problems that significantly less time is spent figuring out possible causes or explanations for the client's psychopathology. This stems from the assumption that psychopathology is a collection of symptoms that together form the best way possible in which the client still succeeds to keep their proverbial head above water. Starting from this idea, creating a context of ample freedom of choice inevitably brings about change through the renewal of the choice process, where people will always choose those options that cause them less distress or suffering when they see multiple ways of dealing with current life challenges. Thus, it becomes interesting to know what other attempts the client has made to create change and most of all, what/when this brought about positive change (O' Hanlon & Weiner-Davis, 1989). Often three rules of thumb are maintained in this process:

- if something works, do more of it
- if it is not broken, don't try to fix it
- if it doesn't work, quit and try something else (Carpenter, 1997; De Bisscop, 2018).

Within the Solution Focused framework problems are viewed as nothing else but well-intended, albeit failed, attempts to solve problems instead of viewing them as symptoms within a larger framework of illness and dysfunction (O' Hanlon & Weiner-Davis, 1989; Evans, 2013). Problematic attempts of dealing with problems can be related to not doing things that should have been done (problem-denial) or just the opposite - having done things that should not have been done, whilst striving for an ideal and desired situation. On top of this humans are creatures of habit. The formation of habits serves the function of creating and maintaining the illusion of stability in an ever-changing world. Non-functional solutions are repeated over and over and form self-reinforcing patterns of action, thought and feeling which ultimately lead to situations growing ever more problematic (McKeel, 2003). For instance, in The Bruges Model of Psychotherapy clients are seen as actors, constantly making the best possible life choices based on the information they perceive at any given point in their life. Therapy then becomes the process of making new information available to the client, both by shifting their gaze on their current situation, for example by exploring the client's desired future, searching for situations in which aspects of the desired future are already present, as by providing new input as a therapist, so that the client can then make new, less problematic life choices (Isebaert, 2016).

Virtually any package of basic communication skills places importance in learning to paying attention to emotionally charged behavior or clearly expressed feelings on the part of the client during sessions. This practice is commonly referred to as acknowledging feelings (Knispel, 2015). Looking at this technique from a Solution Focused point of view, we can stipulate two dangers when acknowledging feelings during session. On the one hand, when acknowledging negative feelings, you run the risk of enhancing these feelings by emphasizing something that is difficult for the client at that given time. This could be viewed as a light version of the broadly accepted risk of re-traumatization, when asking trauma victims to recant their traumatizing experiences to the therapist in session (Sweeney et al., 2018). The second risk in acknowledging feelings is that the therapist runs the risk of positioning himself above the client - I'm feeling fine and you're not (Le Fevere de Ten Hove, 2016).

Starting from a Solution Focused framework acknowledging feelings is only helpful when it either strengthens the alliance, enhances the client's autonomy and decision-making skills, or gives room to client's resources or positive elements in their story. Students often try to acknowledge the client's feelings in a very basic way (e.g., I can see that this makes you feel bad), often followed by a respectfully intended silence, leaving room for the client to fully experience his emotions at that moment. From a solution focused point of view this basic approach is at best a gamble. Where one client feels recognized in their emotional state at that time, another client might feel more discomfort than before, after having their negative emotions being placed in the spotlight and given room to grow throughout that respectfully intended silence.

In Solution Focused work we try to combine the helping effect of acknowledging feelings, the client feeling emotionally validated by the therapist, with an intervention aimed at minimizing the possibility of negative effects of giving room to the client's negative emotions during session. We still recommend that therapists acknowledge their client's feelings in session. On top of that we feel it to be the Solution Focused therapist's responsibility that the client does not get invited to get stuck in their negative emotions. Hence the therapist should, before acknowledging negative feelings, already have in mind a suitable Solution Focused intervention to follow up with. An example would be reflecting on feelings and then asking a Solution Focused question: what has helped you in the past to get past this negative feeling? What can help you now? In this way the client is invited to move away from this undesirable feeling, going back to resources discovered previously in this or earlier sessions.

The therapist can also explicitly acknowledge positive feelings detected from or by the client during the session. The same logic applies here: thinking of a suitable Solution Focused follow-up question beforehand enhances the positive effects of acknowledging positive feelings during session. An example could be: When were the other moments you felt this good? What triggered your happiness at that time? Or any other question that places the client in a strong and active position within the session itself.

Eye-Contact

When bringing to bear indirect emotional and affective empathy the therapist tries, using their mirror neurons and based on their experience and creativity, to reconstruct in themselves the emotional state of the client. We try to feel as the client does, albeit in a more contained manner. The therapist then tries to communicate this to the client in their choice of words and body language. In this way the therapist makes clear that they accept the way the client is now experiencing the world and shares, in a sense, this mental and emotional state. Within the Solution Focused framework empathy is closely connected to the therapist's caring for the client's well-being, starting from an unconditional acceptance of the client as who they are and what they do. Part of this is acknowledging all signals, both verbal and non-verbal, the client is sending us about their current emotional state.

