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# Journal of Solution-Focused Brief Therapy

Volume 2, Number 1 — 2016

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

The journal invites submissions as follows:

**Research reports** — We are committed to helping expand the evidence base for Solution-Focused Brief Therapy. 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 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 or 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 then distils 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!

**Not just “therapy”** — The Journal recognises that many useful and interesting manifestations of the Solution-Focused approach occur in settings that are not to do with therapy. Nonetheless, Solution-Focused interventions are all concerned with helping to facilitate change. The journal is called the *Journal of Solution-Focused Brief Therapy*, at least in part in homage to our heritage. Nonetheless, the journal welcomes submissions that explore the use of Solution-Focused ideas in other settings. The journal enjoys a collegial relationship with the journal *Interaction: The Journal of Solution-Focused in Organisations* and, where appropriate, will discuss which journal offers the more appropriate publication forum.

## 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, any conference presentations relating to the paper, any potential (or even perceived) conflicts of interest.

Spelling should be anglicised, with -ise endings and English spelling of words such as colour, counselling, and so on. 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 Association (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 separate pages (or in separate computer files) in black and white and their position indicated in the main document. For any images or photographs not created by the author, the submission must include written permission to reproduce the material signed by the copyright holder.

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

### **Clinical/client material**

The Journal's policy is that any actual clinical detail in a paper (including, but not limited to, therapy transcripts, client/patient history, descriptions of the therapy process) should have signed consent from the clients/patients for the material to be published. If a paper includes clinical material or descriptions, please include a declaration, signed by the first author, either that signed consent of clients/patients, specifically for the publication of their clinical information in this journal, has been obtained and is available for review OR that clinical material has been altered in such a way as to disguise the identity of any people.

### **Review**

Manuscripts will be reviewed by at least two members of the Editorial Board, who will be asked to recommend that the paper be accepted or rejected for publication; however, 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 changes are required or recommended, we are happy to work with authors to review amended submissions with a view to achieving publication. When the reviewers both recommend that the paper not be accepted, and make no recommendations for changes, and when the Editor accepts this recommendation, no further consideration of the paper will be given. When the reviewers (and the Editor) suggest that your paper, while it might have merit, does not meet the requirements for this journal, we will endeavour to suggest other journals to which the author might submit the paper; however, we are under no obligation to help achieve publication.

Where one or more authors of a paper is a member of the Editorial Board, that person will take no part in the review process and the review process will still be anonymous to the author or authors.

Send manuscripts to: [michael@briefsolutions.com.au](mailto:michael@briefsolutions.com.au)

## Editorial

**Michael Durrant**

Welcome to the third issue of the *Journal of Solution-Focused Brief Therapy*.

You may have been wondering when the next issue of the journal would eventually appear.

Starting a new peer-reviewed journal is not an easy process and we were significantly behind schedule even when Volume 1, Number 1 was actually published in 2014. Thus, the Board decided to “skip” 2015 and for Volume 2 to be dated 2016. Thus, we should be more or less back on schedule.

Steve de Shazer often referred to Solution-Focused Brief Therapy as a “minimalist” approach. While it seemed that minimalism was little more than a brief therapy tool, it is clear from the Solution-Focused literature broadly that doing as little as is necessary is a core value of the Solution-Focused approach. Solution-Focused practitioners believe that people should be out there living their lives rather than in here talking about their lives and that it is, in one sense, unethical for the practitioner to do anything more than the minimum necessary to assist the client.

de Shazer embodied minimalism. Despite Solution-Focused originally being developed as a “talking therapy”, de Shazer was renowned as a man of few words!

The team at BRIEF in London have continually attempted to “test” the extent to which different aspects of the approach were actually necessary and do simplify Solution-Focused as much as possible. Simple does not mean simplistic and the paper in this issue by Chris Iveson and Mark McKergow attests to that. Iveson’s quest for simplicity coupled with McKergow’s ongoing fascination with trying to figure out how we describe HOW Solution-Focused actually works results in a stimulating suggestion of a new way to think about the Solution-Focused process — a way of thinking that might just mean

some of the Solution-Focused techniques we have held dear are actually not necessary.

Frank Thomas considers the process of giving “compliments” to clients, a practice once suggested by de Shazer and Berg (1997) as one of the defining aspects of the Solution-Focused approach. Mindful that the fact of the practitioner deciding what aspects of the client’s achievements warranted compliments might be seen as inconsistent with Solution-Focused’s claim to a “not-knowing” stance (De Jong & Berg, 2012), Thomas explores some different ways to think about the process of complimenting.

Cynthia Hansen relates a fascinating journey from using Solution-Focused ideas in a school psychology setting to implementing Solution-Focused ideas (in some very different ways) in disaster recovery work and I offer some thoughts about what is ... and isn’t ... Solution-Focused.

De Jong, P. & Berg, I. K. (2012). *Interviewing for solutions (4th ed.)*. Belmont, CA: Thomson Brooks/Cole.

de Shazer, S. & Berg, I. K. (1997). ‘What works?’ Remarks on research aspects of Solution-Focused Brief Therapy. *Journal of Family Therapy*, 19(2), 121–124.

# Brief Therapy: Focused description development

Chris Iveson<sup>1</sup> and Mark McKergow<sup>2</sup>

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We present a potential new view of Solution-Focused Brief Therapy (SFBT), based on the development of descriptions in therapy conversations. This version of SFBT leaves out many accepted aspects of the model, so far, including: tasks, end of session messages, exceptions to the problem and compliments. We address the issue of theory in Solution-Focused practice and make a distinction between theory as mechanism and explanation — a ‘scientific’ approach — and more philosophical theory which can act as a useful guide to attention for practitioners. We point to potential connections between this view of SF work and recent developments in the field of enactive cognition and post-Wittgensteinian philosophy of mind, including narrative philosophy.

*“Have you heard the latest rumor ... ?”*

— Miller and de Shazer, 1998

In a tradition espoused by one of its key founders, Solution-Focused Brief Therapy (SFBT) has remained more of a rumour (a fuzzy bundle of ideas and practices) than a well-defined fact (Miller & de Shazer, 1998). Since the publication of the ground-breaking paper *Brief Therapy: Focused Solution Development* (de Shazer et al., 1986) there has been far-reaching evolution within the field. In the spirit of ‘rumouring’ this evolution has been documented more by story-telling than through rigorous academic discourse. Practitioners have been inspired as much by conferences and conversations as by the written word and even that has been in the story-telling tradition: what to do rather than why to do it. This practical approach to learning and developing Solution-Focused skills has brought great benefit to the field which is now global, not only in its therapeutic mode (Franklin, Trepper, McCollum & Gingerich, 2011; Ratner, George & Iveson, 2012) but also in its applications to organisa-

tions (Jackson & McKergow, 2002; Berg & Szabo, 2005; Lueger & Korn, 2006; Iveson, George & Ratner, 2011). There is also firm evidence of the effectiveness of SFBT across a variety of contexts (see Macdonald, 2011 as well as Franklin *et al*, 2011 cited above). However, the absence of Solution-Focused accounts in the wider academic world, particularly in big-hitting fields such as psychiatry and psychology, places the field in a curious limbo when seen from the viewpoint of policy-makers and commissioners.

Solution-Focused Brief Therapy's lack of a 'scientific' psychological theory has placed it at a disadvantage within the medicalised mental health field within which most academic discourse takes place. In this paper we hope to initiate a fresh look at theory within the SF field; not a scientific 'causal' theory but a theory based in that other equally long-lived academic endeavour to come to grips with the world, philosophy. We might even begin to see Solution-Focused Brief Therapy as a form of 'clinical philosophy', interested not so much in causes and cures as in influences and possibilities.

## Development of Solution-Focused Brief Therapy

*"A year on from now ... our thinking about change will change"*

— Nunnally, de Shazer, Lipchik and Berg  
(members of the original Milwaukee team), 1986

This conclusion to an early paper by the Milwaukee team is as true today as it was thirty years ago. Solution-Focused Brief Therapy continues to evolve but not as a single entity. It has become a growing collection of ideas and practices that share a common ancestor and consequent family resemblances as well as increasing differences. Its roots lie in a complex mesh of therapeutic theories and practices chief of which were the systemic and interactional approach of the Mental Research Institute (MRI) in Palo Alto, California (Weakland & Watzlawick, 1974) and the hypnotic approaches pioneered by Milton Erickson in Phoenix, Arizona (Haley, 1973). The MRI focused on determining repetitive patterns of problem behaviour and then creating interventions intended to disrupt those patterns so new possibilities could emerge. Many of these interventions were inspired by Erickson's work which was almost always indirect — creating a new experience from which to build new ways of living. Erickson's other major contribution was to focus therapeutic attention on the client's own resources — searching for future possibilities within the client's existing (though perhaps unrecognised) repertoire of behaviours.

Many Solution-Focused brief therapists have remained close to these early influences (best summarised in Steve de Shazer's *Keys to solution in*

*brief therapy* — de Shazer, 1985 — though the ‘blueprint’ for most is probably de Shazer’s *Clues: Investigating solutions in brief therapy* — de Shazer, 1988). Though ‘the problem’ is still necessary in this framework it is much less central. It is needed because ‘exceptions’ are the preferred route to solutions with a future orientation being directed towards specific goals. In de Shazer’s next book, *Putting difference to work*, (de Shazer, 1991) he tried but could not quite manage to remove the notion of problem altogether. Instead the word is always written *problem*, in the sous-rature style of Heidegger and Derrida, in order to denote its irrelevance to the ‘solution’.

## Leaving the problem behind

The next development, dispensing with the need even to know the client’s problem, came from a number of sources including the work of John Walter and Jane Peller (Walter & Peller, 1992) and Harry Korman and Martin Soderquist (Korman & Soderquist, 1994). At BRIEF, instead of asking “What brings you here?” — which elicits a problem account — they began to ask, “What are your best hopes from coming here?” — which invites the client to specify an outcome (George, Ratner & Iveson, 1999). With this question the client is freed from the need to describe a problem (though many clients still choose to do so). An associated development is that without knowing the problem it is impossible to ask for exceptions so the second question became the ‘miracle’ or ‘tomorrow’ question eliciting a description of the client’s preferred future. Exception questions are then replaced by finding instances of the miracle already happening (Iveson et al., 2011). The more detailed the description of the hoped for future the more likely were these instances to be uncovered. This greater attention to the client’s preferred future (as opposed to the dreaded future, harbingered by problem-defined past) appeared to have a therapeutic value in itself and this realisation led to further experimentation with the model.

Similar thinking about the connection of exceptions to the problem was also going on in the organisational consulting arena. Jackson & McKergow (2002) coined the term ‘Counters’ to describe examples of the preferred future happening already, or in part, or sometimes, or even a little. They too were dissatisfied by the way ‘exceptions’ kept the problem in the room, where a more focused conversation could be had by asking more specifically about elements of the preferred future already sometimes occurring. Jackson and McKergow’s version also includes strengths, skills, resources, co-operation and know-how relevant to the preferred future (as opposed to just not to do with the problem).

## **‘Ockham’s Razor’**

*“Numquam ponenda est pluralitas sine necessitate”*

— William of Ockham, 1334

A guiding principle in de Shazer’s work and continued by BRIEF has been ‘Ockham’s Razor’ — simply put, ‘don’t do more than you have to in order to achieve your desired end’. This requires us to test and continue to test the necessity of what we do. One example was to dispense with tasks. As clients’ progress did not seem to be conditional on task performance it was logical to test their necessity. BRIEF, therefore, decided to drop tasks and see what happened to outcomes. What happened (in an admittedly modestly-sized survey) was that the average number of sessions dropped and the outcomes remained the same (Shennan & Iveson, 2011).

As therapists became more skilled at eliciting descriptions of possible futures and the histories that could support them they also became more aware of their own insignificance: well-meaning interventions like tasks and even encouragement looked more like intrusions, interrupting rather than assisting the client’s progress. Similarly, when single-session therapy is a common occurrence, it is difficult to award much credit to a ‘special relationship’. Instead, the credit must go first to the client: whatever changes he makes tomorrow will have its setting already intact — if not in view — before the first session begins. The therapist’s part is to be skilled enough in the conversational process to help the client describe a possible future and uncover its potential history while not becoming a stakeholder in the client’s life. As will be seen later in the transcript section of this paper this is a deceptively simple-yet-not-easy task and one which requires acute attention to each of the client’s responses and quick decisions about what parts of each response to follow.

## **Why do we do what we do? Why does what we do work?**

The apparent circularity of these two questions is a trap that this paper is seeking to avoid. The version of Solution-Focused Brief Therapy described above did not develop ‘because it works’ but rather through a mixture of deliberate and accidental trial and error at BRIEF. The ‘because it works’ came later when the next outcome study showed no change in effectiveness alongside a reduction in the average number of sessions. As we continue to experiment we can expect (and hope) that what we do continues to change and continues to work. What endangers this evolution is the question ‘Why

does what we do work?’ and the danger is to be found in the word ‘because’. Once we fix on a theory (x happens because y — e.g. the client improved because the therapy raised his self-esteem) we, and those who subscribe to our theory, start putting the theory into practice (doing y to achieve x — e.g. raising the client’s self-esteem to achieve change). Practice then begins to follow the theory and the client ceases to be the ‘expert’. Positive Psychology has followed exactly this route (Seligman, 2011). The challenge for us is to keep theory subservient to practice, to what actually happens while at the same time answer, at least provisionally, the legitimate question ‘Why does what we do work? This brings us to the vexing question of ‘theory’.

## Theory, no theory and what kind of theory

*“I think theories are, at best, useless ... Among other things, a Theory offers explanations, where explanations are dubious and are not connected to solutions.”*

— Steve de Shazer, SFT-L listserv, October 1998

It is sometimes said that SF practice has no theory — that it’s about finding what works for each client, whatever that turns out to be. We think this cannot be the whole story. There are many kinds of theory. The one being complained about by Steve de Shazer in the quote above is to do with explanations — explanations of how the client came to their present situation (and therefore what to do about it) and explanations of how change happens. Many therapy schools have theories like these — that change happens by changing thoughts, by addressing past fears, by ‘working through’ negative feelings, and so on. This is theory of mechanism. Similar kinds of theory are found in the natural sciences, where iron rusts because of exposure to oxygen, diseases spread by infection of viruses and planets attract each other because of gravity.

In this kind of theory, knowing the theory helps us to get the results we want. So galvanising (protecting iron with zinc) helps prevent rusting (by keeping the water away from the iron), hand washing helps prevent the spread of infections (by removing bacteria). If we want to send a rocket to the moon, having a theory of gravity will help calculate the exact trajectory for the rocket to arrive in the right place, given the competing pulls of the moon and the earth.