From this point of view, we propose that the therapist's is on their best Solution Focused behavior if they try to take into account the client's nonverbal signals concerning their emotional state and perhaps even copies them to a certain extent. With regard to eye contact a much asked question by students is 'how much eye contact is enough, appropriate, how much is too much?'. As Solution Focused therapists we suggest to follow our client's lead, even in their non-verbal communication habits. When a client does not make eye contact with the therapist, it is the therapist's job to notice this and as a consequence not try to force eye contact with that client. When the client makes eye contact almost in a constant manner, the therapist enables this large amount of eye contact as long as it is comfortable and authentic for them to do so. The limit here being therapeutic authenticity. When the therapist forces themselves to do something, e.g., make more eye contact than feels authentic for them, the client tends to pick up on this, creating feedback, which negatively affects the therapeutic alliance. If the client makes eye contact, then breaks it, makes eye contact again and then breaks it again, the Solution Focused therapist follows the client. Our client is the barometer for the appropriate amount of eye contact. They know what is 'just the right amount.' The therapist needs only to follow their lead. Even in the appropriate way of communicating non-verbally our clients are the experts of what makes a therapeutic connection work. In the ideal therapeutic relationship client and therapist would find themselves in eye-contact-memesis.

Concretizing

O'Hanlon and Wilk (1987; 1989) stated that the more detail used to describe a problem in therapy, the more clear the possible steps towards change become. A simplistic focus on the problem will not function as a catalyst for change. Within a solution focus view such a focus on the problem can only be helpful when the therapist searches for possible resources or aspects of the client's motivation that can become apparent when the client describes their problem. This can bring to light resources and skills the client is possibly not aware of themselves. On the one hand, concretizing – even the problem – communicates a sort of emphatic interest for the client's life; on the other hand, the client is complimented on their resources already present in their story. Taking note of how the client describes their problem can thus shed light on the existential choices the client makes, which can serve as motivation factors for fostering change.

Focusing in this way on those elements already helpful on the road to the desired future, even when they are found in the currently problematic parts of the client's life, helps to re-orient the client's view of themselves from failing to capable.

Within this technique it again becomes possible to build in an extra element of being able to make desired choices. By asking the client's permission to pursue a line of concretizing questioning beforehand, the client's feelings of autonomy can be bolstered. On top of that the client is given more control over the way the therapeutic process will continue, actively putting the client more in an equal position to the therapist. Both client and therapist are so made equal as experts, the client being the expert of their own life story and the possible solutions or avenues to take towards desired change, the therapist as expert of the process to bring about that same desired change (de Shazer & Isebaert, 2004).

Reflection, Discussion and Conclusion

McKeel (2003) concluded his large review with the insight that when basic communication skills are applied in the right way this always leads to significantly more positive treatment outcomes. Still, he warned that too large a focus on just conversational skills could lead to diminished attention for the other keys to the success of therapy: forming a working alliance with your client. He ultimately claims that Solution Focused therapy can only be successful if it is both Solution Focused and directed by the client at the same time. Odell, Butler and Dielman (Odell et al., 1997), came to a similar conclusion, stating that when techniques are used in the right way, but the client did not feel understood and heard by the therapist, this client leaves therapy prematurely.

Because Solution Focused work is more about a basic attitude on the part of therapist characterized by a specific way of thinking about, looking at and listening to the client, these communication skills would be applicable to almost any and all terrains where people purposely engage in helping conversations. Immediately applying these basic communication skills in a Solution Focused way has the potency to add to the basic benefits of good professional communication, the bonus a Solution Focused mindset brings by already approaching your client in a positive, resource oriented way. Solution Focused basic communication skills will immediately focus both therapist and client on restoring the freedom of choice and the competence to choose differently by installing a temporarily healing alliance as means to achieve the goals set forth by the client, not the therapist.

This of course today remains a hypothesis, based on our joint experiences as psychotherapists and lecturers. Still, immediately teaching these basic communication skills to students in social, health and well-being-oriented courses gives both these new, young professionals and their clients the opportunity to achieve the above described extra therapeutic gains a Solution Focused approach brings.