SF practice is notable (though not unique) in eschewing this way of thinking. We do not claim to know how our clients get into difficulties nor what they need to do in order to get out of them. We assume that knowing ‘why’

(especially given the number of competing ‘why?’s) will not help the client do ‘something other’ nor can we know what that ‘something other’ could be until the client develops it in practice. This not knowing position requires us to change our way of listening to what the client says. When we have a theory we process the client’s answers through that theory and ask questions which derive from the theory. If we have linear causal theory we might ask “When did it begin?” If we have a systemic theory we might ask “How does that affect your relationships?” There is then a danger that the theory begins to drive the conversation or, even worse, the client is shoe-horned into a fit with the theory. As soon as we start to think in these terms, whether from our training or our ‘hunch’ about this client, we can only ‘listen with one ear’, the other ear being engaged in an internal conversation with the theory.

### **Theory as ‘what to pay attention to’**

For most scientists a theory is about a mechanism, an explanation of how things work. This works well in the ‘molecule’ fields such as physics but in the ‘meaning’ fields such as therapy, where meanings are in a permanent state of being socially and publically constructed and reconstructed, theory cannot be separated from the feedback loop of practice. John Shotter (Shotter, 2005) points to theory-in-use by practitioners — the ways in which the practitioner has learned what to pay attention to and how to respond to what he is hearing. Though useful this is not an easy idea. It is useful because it provides a way for the field to study and discuss what we do and why we do it. It is hard because it is not an ‘A + B causes C’ theory but a more inexact ‘process’ theory in which every time A and B come together they rub up against each other in unpredictably different ways so that C never quite looks the same; our understanding of the relationships between A, B and C is always provisional, always needing adjustment. When we then factor in the ‘observer influence’, the fact that how we look at the As, Bs and Cs makes a difference to what we see (and how they each react to being seen), it is easy to understand why on-the-ground practitioners might decide to dispense with theorising altogether.

Fortunately, doing this ‘clinical philosophy’ is easier than talking and writing about it. One practitioner can watch another at work and notice what aspects of their practice seems to generate positive effects. They might particularly notice a variation in the use of a particular technique such as the ‘miracle question’ that leads to a different sort of conversation. When therapist and observer have their post-session conversation they will talk about this difference, consider how it changes their ideas about the therapeutic process, assess whether it can be generalised and made to fit with other cli-

ents and in subsequent weeks talk about the differences that have begun to emerge in the doing and thinking about therapy. This might all take place in formal clinical meetings or in snatches of corridor conversation: it is what we would call practice and theory in evolution and is associated with 'good practice' whatever the model of therapy.

A very marked difference between Solution-Focused conversations and those of many other models is in the way of listening, as summarised by McKergow & Korman (2009). If a model is based on an explanatory theory with its own language and beliefs the therapist must both listen to the client's words and 'translate' them to the language of the theory. She also needs to seek the client's cooperation with her theoretical position and one way to achieve this is to begin paraphrasing the client's responses. If the client agrees with this slight change in the meaning given to his words then he feels heard and possibly understood in a new and engaging way. If he doesn't agree then he can say so and the therapist will adjust her own words until a fit is found. (It is at this, usually very early, point that 'manualised' therapeutic procedures begin to break down since it is impossible to manualise this process of adjustment.)

The 'fit' SF practitioners seek is around a description of the client's aspirations, not an understanding of the client's problem, and for this they need to rely on the client's language, since this will most accurately represent their aspirations. The microanalysis research of Janet Bavelas and colleagues (Korman, Bavelas & De Jong, 2013; Tomori & Bavelas, 2007) shows SF practitioners using the client's words significantly more and introducing their own concepts significantly less than any other model studied. Hearing her own words being spoken back is another way the client will know that she is being listened to carefully.

Though therapists will try to listen to everything the client says they cannot respond to everything, they must select which part of a client's answer will be most useful in constructing the next question. This is why a model is essential — we need to have a coherent framework for making these selections. We might listen to everything but we select very carefully what we pay attention to and it is this selection which shapes the conversation into one about past causes, present challenges or future possibilities. The model we propose here is based on description.

### Three key elements in first therapy sessions

The somewhat pared-down version of Solution-Focused Brief Therapy at BRIEF consists of three questions, based on the assumption that every client, including those mandated to attend, have a good reason — a desired out-

come — for being there.

1. What are your best hopes from our work together? (The ‘contract’ or what McKergow and Jackson (2002) call the ‘platform’ and Korman (2004) refers to as the ‘Common Project’)
2. How will you know that these hopes are being realised? (The client’s preferred future)
3. What are you already doing that might contribute to your hopes being realised? (The history of the preferred future)

There are many versions of these questions but what they share is a focus on description and only description. The broad description of an outcome, a more detailed description (perhaps beginning with a ‘miracle’ or ‘tomorrow’ question) and a description of past and present instances of the hoped-for future happening (usually summarised in a scale).

This process is exemplified in the case of Mary below. The therapist stays entirely within the realm of description, making no attempt to introduce any notion of his own about what Mary ‘needs to do’. Indeed, he works hard the whole time to maintain a neutrality towards what the client does tomorrow (a neutrality he would abandon only if he thought the client or anyone else might come to significant harm.)

### **Case example: Mary and the cuddle**

This case concerns Mary, a woman in her mid-40s who attended BRIEF referred by her GP following depression and the GP’s concern at the risk of suicide.

Having established Mary’s hope that she wants to have a sense of peace and hope for the future, and to not be continually dragged back into the past (the contract), the therapist leads into the following ‘miracle’ question (at five minutes into this particular session):

*Interviewer:* If tonight while you are asleep a miracle happened and it didn’t get rid of the past, but it stopped the past messing with your future, but you were asleep when it happened so you didn’t know, what is the first thing you’d notice when you woke up tomorrow that began to tell you that you had this sense of peace and acceptance?

*Mary:* I think I would probably know...the biggest thing I would know is that I am good enough in who I am. I don’t have to prove myself or constantly seek approval from the people who have let me down and brought me to where I am. That I, in my own right, am good enough.

*Interviewer:* So what time are you likely to wake up tomorrow?

The client's global answer is (non-verbally) accepted and then she is invited to think small. This is one of the most useful ways into a detailed description — locating it in a particular and familiar time and place. The client goes on to describe her breakfast, her drive and entry to the gym, her workout, her meeting with friends, lunch, reading a book and talking to her sister on the phone. These descriptions fall into three broad categories: What she notices about herself, how she appears to others and what happens between her and those others.

Twenty-five minutes into the session, the therapist invites a description of what he guesses is one of the more significant moments of the client's day — the moment her partner discovers and responds to her 'post-miracle' state. Her partner has left for work before she wakes so his discovery of the 'miracle' will take place when he arrives home in the evening. As the most significant persons in each other's lives this meeting will hold many possibilities. (This is an example of co-construction; it's not a question of the client leading or therapist leading, the client has given the therapist information upon which he can act. If this doesn't turn out to be a significant moment for the client, we can move on.) The description starts a few minutes before her partner's arrival, once again with a scene-setting question.

*Interviewer:* And when does Jeff get home?

*Mary:* Usually about five or six o'clock.

*Interviewer:* Okay. And what would you be feeling then in this sort of half hour or so before he is about to arrive home? What would be telling you then that this miracle was still working for you?

*Mary:* I would probably be... instead of locking us both indoors for the evening, maybe thinking about where we could out just the two of us perhaps for a little walk together or just to do something – I spend too much time indoors.

*Interviewer:* Where might you think of going for a walk.

*Mary:* We live quite close to a beach so perhaps along there.

Even before her partner gets home the relationship between them, what they do together is changing thus preparing the way for a different interaction.

*Interviewer:* And what is the first thing he would notice when he got home, even before you spoke? What is the very first thing?

*Mary:* I would be... instead of a worried, stressed, anxious look on my face maybe a smile.

*Interviewer:* Okay. And what would be the first thing you would notice

about his response even before he spoke?

*Mary:* I think my body language would just be so ... you know normally he has to come looking for me whereas I would imagine that I would be open to go and cuddle him instead. You know? So ...

*Interviewer:* Would he faint or ... ?

*Mary:* Possibly, yeah, absolutely. You might have to have the paramedics on standby, yeah. I think it would be shock, but pleasant shock rather than shock shock.

*Interviewer:* So where would that be? Where would you be cuddling him?

*Mary:* I would imagine that ... because I do almost always hear him pull up. I never go to the door. I let him come in through the door and come find me. Whereas I would probably go find him.

*Interviewer:* Okay, so that would be a different ...

*Mary:* Yeah.

*Interviewer:* And what would you notice about the way you cuddled him that fitted with this sense of peace and pleasure, of being you?

*Mary:* He describes sometimes that when he asks me for a cuddle... he said 'When I ask you for a cuddle ...' and I do give it to him, he goes 'You are rigid and you almost ... you cuddle me but you are pushing me away.' So I would imagine that it would be a much more natural, open embrace where I felt relaxed and safe enough to do that. Not rigid and tight.

*Interviewer:* And what would you notice about his response to your cuddling and that kind of relaxed ... ?

*Mary:* I think that he would be delighted with how it felt to have a cuddle that didn't feel like he was a) having to ask for or b) being pushed away from.

*Interviewer:* And what would you notice about his arms?

*Mary:* I think they might be quite tight around me and probably hold me for longer than normal.

*Interviewer:* Okay. And what would you notice about how you handled that?

*Mary:* I think it would be quite difficult because you get so rehearsed in how you do things. Whether that be good or bad, that's how you are. So I think it would be quite a new experience to have that.

*Interviewer:* And if you are feeling like hugging him?

*Mary:* Not wanting to let go either rather than wanting to break that embrace.

*Interviewer:* Okay.

*Mary:* Because at the moment it's like 'Okay, cuddle, quick, out of the way.' Whereas to actually enjoy the embrace and feel it rather than just do it and break away from it.

This description of the cuddle takes about three minutes, considerably longer than the event itself is likely to be. During the description, a visible change takes place on the client's face, in her tone of voice which suggests that the description is evoking some sort of felt experience. This is not an 'accidental' description. Such detail does not come without careful scene-setting which helps place the client's future within her everyday routines.

A little time is spent on the post-cuddle moment and then on to the next 'scene':

*Interviewer:* And what would you notice about him as you do eventually break away from the embrace?

*Mary:* I think that he would possibly be very happy to have experienced a ... not always having to want to ask. To find ... you know, for me to acknowledge his needs and be able to actually do that for him.

*Interviewer:* And how would he know that you are pleased to have had that embrace? What would he notice about you?

*Mary:* Because I wouldn't be rushing away from him, looking at the next task that has to be done. It's like hugging Jeff is on the list, I've got to do that and then I've got to get on and do this and do that. I probably would maybe just stand there with him maybe and chat about his day rather than rush off and try and do something different.

*Interviewer:* Is that when you might suggest a walk or would that be ... ?

*Mary:* After dinner maybe.

*Interviewer:* After dinner? Okay. So what might you have for dinner?

## Experience and description

To simplify (or more likely mangle and misrepresent) Wittgenstein, from whom de Shazer drew much inspiration, conversations will generally include expressions of feelings, descriptions of actions and explanations of both. For

Wittgenstein description was the most clear. Descriptions need to be of something that's open and visible, in order that the description can be seen and agreed to be accurate (Wittgenstein, 1953). This means 'staying on the surface' in Steve de Shazer's terms (de Shazer, 1991) — talking about what the client does within and in response to their surroundings.

The descriptions we are seeking in the therapy room are innocuous looking everyday mundane descriptions of normal events — either in the client's possible preferred future, in the present or in the past. It is clear from the example that the therapist does not ignore the client's 'inner world' of emotions: he frequently asks questions such as "Would you be pleased...?" but this inner or private experience of pleasure is then translated into the public arena of described actions ("I probably would maybe just stand there with him"). Throughout, the focus is on description rather than explanation.

## **Reaching out — embodied and enactive cognition**

Mary's apparent emotional experience, coming with her description, adds weight to the idea that the mind is 'embodied' rather than held within the confines of the skull, and that cognition is 'enactive', comprising our interactions with the world rather than computing all the messages coming from the world. Theories of embodied and enactive cognition have been gaining ground in both psychological and philosophical disciplines (Clark & Chalmers, 1998; Varela, Thompson & Rosch, 1991) and the implications for therapists are still becoming clear. The writing seems to be on the wall for the body/mind separation which has allowed us to imagine, for instance, that it will one day become possible to 'know' ourselves fully by simply understanding how the brain works.

Enactive cognition, see for example Hutto and Myin (2013), challenges the conventional view of the mind as some kind of computer, taking in information to process and produce behaviour. Instead they see thinking as just one part of a cognitive process that engages the whole person. In a similar fashion to Wittgenstein (Moyal-Sharrock, 2013), enactivists propose that the mind has no independent mental function so going in search of desires and beliefs in a skull-bound mind is a fool's errand. People, not minds or brains, believe and desire things, and they do this in their actions and interactions with the world, including other people. Experience, in the enactive account, is not an outcome of cognitive processes, it is the way in which we as 'whole persons' work directly with the world.

It is this notion that BRIEF has bumped into by its application of Ockham's Razor. As therapists at BRIEF concentrated more on description and less on

action they became aware of unexpected 'in-session' changes in the client's way of being in the room. Not just changes of mood associated with an outcome-focused conversation but an entire change in the client's described experience of themselves' in the moment. In these cases it seemed that the description of a preferred future led to the actual experience of (something akin to) that future rather than a 'cognitive map' of something yet to happen.

When Mary describes the future she would like to have, even though she sees no possibility of it happening, the description, because it is so detailed, is no longer just an imagined possibility, it becomes an experience in itself. Mary does not just describe a possible future, she experiences that future and so becomes a person with those experiences, a person with hope who does not have to be "sucked back into the past". It is possible, therefore, that the experience of co-creating a detailed description is a potent therapeutic intervention in itself, the conversation being the thing rather than 'about' the thing.

## Description and Narrative

Humans are story-tellers, we like to 'join the dots' between our experiences and create 'narratives' that somehow make sense of our lives. These narratives then influence our expectations and consequently our ambitions for the future. Our capacity for story-telling has been the subject of much philosophical debate and theorising

At one end of the spectrum "Strong Narrativism" (in its simplest form) argues that we construct the 'self' through the stories we tell and the self can therefore be reformed by changing the stories. The philosopher Anthony Rudd (Rudd, 2012) argues that the self "only comes to exist through its being narrated" (Rudd 2012 p. 1.). Changing the narration must therefore change the self. It is this idea that lies at the heart of Narrative Therapy (White & Epston, 1990 ). A more modest narrativism is proposed by Dan Hutto, who says the accounts we give of our lives, our narratives, have a more metaphorical function "a natural form of self-understanding and self-shaping" (Hutto, 2014), which brings the infinite complexity of our lives to a more manageable size. What aspects of our experience we choose to put with our life story will undoubtedly influence the life we lead but that life will not be determined solely by the story. The story isn't the person and the person isn't the story; the story just a vehicle for making sense of life and our place in life. Thus the more elements allowed into the story of our past the more possibilities we are likely to see in the future. Exceptions (to the problem story) and instances (of the preferred future story) both add new elements from which "self-understanding and self-shaping" can be drawn.