This conceptual framework can be used to form a skill teaching package, aimed at a basic level (e.g., first-year students in higher education courses like social work, nursing, midwifery) and teaching these basic communications skills in a Solution Focused way. Such a skill teaching package would be broader than just the communication techniques highlighted in this article, giving a broader, Solution Focused introduction. Such a skills package could be highly interesting to practice lecturers in professional bachelor's degrees such as social work, nursing, midwifery, creative therapy, etc.¹¹

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¹¹ Readers can contact the lead author for input on how to build the mentioned skill teaching packet

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BOOK REVIEW**What it Takes to Thrive: Techniques for Severe Trauma and Stress Recovery**

John Henden

World Scientific Publishing Co Ltd, 2017, 208 pages, ISBN 9789813230217 (paperback) £25:00 (e-book available from multiple online sources including Google, Amazon and Kobo)

Review by Steve McCarthy-Grunwald

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Within the eye of a global pandemic it could be said that there is no better time to consider ways of reducing stress, anxiety, and experiences of trauma (Hagger et al., 2020). Although this book was initially published in 2017, its value today seems even more prudent for many individuals across the globe. The opening passages clearly identify how the book has been developed from a person centric position, offering advice and self-help tips and techniques for the reader to contemplate trying.

This genre of book in particular faces much criticism as to how effective they really are for readers seeking advice and guidance at a time of personal conflict and have been suggested to giving a potential false sense of an alternative to seeking professional help Bergsma (2008). Interestingly, Bergsma's study which analysed 57 best-selling psychology self-help books in the Netherlands identified that the primary aim of them all was not to alleviate the symptoms of psychological disorders, but to enhance personal strengths and functioning. Considering Henden book, he clearly notes that the design was specifically for 'survivors and practitioners alike' (Henden, 2017), and offers a jargon-free and solution-focused guide with the hope of inspiring change.

The book is arranged in a series of helpful sections covering themes such as dealing with triggers, managing flashbacks and unwelcome thoughts, what to do at times of feeling 'low', sleep disturbance, and how to live life to the full. These sections are supported by an extensive appendix which offers further clarity on dealing with trauma, which is written in a way that is useful to both practitioners and individuals experiencing trauma. What was most useful was the emphasis on removing unhelpful or disabling terminology, offering a positive frame of reference throughout for reinforcing feelings of hope and self-potential.

Each section is set out with a range of exercises varying in levels of difficulty to offer quick solutions for crisis points and more long-term ways to identify and reduce the impact of future episodes. These comprehensively described exercise are supported in many places with real life examples of how they have reassuringly helped others to overcome similar life events. Being only examples they offered a very brief outline of the person's story which at times felt 'sanitised' to the point of offering limited understanding of how the individual went about using the techniques, although it is fair to say the main purpose of the book is not the stories of survivors of trauma.

Having read over the exercises in each of the sections, there was evidence of repetition of many of the techniques, such as mindfulness, and breathing exercises. This in itself can offer some reassurance that there are a certain handful of techniques which are useful for many potential scenarios which could present, making it feel less daunting to pick up new skills. This repetition could make it appear that this was 'all there was to offer', which is not the case. A few techniques towards the latter sections were vague in detail and lacked any deeper understanding of their value such as, the recognition of the potential of using humor, or some suggestions for how to manage sleep disturbance.

What was evident is Henden has considered a range of different approaches such as creative writing, imagery and storytelling, music, exercise, routine formation and neuro-linguistic programming (Bandler & Grinder, 1975) which is both refreshing to read alongside the more traditional approaches. What was surprising was the lack of reference to the aspect of the biophilia hypothesis (Wilson, 1984), and our innate connection with the natural world and its potential for reducing, stress anxiety and depression (Pretty, 2004).

John Henden brings with him many years of experience as a therapist and trainer in severe trauma and stress along with his personal experiences, and this provides the motivation towards the possibilities this text can offer. Supported by many renowned experts in the field of solution focused therapies such as Yvonne Dolan and Alasdair Macdonald the book does offer a sense of celebrity recognition. As the reader I certainly felt that of the authors experiences over his career was the driving force providing hope and positivity in what can be achieved. This instilled a sense of assurance and belief which are fundamental aspects of promoting change.

Although the book is advertised as being for practitioners and survivors of severe trauma in particular, the text could well suit most individuals who are experiencing stress or feeling psychologically overwhelmed, although as the book adopts the atypical 'average person perspective, this may not translate as clearly for all neurodiversity.

The reviewer

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BOOK REVIEW**Hope Without Optimism**

Terry Eagleton

Yale University Press, 2015, 147 pages, ISBN 978-0-300-24867-8,
£34.84 Hardback, £10.99 Paperback, £7.47 Kindle edition

Review by Louise Bower-Hatchard

Solution Focused Practitioner, Signs of Safety practice lead and senior manager in Children & Families Services based in Sheffield, UK.

As Solution Focused practitioners, we usually ask about our clients best hopes. Some reflection therefore on what hope is and how it differs from the general positivity that optimism is associated with seemed to me to be relevant and of interest.

The book seeks to look into the political, philosophical and theological implications of the concept of hope and clearly explain how hope is something very different to and separate from optimism. It does deliver on all of these - comparing and contrasting the concept of hope as described by different political thinkers, philosophers, Christianity and celebrated writers.