What is crucial in this process is that the therapist remains neutral about the future steps the client might choose to take. Any attempt, however subtle, to direct the client towards action is likely to be experienced as a form of expropriation: using the client's ideas to feed the (good) intentions of the therapist. Only by staying with description can this neutrality be maintained and the client be left fully in charge of her life. Similarly, the therapist is not out to create an emotional experience, to make this an aim would be to assume that this is right for the client. The emotional experience that might arise from a description can be best seen as a bonus — one of the many ways SFBT influences lives and one particularly associated with rapid change.

## Conclusions

This paper began with the idea of finding a theoretical home for Solution-Focused Brief Therapy (and its offshoots) but one that did not constrain or direct the continuing development of the model. The best we have been able to do is to follow the habit of the hermit crab and find a home that fits but does not dictate and one which can be exchanged for another as our practice and our thinking about practice evolves.

The new 'home' closely resembles the one provided by Wittgenstein to de Shazer's early ideas but have expanded it with ideas from current developments in philosophy which offer not causal explanations but possible patterns of influence: when A and B come together something like a C often appears. Or, more specifically, when we ask questions about a client's hoped-for future we think that their answers set off different thoughts, emotions and actions which lead them to have richer ways of seeing themselves within their life: a richer history from which to select a view of their past and a wider selection of possibilities in their future. We also have to admit that we have painted a somewhat caricatured picture of psychological 'causal' theories. They are not homogeneous entities and there are many crossovers between psychology and philosophy as well as between the growing number of resource-oriented therapies.

In the end we hope simply to have shown that there is as much intellectual legitimacy as there is pragmatism behind Solution-Focused practice and that this form of theory supports the continued development of a model which provides no way of knowing what any client should do next. Our theoretical exploration grows out of the practice as seen in the 'Mary' transcript and so remains practice-led. If we were bold enough to imagine Steve de Shazer's response to these developments we might expect him to be more than satisfied that the 'facts' as we know them today are as fully supported by the 'theo-

ries' of Wittgenstein as the 'facts' he and his team discovered thirty years ago:

The difficulty — I might say — is not that of finding the solution but rather that of recognizing as the solution something that looks as if it were only a preliminary to it... This is connected, I believe, with our wrongly expecting an explanation, whereas the solution to the difficulty is a description, if we give it the right place in our considerations. If we dwell upon it, and do not try to get beyond it. The difficulty here is: to stop ... for you are already 'at' where you need to be; there is no necessity to 'go beyond' your present circumstances — the way to 'go on' can be found 'there'.

— Wittgenstein's Zettel (1981), section 314.

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## Complimenting in Solution-Focused Brief Therapy

**Frank Thomas**

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Complimenting has been a criterion within Solution-Focused Brief Therapy history and tradition. From the early development of the approach in Milwaukee, compliments played a key role in pointing out client strengths/resources and heightening the end-of session task. In this manuscript, complimenting is reviewed historically. Then the practice is critiqued using the notion of “not-knowing” (Anderson & Goolishian, 1992; De Jong & Berg, 2012), followed by a commentary on possible cultural considerations that need to be considered by the SF practitioner. Finally, a review of traditional complimenting is offered along with additional types, with alternate applications and clinical examples that better fit with not knowing and intercultural practices (Miller, 2014).

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Several years ago, I presented a two-day workshop in a large European city. Simultaneous translation from English to the local language was made available to the participants. I met the professional translator (who was not a psychotherapist) at the beginning of the day but did not speak with her at length.

She sat in the back of the room quietly speaking into a microphone during the workshop and attendees heard her translation through headphones. Near the end of the first day's presentation, I said to the group, "I appreciate the translation services offered by the workshop organisers and want to thank Ms. X for her valuable contribution to today's presentation." We concluded the first day's time together, and after speaking with colleagues for a few minutes I went looking for the translator to thank her personally. The workshop organiser noticed my puzzlement when I could not locate her. "She left immediately after you concluded," he said, "and she said she might not return tomorrow for your second day." "Why not?", I asked. "Well ... You were too direct with your praise, and she felt embarrassed." I was mortified and felt ashamed. I pride myself in being culturally sensitive and yet I had committed a personal offense that created discomfort for another and quite possibly altered the experience for all of the attendees if she would not be available to translate the next day. The organiser contacted her that evening, passing on my apologies, and she agreed to translate the second day. At the end of the workshop, I said to the group, "It appears that you were focused on the content of the workshop whether you chose translation or listened without headphones. Although I may be wrong, it seems as though the support team has taken care to provide a professional experience for everyone, and I am grateful to all who contributed to our success today." I looked to the back of the room and noted the smile on the translator's face ... this time, my compliment was appropriate.

I learned a great deal about culture through this experience that has served me well as I have presented around the world. But I also came to the realisation that the Solution-Focused (SF) community has not systematically addressed complimenting and all its forms so practitioners and trainers can adapt this SF heritage to the sensitivities of culture and context.

## The Not-Knowing stance

One means toward honouring others' experiences is adopting the position of "not-knowing" (Anderson, 2005; Anderson & Goolishian, 1992; De Jong & Berg, 2012). The philosophical stance of "not-knowing" is simply "that the therapist's contributions, whether they are questions, opinions, speculations, or suggestions, are presented in a manner that conveys a tentative posture and portrays respect for and openness to the other ..." (Anderson, 1995, p. 36). Insoo Kim Berg and others adopted this posture within SFBT in the 1990s, appealing to SF professionals to practice less strategically and more collaboratively (Berg & De Jong, 1996). This approach involves being tenta-

tive and curious in one's contributions to the conversation whenever possible. A practice of "not-knowing" supports a constructionist approach that rejects the notion that professionals have special knowledge about clients and sustains therapeutic partnership.

However, adopting a philosophical posture of "not-knowing" and applying it in-session is often challenging. Extending the concept of not-knowing in SFBT, Chris Iveson called attention to compliments and other SF practices over a decade ago when he wrote:

This most extreme version of the many ways Solution-Focused Brief therapists try not to know puts into question the necessity of both tasks and compliments. ... The fact that it is not a "problem-focused knowing" makes it no less "knowing." Compliments .. require a form of knowing that does not sit easily with the principle of "not knowing." They are, after all, the product of an assessment. We only have to give a bad compliment (e.g. one which celebrates a positive quality within our own culture which is regarded differently within the client's culture) to know how flimsy and provisional these assessments can be. (Iveson, 2005, p. 5)

Iveson's reflections pushed my own thinking. Are there alternative forms of complimenting that are less declarative? Have SF professionals been practicing forms of complimenting but not articulating differences regarding uncertainty and cultural sensitivity? And, how can those who choose to extend the legacy of complimenting, an integral part of SF practices, do so while holding closely to the not-knowing stance?

## **SF Approaches and complimenting**

### **Early Development: de Shazer, Berg, and the Brief Family Therapy Center (BFTC)**

Early publications from Steve de Shazer reveal a strategic orientation to the use of compliments (de Shazer, 1980, 1982, 1988). Compliments "provide(d) an effective 'anaesthetic'" for the task assignment that followed (de Shazer, 1980, p. 471). In these early days of developing the Solution-Focused approach, compliments were often utilized as reframes, tools to elicit a family's cooperation as the therapist and team crafted an intervention. Clients were induced into more relaxed postures by compliments, which fit with de Shazer's background and use of Ericksonian hypnosis techniques (de Shazer, 1988).

In their classic paper outlining the Solution-Focused approach, de Shazer and his BFTC colleagues articulated the role of compliments in their early work:

The purpose of the compliments is to support the orientation toward solution while continuing the development of what Erickson called a “yes set,” ... the start of the therapeutic message is designed to let clients know that the therapist sees things their way and agrees with them. This, of course, allows the clients to agree easily with the therapist. Once this agreement is established, then the clients are in a proper frame of mind to accept clues about solutions, namely, something new and different. (De Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich & Weiner-Davis, 1986, pp. 216-217)

Compliments focused on “anything the client did that worked” (p. 218) to encourage replication of such changes.

Documents from the first years of SF practice at BFTC reveal more than the strategic uses and placement of compliments. In an unpublished training handout (BFTC, “Eyes,” 1991), Berg, de Shazer, and their colleagues sketched out several types of compliments. *Direct* compliments are therapist statements about client self-reports or therapist reactions or conclusions. This type of compliment was to be used “sparingly” if conclusive but encouraged if reactive (“Wow! I like that!” would be an example of a reactive direct compliment.) *Indirect* compliments imply using the interrogative form. Several subtypes were listed and illustrated, making use of client language, relationships, and self-knowledge. Finally, *self*-compliments are client statements about themselves that are positive in nature. In this training document, the therapist is directed to notice (not elicit) self-compliments and trained to call attention to the clients’ positive conclusions about themselves by reacting. An example: if the client says, “I decided to quit X because I finally wised up,” then one should respond/react with “How about that!” The training goal was clear: “for clients to *notice* positive changes and not for them to accept compliments” (p. 2, emphasis in original).

This original set of distinct compliment types — direct, indirect, and self-compliments — was incorporated into Berg’s writing and training throughout her career (Berg, 1994; De Jong & Berg, 2002, 2012). It is also clear that de Shazer distinguished types of compliments and used them clinically to the end of his career as well (de Shazer, Dolan, Korman, Trepper, McCollum & Berg, 2007). These compliment types, along with other possible categories, will be further defined and developed later in this paper.

## Cultivating compliments in the SF Tradition

This tradition of complimenting-with-purpose continued into the 1990s with the development of compliment templates (Campbell, Elder, Gallagher, Simon & Taylor, 1999) and other specific complimenting strategies including summaries of successes, reminders of client goals, and calling attention to client strengths (De Jong & Berg, 2002, 2012). Campbell and her colleagues (1999) designed their template to generate cooperation but also to call attention to client competencies. Compliments had transitioned from a means to an end (cooperation with a task and acceptance of therapist/team conclusions) into a technique with multiple applications. Client responses to compliments informed the therapist regarding normalising, connection, affirmation, and validation, purposes not emphasised previously. What continued was the specific placement or normal timing of compliments. Much like de Shazer's original use, compliments were offered after a team consultation break and prior to the delivery of a message or task.

Complimenting evolved at the Brief Family Therapy Center (BFTC) in Milwaukee, Wisconsin as well. When working with clients experiencing problem drinking, compliments differed with relationship type (Berg & Miller, 1992). Practitioners would vary compliments based on how the therapist defined the relationship with the client as visitor, complainant, or customer. Whether one compliments a client for taking positive steps, suffering, or working hard was based on the professional's assessment of the working relationship rather than client goals or developing a yes-set. Compliments were seen as intervention tools to enhance cooperation — again, a strategic means to a therapeutic end.

According to De Jong and Berg (2002, p. 35):

When complimenting was first introduced at BFTC, compliments were mainly used at the end of the interview, to draw clients' attention to strengths and past successes that might be useful in achieving their goals. Little by little, practitioners turned to complimenting throughout sessions because the procedure seems to help clients grow more hopeful and confident. In-session complimenting also helps to uncover more information about client strengths and successes.

Although they caution practitioners regarding the use of different compliment types, De Jong and Berg continue to describe compliments as purposeful; that is, the practitioner should "remember that the first goal in giving compliments is for clients to notice their positive changes, strengths, and resources" (2002, p. 36). At this point in time, compliments were not yet

part of the conversational repertoire of the practitioner to build solutions; they were still tools to be used intentionally to further goals. Even if clients become more aware of strengths and resources, this awareness aligned with the professionals' view of what was useful or necessary to transition client relationships toward a customer-type and encourage client cooperation with the therapeutic process.

In a significant evolutionary shift, Berg and De Jong (1996, p. 390; c.f. 2005) articulated the value of "in-session compliments" in addition to end-of-session complimenting integral to task development and assignment. They also noted the necessity of maintaining a "not-knowing" position (Anderson & Goolishian, 1992) while complimenting and encouraging clients. However, Iveson's (2005) point that direct compliments spring from a posture of knowing had not yet been addressed.

### Compliments in current SF practices

In de Shazer's final book (de Shazer et al., 2007, p. 4f), compliments are listed as a "main intervention" in and "essential" to the SF approach. In addition to their traditional importance in end-of-session messages, the authors note compliments are an effective way to validate client experiences. Compliments also call attention to client success while communicating, "I am listening."

De Jong and Berg (2014) place emphasis on complimenting for SF trainers, stressing curiosity and specificity along with utility. While important to note compliments the interviewer offered to the client, the trainer is directed to be specific whenever possible. Instead of, "You gave great compliments," the trainer is encouraged to point out the content of the interviewer's compliment and the observed client response (p. 6). Complimenting is an important SF skill to be developed through training exercises and role plays with a clear emphasis on locating experiences or resources to compliment as well as responsiveness to the observed effect of the compliments. Learners are instructed to incorporate complimenting into their normal course of practice as a part of "EARS" (elicit, amplify, reinforce/compliment, start again), a way to amplify client exceptions and strengths and encourage client engagement in the process (Turnell & Hopwood, 1994; De Jong & Berg, 2012). Faithful to its historical use, De Jong and Berg (2014) also emphasize the essential role compliments play in end-of-session feedback to clients.

Other prominent SF trainers, educators, and practitioners vary greatly in the use of compliments. The practice manual created by BRIEF (George, Iveson, Ratner & Shennan, 2009) does not mention complimenting at all. Progress is noted through questions (often involving scaling) of current positive

change and small signs of future progress, but the word “compliment” is not used in the document. Instead, these trainers take a different tack:

...Solution-Focused therapy aims to create a context within which the client gives self-affirmative feedback which in turn builds new possibilities for the client’s future. Clients seem to be least likely to argue with or to minimise the constructive feedback which they give themselves and thus solution focus tends to work through a questioning process within which it is the client’s answers which will make the difference. This is very different from a process of “pointing out positives” to clients and giving them praise! (George et al., 2009, p. 8)

In their 2012 book on SFBT, the BRIEF group stated that compliments “need to be honest and evidence-based” as well as “relevant to the client’s purpose for being in therapy” and “given in a way that the client can accept and can agree with” (Ratner, George & Iveson, 2012, p. 43). They also believe end-of-session complimenting can bring a focus to the therapist’s “attention *during* the session” (emphasis in original). However, compliments do not seem to be prominent in the clinical work and training at BRIEF.

My sense is that the BRIEF group has made a shift from compliments-as-tool to a curiosity-guided approach that includes conversation surrounding instances (times when they experience moments of their preferred future) and exceptions (times when the presenting complaint is absent or different). The BRIEF group asks the questions, “How did you do it?” (influence progress) and, “What have you learned about yourself?” (pondering progress) (George et al., 2009, p. 24), which invite reflections and may result in what Berg (1994) would call self-compliments. And since the BRIEF group has shifted away from formal end-of-session tasks (Ratner, George & Iveson, 2012), compliments as reinforcers of the team messages are largely absent, a significant change from mainstream SF practices since the 1980s.

Others have also de-emphasised complimenting, usually as a result of adopting a more conversational or social constructionist approach to SF practice. McKergow and Korman (2009, p. 40) describe their shift this way:

Readers may be wondering about the position of compliments — offering views of the client’s strengths, qualities, and so on — in SFBT practice. It is quite true that we as Solution-Focused practitioners offer such compliments, so that strengths may enter the conversation. In our view, these strengths are used conversationally, to give an alternative view of the client and their situation, rather than as fixed elements which must somehow be worked on, worked around, or taken

into account.