If you're an academic thinker, well versed in philosophy and enjoy dense analysis of different modes of thought then you may well enjoy the diverse references and viewpoints presented within this book. Be warned - this is not a light read! The pace of cross-referencing of different thinkers assumes knowledge of a wide variety of philosophical viewpoints - it is not aimed at the casual reader.

This book is written by a Professor of English Literature who has written over 50 books in fields including postmodernism, ideology, religion and politics (particularly Marxism). The preface opens with "As one for whom the proverbial glass is not only half empty but almost certain to contain some foul-tasting, potentially lethal liquid, I am not perhaps the most appropriate author to write about hope". The author comes across as incredibly knowledgeable and articulate with a dry sense of humour.

There are four sections - the first explaining "The Banality of Optimism". In this section, the point is made the optimism is a temperament rather than a virtue - some people are just naturally more optimistic than others "you are chained to your cheerfulness like a slave to his oar". The book goes on to suggest that optimism can lead to conservatism as it the lack of acknowledgement of despair can also mean a lack of motivation to make changes.

The second section compares and contrasts view of "What is Hope?". In this, the distinctions and inter-relatedness of the theological virtues of faith, hope and charity are discussed, as well as the links with faith, love and desire. "To believe that something will happen is to expect it to, but to hope that it will is not necessarily to do so...Impossibility cancels hope but not desire". The concept of hope as being cruel and keeping us in our own human suffering is also examined - "If it is the most pestilent of the evils to emerge from Pandora's box, it is because it stops us putting an end to ourselves, and thus from putting an end to all the other evils that beset us (P44)". Also, the idea that hope can cause us misery is presented "Schopenhauer regards hope as the root of evil, disturbing one's tranquillity with false expectations (p87)". The concept also of the perpetually hopeful individual of living without fully enjoying the present is also presented, with their hope depriving that person of truly living each moment. "Hope is the crack in the present through which a future can be glimpsed, but it is also what hollows the human subject into nonbeing. It devalues each moment, laying it on the sacrificial altar of a future fulfilment that will never arrive (P44)".

The third section focuses on "The Philosopher of Hope" and is dedicated to a discussion of the thoughts of Ernst Bloch, a "great luminary of Western Marxism", who believed that "hope is in love with success rather than failure" (p. 107) with a tendency towards perfectionism. The views of Bloch are compared with other eminent thinkers and

philosophies of that era, with the author finding his ideas limited in terms of usefulness “those who invite us to hope unreasonably risk plunging us all into chronic disaffection” (p. 110).

The final section is titled “Hope Against Hope”, and it discusses the place of hope when situations seem hopeless, and that even when things are at their worst it is “in some perverse sense a source of hope, bringing as it does the assurance that one can sink no further”. The view is that the optimist, because they will not recognise the darkness of despair, cannot truly hope as hope springs from a place of recognition that the preferred future may not become a reality.

So how is this helpful for us as Solution Focused practitioners?

An understanding of what hope is explains to some extent why using the language of hope rather than desire get such useful responses from clients. When we invite our clients to articulate their best hopes, rather than asking about their wants, they are more likely to come up with an answer that is feasible to achieve. “Precisely because it anticipates rather than simply desires, hope must intend the possible, or at least what those in the grip of it regard as possible, which is not necessarily true of desire. (P48)”

“For there to be genuine hope, the future must be anchored in the present. It cannot simply irrupt into it from some metaphysical outer space. At the same time, the yeast-like powers at work in the present do so in a way that finally surpasses its limits, pointing to a condition beyond our current imaginings” (p. 38).

The miracle question, with its invitation to describe a future where the issue or problem no longer exists acts to create hope that things could possibly be different.

“The mere act of being able to imagine an alternative future may distance and relativise the present, loosening its grip upon us to the point where the future in question becomes more feasible” (p. 86).

There are also some views of hope that perhaps explain the enjoyment and fulfilment that a solution focused mindset brings to both practitioner and client - the regular discussion of hope bringing joy and provoking the imagination. “John Locke regards hope as the ‘pleasure in the mind’ we feel when anticipating some future source of enjoyment (p55)”.

The book, with its thorough discussion of the distinction between hope and optimism, perhaps explains in part why the focus on hope in the Solution Focused approach is quite so powerful.

The reviewer

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BOOK REVIEW**Tools for Effective Therapy with Children and Families: A Solution-Focused Approach**

Pamela K. King

Routledge Publishers, 2017, 155 pages, ISBN 978-1-138-12617-6, £29.99 pbk (hbk, ebk also available)

Review by Benjamin Finlayson

Doctoral student at Texas Tech University in the Program of Couple, Marriage, and Family Therapy

We are seeing more literature in support for Solution Focused Brief Therapy (SFBT). Pamela King's book demonstrates the sound use of SFBT with children and demonstrates tangible ways for you to incorporate them into your practice. During the pandemic of 2020, many clinicians are now working virtually. This may raise some concern in how to work with children across teleplatforms. Though the author is not writing specifically for tele-therapy, the tools she introduces and the resources she recommends are likely ones your clients have in their home currently. I think this book can help you as you reopen your in-person practices and is also useful for immediate work with your children and families in tele-therapy settings.