McKergow (2014, p. 36) refers to the SF shift as a move from tools to “conversation expanders” resulting in “narrative emergence” rather than internal or structural shifts (c.f. Miller, 2013).

A rift in complimenting may be occurring. While some value its continuation, others are shifting from techniques to conversation as the primary means toward agreed-upon ends. One thing is certain: there is no unanimity on the use or value of complimenting within SFBT.

## Current state of complimenting in SFBT

Complimenting is still required by significant professional organisations and many reviewers if research is to be considered Solution-Focused. In one of the most thorough reviews of SF research prior to the current century, Gingerich and Eisengart (2000) named complimenting as one of the core components of the SF approach. Complimenting is listed by the Research Committee of the Solution-Focused Brief Therapy Association (SFBTA) (Trepper, McColium, De Jong, Korman, Gingerich & Franklin, 2009, p. 5) as an “essential part of SFBT.” Bliss and Bray (2005, p. 66) say complimenting has historically been one of the SF therapist’s “key tasks” and call attention to its prominence in the European Brief Therapy Association’s (EBTA) requirements for evaluating whether or not clinical work is Solution-Focused. And keeping with Gingerich’s standards from his 2000 article, Gingerich and Peterson’s (2013) review of controlled outcome studies utilising SF approaches cited compliments as one of the key techniques in their operational definition of SFBT.

Finally, leading SF authors, trainers, and educators continue to promote and apply compliments in their work. Dolan notes she and other SF trainers have altered their forms of complimenting but imply the practice continues (Chang, Combs, Dolan, Freedman, Mitchell & Trepper, 2013). Well-known and respected SF trainers like Coulter (Coulter & Nelson, 2014), Crow (2014), De Jong (De Jong & Berg, 2014), Dolan (2015), Durrant (Huber & Durrant, 2014), Furman (2015), Nelson (Coulter & Nelson, 2014), Pichot (Pichot & Bushek, 2014), and Simon (2015) continue to utilise complimenting as part of their practices and training. In addition, SF authors and trainers promote the value of complimenting across such diverse contexts as mental health nursing (Ferraz & Wellman, 2008), supervision (Berg, 2003; Lane & Thomas, 2013; Thomas, 2013, 2012), child welfare (De Jong, Jiordano, Cowan & Kelly, 2006), career counselling (Burwell & Chen, 2006), coaching (Grant, 2013; Roeden, Maaskant & Curfs, 2014), play therapy with children (Nims, 2007; Taylor,

Clement & Ledet, 2013), and bullying (Young & Holdorf, 2003).

My conclusion is this: complimenting remains prominent in SF training, research, and practice, but it is not universal.

## Complimenting: Cultural considerations

Discussions about the role of culture in SF approaches have continued for decades, including the necessity for sensitivity when complimenting across cultures (Berg & Jaya, 1993; Berg, Sperry & Carlson, 1999; Chang & Ng, 2000; Corcoran, 2000; Hsu & Wang, 2011; Kim, 2014; Kuehl, 1995; Miller, Kim, Simon & Lee, 2014; Song, 1999; Thomas, 2007; Thomas, Sunderaraj Samuel & Chang, 1995; Yeung, 1999). In the early years of SF practice, Berg and Miller (1992) wrote this about culture in the context of problem drinking:

We discovered through our cross-cultural and international presentations that all cultures use compliments as a means to cementing social relationships at all levels. However, the cultural norm dictates the manner in which compliments are presented. For example, a commonly accepted form of insuring a positive relationship in North America highlights personal achievements and individual traits ... In other cultures, the compliment may be directed at what a person does on behalf of the family, the group, the clan, or the employer ... While North Americans value an open, clear, and direct manner of complimenting one another, other cultures are much more subtle about giving compliments... Such unique cultural and ethnic differences need to be taken into consideration when a therapist selects what to highlight and compliment the client on. (p. 102)

While some have downplayed culture as a significant variable in the effectiveness of SF approaches, Holyoake and Golding (2013) clearly connect multiculturalism and the non-expert stance in the approach. Similar to Miller (2014), Holyoake and Golding start with a conversation metaphor, moving away from structural and intrapersonal assumptions about interaction toward understandings centred on language and discourse. From there, the authors critique “hidden discourses” that “sneakily undermine both the nonexpert and multicultural message” (2013, p. 77). These hidden discourses may include practitioner assumptions that are applied universally, such as an emphasis on personal reports over cultural narratives or ahistoricising individuals by neglecting social relationships and emphasising personal agency. Miller (2014) wrote an eloquent article on culture and SF practices. He concludes, “I cannot imagine a form of Solution-Focused practice that is culture-free ... it

is hard to argue that we live in a world of multiple realities without including the concept of culture" (p. 38). Social constructionist assumptions endemic within SF approaches, such as the construction of meaning in conversation and the importance of considering multiple social realities, require a developed sensitivity to people's contexts within the therapy room and the world they inhabit when they leave our SF conversations.

Although discussions regarding culture and SF approaches have been ongoing, three fairly recent publications (Iveson, 2005; Hsu & Kuo, 2013; Kim, 2014) precipitated my interest in the challenges of complimenting in culturally sensitive ways. As discussed earlier, Iveson (2005) created an enigma for me by overlaying the "knowing" of complimenting with a not-knowing assumption. Kim (2014) juxtaposed the not-knowing stance with the necessity to educate counsellors on multicultural issues. He proposed continuing the SF notion of not-knowing augmented by a research-informed multicultural approach that enhances the clinical relationship by acknowledging barriers and resources unique to clients with diverse backgrounds. And Hsu and Kuo (2013) noted the necessity for cultural sensitivity when conducting Solution-Focused supervision in Taiwan. They found that supervisees in their culture often had difficulty listening to "direct verbal praises" ... "because of the supreme (Chinese/Taiwanese) emphasis and value placed on humility and modesty" (p. 202). They adjusted their complimenting style and technology, asking the supervisee to sit outside the circle of her peers and eavesdrop on their conversation of appreciation for her and the clinical work they had just observed. This indirect complimenting format was highly effective and culturally sensitive, enhancing the supervision by adjusting to cultural values.

In summary, I cite the work of De Jong and Berg (2002) as they discuss the junction of SFBT and culture, stating that

... efforts to foster diversity-competent practice in the field mainly presume the problem-solving paradigm ... . We regard cultural diversity as one aspect of the enormous differences among people and as further confirmation of the need to take a posture of not knowing when interviewing clients. (p. 257)

## Spaces for complimenting in SF practice

Compliments are and will probably continue to be part and parcel of SFBT. Although their early use in SFBT was limited to strategic reinforcement of tasks, they have evolved while maintaining their relevance in practice and research. At the same time, the posture of not-knowing has gained promi-

nence within SF practice, influencing the intentions and forms of complimenting. In addition, sensitivity to culture has gained attention as SFBT continues to spread around the world.

In an attempt to extend the SF approach, I propose changes in complimenting that fit with current research expectations, respecting the stature of complimenting within our common SF history and hopefully expanding applications in culturally sensitive ways. These questions guide my ideas for creating spaces for complimenting: How do those who value the practice of complimenting utilise it while remaining loyal to the concept of not-knowing? and, How do we allow culture to inform our work, especially regarding complimenting?