Taken from the front-matter of the book, *Tools for Effective therapy with Children and Families* provides tools and strategies for work with children and families by integrating SFBT and play therapy. The book delivers on this promise considerably and uses several techniques to deliver high quality material to the clinician and their clients. First, the author uses strong theoretical foundations throughout the book; the thread between SFBT and play therapy is apparent and well-articulated. Second, the author uses case vignettes to demonstrate how these techniques can look. These vignettes provide insight into how the child and the family respond to the use of SF play therapy. Lastly, Pamela applies her knowledge of play therapy and SFBT to several presenting concerns, including a section focused on childhood trauma and abuse solutions.

The author includes detailed vignettes with each technique. I appreciate that Pamela took the extra step to help clinicians better understand how children and families incorporate her suggestions. Client work is included in this book as well (with permissions and with identity removed), which gave a visual to the child's interpretation of the intervention. These tools are to help us, adults, better understand and be invited into the understanding of the children we work with rather than expecting them to meet us at the communication level we are at. Further, the author uses items that the children are likely to have when they leave the therapy room. For example, Pamela invites the child to choose from a random assortment of toys to describe their progress. Families may have similar objects at home for them to recreate the conversation after the therapy session has ended. As clinicians, we may not know all the resources of our clients, so to use toys or objects that can be more adaptable makes home-application more tangible across cultures and demographics.

The author has crafted a book that is approachable and exciting to read. My critique comes from a stylistic idea. When reading, there were times when I wish the case vignettes stood apart from the main text, such as having them overlaid a grey box like the quotes at the beginning of each chapter. This is, in my eye, is minor but would make the chapters easier to reference back when looking to apply this material.

Pamela King writes with an honest voice. As I read through the book, in particular the case studies, I read the hope she sees the kids and families she works with. The language is clearly strengths-based and genuine. The passion she has for working with families, I felt, came through in this text. To the credit of the author's writing, it also felt like I was reading a gift rather than reading a manuscript from an expert telling me how I should do things.

The author specifically addresses this book to professionals in mental health fields. Mental health clinicians, whether just starting out or "seasoned", should take time to invest in this thoughtful and well-articulated book. She offers innovative tools for creating solution conversations that meet kiddos and families where they are at. I would also suggest

this book for any professional that works with children or families. I think the discussion within this book can offer useful techniques for any professional working with kids or families. The author integrates solution-focused dialogue throughout the book so that the connection between model and application is clear. Even if you are new to SF or well-versed, there is something to gain at any experience level of SF practice.

The reviewer

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BOOK REVIEW**Rekindling Democracy: A Professional's Guide to Working in Citizen Space**

Cormac Russell

Cascade Books, 2020, 284 pages, ISBN 978-1725253636, £27 paper (Kindle edition available)

Review by Steve Flatt

Psychologist, business manager, academic researcher and Solution Focused Practitioner

For some time now there has been a growing awareness around the inadequacy of top down interventions in many aspects of our lives both nationally and internationally. Cormac Russell provides a great antidote to the top down, expert driven approach to community life.

Back in the 19th Century Rudolph Virchow said,

"Medicine is a social science, and politics is nothing else but medicine on a large scale. Medicine, as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution: the politician, the practical anthropologist, must find the means for their actual solution. The physicians are the natural attorneys of the poor, and social problems fall to a large extent within their jurisdiction."

Olshansky (2017) makes another rather more wry observation about the way medicine goes about its business,

"As soon as the disease appears, attack that disease as if nothing else is present; beat the disease down, and once you succeed, push the patient out the door until he or she faces the next challenge; then beat that one down. Repeat until failure."

There is a real irony in these statements. Cormac Russell's book makes a great effort at pointing out and signposting new and better ways forward. Both quotes illustrate today's responses to difficulties in our lives – a top down expert driven process that ignores the skills, qualities and ability of communities to manage their own difficulties if given the chance.

Russell is seeking, with lots of evidence and stories to show it, that communities consistently know what is best for them, especially when they get together to discuss possibility. He notes that they frequently have all the necessary resources to solve their difficulties in their own unique and effective way. He carefully acknowledges the role of institutions and experts in the process of re-igniting community action and life, and clearly illustrates a both/and approach, but with a much more facilitative paradigm.

Russell is a clear and easy-to-read writer and his style draws the reader into a world that is possible and probable but that still requires some imagination and consideration of preferred futures. His level of experience and breadth of knowledge is considerable. He provides huge amounts of evidence for more effective ways of working while at the same time drawing us in with human stories of success that evoke emotion that are pleasurable and painful, embarrassing (as a professional) and delightful (as a member of a community).

This book crosses the boundaries of all professions working with people and communities. If, as a professional, you have worked largely with individuals in the health, education, law or political arenas then this book will provide you with an utterly different view of what is effective and open your eyes to possibility. If you are already working with communities or helping others develop community-based organisations run by the people for the people, then this book will potentially offer new ideas and tools to help you think about how to be even more effective.

For Solution Focused practitioners this is a logical step from individuals and groups to community working in an SF paradigm. Although Russell does not use phrases that we as SF practitioners might recognise, the drive for a preferred future, possibility and growth is undeniable in his writing. His clear desire to facilitate others underpins his thinking and it is clear, despite Russell probably never having heard the phrase, that he wishes to leave, 'the smallest possible footprint' in the lives of the communities he has worked with, continues to work with and write about.

I would recommend this book to anyone who values connection with their community and wishes to enhance the place of community in the world today. Russell observes that so much of our lives have become commodified in order to make money and 'grow the economy' and then points out the ultimate futility of this approach as it benefits the few at the expense of the many.

I thoroughly enjoyed reading the book. It touched on so many of my own thoughts about the way we currently structure our lives and exist together (or not) on the planet today. It gave me more foundations upon which to build my own way of working while, at the same time without Russell insisting that his is the new way. Indeed, it is rather the reverse, he acknowledges Socrates famous statement "I know only that I do not know" and admits it was sometime before he put aside his own certainties and began exploring the territory "with real curiosity and humility, and by invitation". Sound familiar?

I was reading another book at the time, *The Wealth of the Commons* edited by David Bollier and Silke Helfrich, a compilation of 73 essays that "describe the enormous potential of the commons in conceptualising and building a better future". It critiques current systems of governance, at local as well as national levels, in much the same way that Russell does and provides information from 30 different countries. The two books very much complement each other.

However, I prefer Russell's writing as he takes a much more personal view that feels real and reachable for the individual reader without being overwhelmed by the panoramic view of the *Wealth of the Commons*. Thank you, Cormac Russell, for a great book full of possibility and more ideas for a better future.

The reviewer

Steve Flatt is a psychologist, business manager, academic researcher and Solution Focused Practitioner living and working in Liverpool and across the planet.

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BOOK REVIEW

Theory of Solution-Focused Practice: Version 2020

Peter Sundman, Matthias Schwab, Ferdinand Wolf, John Wheeler, Marie-Christine Cabié, Svea van der Hoorn, Rytis Pakrošnis, Kirsten Dierolf, Michael Hjerth

European Brief Therapy Association, 2020, 124 pages, ISBN 978-3751976749, £7.90 (Kindle and e-book edition available)

Review by Rayya Ghul

Academic Developer at the University of Edinburgh

This book is not a book. It looks like a book, but in reality, is an exploratory paper with some thoughtful and sometimes exciting ideas of what theory in solution-focused practice could look like, bound together with a collection of reflective responses to the paper. Once I realised what I was holding, it became easier to engage with it on subsequent readings where I was able to admire certain strategies the authors have taken towards theory development. The fact that it contains six excellent critically reflective reviews of the content means that I will not do that here as the best reason for reading this document is to join in that conversation yourself – and indeed there is an explicit invitation to everyone to do just that.

The authors' aim is to “present a coherent theory of solution-focused practice for those who wish to understand the rationale, together with a comprehensive description of solution-focused practice that can be used for training and developmental purposes” (p. 12). In this, it has fallen short of achieving either but that does not mean that it is not worth reading. Solution-focused practice has been notoriously difficult to define outside of a description of commonly-used techniques and speculations on why they work. That they do work is not in question anymore, but the ‘why’ and ‘how’ remain elusive.

The authors (who are all scholarly practitioners) have taken a discursive, collaborative approach to build a process theory from the ground up, testing it through discussion with the wider solution-focused community. Knowledge of the founders' thinking, most notably the relationship of solution-focused practice to spoken language within practitioner-client conversations is drawn upon, as would be expected. Here it casts a fresh perspective on meaning and purpose and particularly, on the reason why solution-focused practitioners pay such close attention to detailed descriptions of daily life. It is a shame that this was not expanded on more and in particular, on p30, the inclusion of opaque terms such as ‘causal nexus’, ‘causal chains’ and ‘semantic relations’ without any definition or elucidation would make the book less accessible to some readers. This was an example of a less successful aspect of the book, which was that the distillation of ideas was sometimes so great as to lose the richness of the argument (which I have no doubt exists). On the other hand, this distillation also produced some of the great quotes which I highlighted, such as:

“Solution-focused practitioners do not think that there has to be an agreed upon and unified way of life and they value the diversity of the unique solutions by each client” (p36).

“Empowerment is understood as inviting clients to become aware of their power and agency in taking control of the meaningful change they seek” (p37).

“[Solution-focused practice is] a relationship of equals in which the practitioner takes the leading responsibility for setting in motion a constructive growth-oriented process and the client take leading responsibility for offering the content relevant to their desired change” (p48).

As might be expected, ‘change’ features in different ways throughout the text. It is used to help define the theory: “This theory is [...] a theory of how change in the solution-focused practice happens and how it supports clients to implement those changes in their lives” (p22). This is unpacked in the second section, titled, ‘Explanation: Why be solution focused?’, which makes a reasonable case for the ethical underpinnings, but doesn’t quite provide the full argument to answer the question posed and tends towards remaining descriptive rather than analytical.

The third section, which explores what makes practice solution-focused, avoids focus on recognized techniques (e.g. miracle question, exceptions) as defining factors, and presents something closer to a description of the orientation, stance and underlying ethics of a solution-focused practitioner and provides helpful illustrative examples. I think integrating this with the earlier chapters, or perhaps including illustrative examples that demonstrated theory in practice in the earlier chapters would also have improved the usefulness of the book.

The six critically reflective reviews also contain some very useful ideas for improvement, but their value lies more in the respectful and thoughtful way that they have both expanded upon and pointed to alternative ways to theorise about solution-focused practice. Initially, I wished that the authors had used more of their comments to improve the main document, but on reflection, I think that it adds to the sense of the book as an invitation to join in the development of theory.

If there were one thing which I would have wished to be different about this book, it would be that the authors had spent more time in thinking about the title. 'Theory of Solution-Focused Practice' implies a final, consensus view that will inform the reader of, well, the theory of solution-focused practice. Sadly, if the book were solely to be judged by the expectation inherent in the title, it has not succeeded. A better title might have been 'Towards a Theory of Solution-Focused Practice', 'Developing a Theory of Solution-Focused Practice' or 'Theory in Solution-Focused Practice – A Work in Progress'.

Why does this matter? In carrying out the review of this book, I spent considerable time thinking about what a book review in an academic journal is for; what is its purpose? By its nature an academic journal is the place where the knowledge within a discipline is reported, debated and honed through presentation of research and scholarship. This takes place through articles, counter-articles and articles which build on previous articles. In that sense it is a record of the ongoing discussions and debates within a discipline. There is recognition of the contested nature of knowledge and therefore, contingency.

An academic book, (any book whose title starts with 'Theory of ...' is positioned as an academic book) on the other hand, is generally a synthesis of knowledge, usually carried out through a rigorous analysis of the available knowledge that is presented for the reader. Of course, a book can be whatever the authors wish it to be, but to put a book into the world is to take an action whereby they will be judged within the context of 'book' and in that context, titles matter. They matter because a 'language game' of book titles exists and that inevitably will colour the reader's expectations (and subsequent valuing) of the book. A review of an academic book is therefore one which should inform the reader of whether and why they should buy that book in the context of the purpose of an academic book.

Overall, I think this book is a useful addition for existing practitioners of solution focus and the authors are to be applauded for their tenacity in working together to start what are important conversations for the maturation of solution-focused practice. However, I am less sure that it would be a good way for solution focus to be presented to external audiences or to novices, such as students – at least not without an experienced interpreter. And that, in the end, is what is disappointing about the book with the title 'Theory of Solution-Focused Practice'.

The reviewer

Rayya Ghul works at the University of Edinburgh where she is an academic developer, using solution focus to enhance personal tutoring and PhD supervision. She also teaches solution-focused conversation to student peer supporters. Originally a mental health occupational therapist, Rayya is the author of *The Power of the Next Small Step*, a solution-focused self-help book.

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BOOK REVIEW**Small Steps to Big Changes: Create the Change You Want Now**

Kenneth Kwan

Smashwords Inc., 2018, Amazon ASIN B079NMMC8M, Kindle edition £7.19 (available through Amazon)

Review by Paul Z Jackson

A coaching, consultant and online facilitator

In these days of the plague, how do you manage to get anything done at all? Almost all my work now takes place in front of a screen. I was going to say, ‘virtually all my work’, but that’s a word whose meaning has been shifting faster than ‘Zoom’.

There’s so much online to distract our attention from our purposes - an infinity of rabbit holes. And when there are fewer opportunities for trainers, coaches and consultants to go visiting clients in their workplaces, there’s also less variety in everyday experience, so that the relentlessness of being online takes greater toll of our energy and imagination. Which make it harder to achieve what we set out to do.

The solution-focused answer, of course, is to pay careful attention to when you do accomplish something, so that you can do more of whatever it is that you have identified works for you.

There’s a story in Kenneth Kwan’s new book, *Small Steps To Big Changes*, of an organisation in Singapore getting more people to read their emails by sending them from the email address of their company mascot. It’s one of several illustrative examples from Kenneth’s practice which pepper this brisk recounting of the main ideas of the solution-focused approach.

Everything in the book is presented simply and logically, mostly in the contexts of organizational change, with topics ranging from goal-setting to improved performance conversations. These are supplemented by downloadable bonus videos and worksheets.

Applying his advice to his own business when sales are dropping, he wonders ‘Who buys in a recession?’ The answer is the government and the small step of revisiting his contacts there leads to significant success.

It’s a timely reminder as we face a global crisis that it’s still possible to use our SF principles to choose actions that will increase our prospects of surviving or even flourishing – virtually guaranteed!

The reviewer

Paul Z Jackson is coaching, consulting and facilitating online; and continues adding to his writing which includes the classic book *The Solutions Focus*, co-authored with Mark McKergow.

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BOOK REVIEW

The Solution Focused Approach with Children and Young People: Current Thinking and Practice

Denise Yusuf (editor)

Routledge, 2020, 206 pages, ISBN 978-0367187620, £24.99 paperback (Kindle edition available)

Review by Alasdair Macdonald

Retired psychiatrist and freelance trainer

Denise Yusuf is a qualified social worker and a solution-focused coach and supervisor. She has worked in a variety of settings, including a long relationship with the internationally known training practice developed by BRIEF in London.

This book contains 26 chapters by a variety of well-known authors in the field of solution-focused therapy. There are a total of 27 contributors drawing on their own work and experience with children in many settings. There is also an interesting foreword by Michael Durrant from Australia, highlighting children's interest in the future. The contributors report experience in 12 different countries around the world, including but not limited to the United States of America, Canada, Australia, Hungary, Belgium, Finland, Cyprus, Singapore, New Zealand and of course the United Kingdom.

One of the special features of this text is that the contributing experts come from many different backgrounds and fields of study. The book opens with a concise series of snapshots of each author. You will find teachers, educational psychologists, counsellors working with young offenders, social workers, specialists in communication and linguistics, speech and language therapists, psychiatrists and others, many of whom have international reputations as trainers and therapists.

In her introduction Denise Yusuf emphasises the value of scaling in work with children. Ben Furman, a Finnish psychiatrist, describes the development of his fifteen-step protocol 'Kids' Skills' which has become internationally famous, including regular teaching in China and the Far East. Felina Heart reports her innovative work with parents, children and teachers in an English-speaking international school in the Ukraine. Elliott Connie from Texas provides an excellent metaphor for our work, helping children grow from caterpillars to butterflies. Evan George comments on the reluctance of young people to be involved with 'therapists' and describes some of his methods for engaging their interest.

Harvey Ratner of BRIEF presents an interesting discussion of the link between the miracle question and the use of scaling, referencing both Steve de Shazer and Harry Korman. He offers some sequences of dialogue from his own practice.

Harriet Conniff provides examples of the use of solution-focused thinking when working with young people with chronic or life-threatening conditions. She suggests the use of 'solution-focused injections' in which a few solution-focused questions can promote new thinking and positive developments for children and families in such difficult situations. The offering by Anita McKiernan reports her experience as a speech and language therapist working with selective mutism, often with very young children.

An impressive project in Hungary is described by Arpad Barnai and Viktoria Soregi. The Roma communities in many European countries live in conditions of significant poverty and neglect. The project aims to provide informal and non-formal learning situations for some of the adolescents in these situations. The application of solution-focused ideas as proposed here appears to have had very significant benefits. The model has been supported by the European Union and is being extended to the Roma communities in other countries.

Elke Gybels and Rik Prenen work in Belgium. Their favoured tool is known as 'Figuring Futures'. It consists in using visual aids such as Lego figures or decorative boxes as a method of extracting details and supportive ideas during interviews with children, thus stimulating visualisation and imagination. Pamela King's article about solution-focused play therapy follows some similar themes. She also proposes methods of developing useful conversations after traumatic

experiences. Xenia Anastassiou-Hadjicharalambous reports her use of solution-focused conversations in bereavements following the loss of a parent.

There are two contributions which address work with young offenders. Emma Burns works extensively with the police force in New Zealand, producing both effective help for the young people referred to her and valuable training experiences for police officers. Joe Chan reports his experience of coaching for youth offenders in an institutional setting in Singapore. Like Felina Heart (see above) he confirms the value of solution-focused methods in cross-cultural practice.

Michael Petersen and Rikke Ludvigsen, working with high-risk child protection cases in Denmark, highlight the value of solution-focused concepts in these families. They specifically report on their use of the Signs of Safety approach developed by Turnell and Edwards for indigenous peoples in Australia. Jeff Chang's paper presents material from similar family situations in Canada addressed in a different way.

Most of the contributions include references to other authors quoted in the text. The book is therefore also a useful summary of the overall field of solution-focused work with children and young people. Space does not permit commentary on every piece of work included. However, I found the book interesting from start to finish, and I strongly recommend it to anyone working with children and young people.

The reviewer

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