### Traditional SF complimenting practices re-visited

In this section, several forms of complimenting used in SFBT will be outlined as described in prominent publications. In addition, suggestions on the process of complimenting within each form will be offered that may allow the practice to better fit with the notion of “not-knowing”. Although others have suggested templates (Campbell et al., 1999) in compliment formation, I find this too influential, potentially conflicting with the not-knowing construct. Moving away from such instrumentality and keeping with the conversation metaphor that is perhaps the greatest current influence on the SF approach, I suggest a transition from noun to verb, from compliment-as-tool toward complimenting-as-verb. Movement in this direction may also create space for greater cultural sensitivity, a notion that has been promoted for decades within SF approaches and discussed above.

**Direct compliments:** An early training document (BFTC, 1991, p. 1) describes a direct compliment as “a statement with a positive verb or positive attribute or positive *reaction* to a client statement” (emphasis in original) and recommends statements be used “sparingly” but positive reactions frequently. Examples of a positive reaction would be “Wow!” or “That’s good!” Sensitive to the context, the BFTC trainers note that “both are better when they reflect what the client values.” Berg and De Jong (2005) state that such direct practitioner statements may be useful in raising clients’ awareness of change and resources.

*A not-knowing stance:* Honest positive reactions — not preformed, but spontaneous — certainly honour the “not-knowing” position. Anyone familiar with Insoo Kim Berg’s “Wow!” response knows the genuineness such a reaction can convey. A suggestion: avoid declarative statements within this category to keep with not-knowing. Assertions such as “That’s good!” are just

as certain as “You are a strong person,” and both can lead to disagreement with the client’s own perception or experience. In addition, declaratives like “You are so smart!” (common among those working with children) or “You are so creative!” may be intended as praise but can actually inhibit future effort (Dweck, 2007). Practitioners taking a “not-knowing” stance seek to be tentative (Thomas & Nelson, 2007), honouring clients’ views and not imposing their own. For those who compliment clients using the time-honoured end-of-session format, endorsing client self-compliments may be useful. An example would be, “You said you are a ‘strong person’ when we discussed your journey with addiction ... I like that.”

**Self-compliments:** BFTC (1991, p. 2) defined a self-compliment as “an ‘I statement’ made by clients saying they do what is good for them.” The trainers direct practitioners to “react” to client reflections on progress to draw attention to the positive self-statement. Berg and De Jong (2005, p. 52) add questions that elicit descriptions of “successes and hidden abilities,” such as, “How did you know...?” or, “Did it surprise you that you did it?”

*A not-knowing stance:* Clients may offer “I statements” regarding their intentions, abilities, or self-knowledge regarding successes; however, culture may influence one’s perception of taking or sharing credit. The concept of personal autonomy is not universal, and pushing clients to take credit for change may be counterproductive. Presuppositional questions such as “How did you (singular) do that?” imply an agency the client may not own or accept. A suggestion: take less direct approaches when asking about clients’ designations of positive change. Since many cultures are more collectivist and less individualistic, the practitioner might offer this line of inquiry:

Practitioner: Tell me about this success you’ve experienced this week.  
How much came about because of something you changed?

Client: Most of this happened because I just decided I’d had enough and had to move on.

P: What is there about you that contributed to this decision to “move on?”

C: I’m the kind of person who...well, when I put my mind to it and tell myself, “That’s IT!”. I make different decisions.

*[Practitioner and Client discuss this.]*

P: You said “most of this” was deciding you’d “had enough.” Were there others who played a part in the success you’ve had this week?

C: Oh yes, for sure. I went to my minister, and she was very supportive. She

gave me some great advice.

P: What is it about you that allowed you to take this “great advice” and make it work for you?

C: I think it’s because I know I need help sometimes and I’m not afraid to accept it. I don’t know everything.

P: So you know yourself well enough to know when you “need help” and are “not afraid to accept it?”

C: [*nods*]

P: I wonder if that’s common or unusual, knowing yourself that well?  
[*hedging — see below*]

C: I think I’m pretty unusual in that way.

Furman and Ahola (1992) called this approach sharing credit, noting the importance of acknowledging the role others often play in our change processes. While some psychotherapy approaches assume clients have ultimate control over the changes they make and should acknowledge such control, a “not-knowing” stance allows space for clients’ personal understandings to take precedence. When asked of their actual experiences and knowledges, clients often share credit with a higher power (God) and those in close relationship as well as fate, chance, and spontaneity. Taking (full) credit for change should not be forced on clients; taking a not-knowing position allows clients to self-compliment when appropriate but does not impose assumptions of agency.

**Indirect compliments:** BFTC (1991, p. 1) defined an indirect compliment as “a statement that *implies* something positive” (emphasis in original). Several types were outlined. First, the practitioner is encouraged to “use the same words the client uses when the client describes desired outcomes.” Next, relationship questions (De Jong & Berg, 2014) can be used to draw forth indirect compliments. An example might be, “What do you think your spouse noticed about you that led her to give you more time with your son on that last visit?” Finally, these trainers encourage “how” questions to imply positive change. “Instead of saying, ‘That’s good,’ ask, ‘How did you know that would help?’” (BFTC, 1991, p. 1). Berg and De Jong (2005) refined this complimenting category, limiting it to relationship questions that ask the client to take another’s viewpoint and reflect on the situation, often resulting in a positive statement about the client.

*A not-knowing stance:* Because inquiry into how clients make sense of their successes is discussed in the extending curiosity category (see below), I would suggest relationship questions around positive exceptions and instances as a main avenue for indirect complimenting. As traditionally described, using the client's words is a good starting point for this complimenting response. An example: "You said earlier your adult daughter knows you well [*client nods*] and is a kind and honest person [*client nods*]. What would she say about this ability you have to 'bounce back' [*client's words*]?" Indirect complimenting allows clients to use familiar terms to additionally name their abilities, choices, or traits that contribute to success. And because the terms they use may be similar or different from others', follow-up can be fruitful: "So you think your daughter would say you are a 'tough cookie,' right? So do you think 'tough cookie' is related to this ability you have to 'bounce back'? [*client nods*] What other ways might your daughter view this positive change you've made?"

## Additional complimenting practices in concert with not-knowing

**Hedging:** (Lakoff, 1973; Varttala, 2001). Hedging is a SF practice used and encouraged by Insoo Kim Berg (Berg, 2003; Berg & Reuss, 1998; Rudes, Shilts & Berg, 1997; Thomas, 2013). Berg (2003, p. 48f) illustrates the practice:

Getting in the habit of using tentative language helps to facilitate collaboration and negotiation. So, what is tentative language? Phrases such as, "It seems like ...", "Could it be ...?", "It sounds like ...", "Perhaps ...", "I am not sure ...", or "I wonder ...", and many other questions that are put forth with a tentative tone of voice facilitates collaboration.

Hedging is a way to "assert uncertainly" (Legg & Stagaki, 2002, p. 389), keeping with postmodern assumptions that avoid truth statements and remaining indefinite when one speaks. When practitioners hedge they are imprecise, leaving space for (and even encouraging) differences when clients respond. Examples of hedging (*in italics*) that encourage self-compliments are:

Practitioner: *Could it be that* you did some things this week that contributed to the positive changes?

Client: Well, maybe ... I did get a fresh start Tuesday because I went to bed earlier.

P: *I think that probably* you had a role in this "big shift," as you call it.

C: You could be right, but I'm not sure what it is ...

P: *I'm not sure, either, but maybe* it's tied to your response to your boss on Wednesday...

C: Maybe ... I was more assertive when I told him I had to pick up my kids and couldn't stay late...

According to Rudes, Shilts, and Berg (1997), the practice of hedging relinquishes a "privileged position of knowledge" (p. 209) and recognises the multiplicity of understandings possible in a situation. A usual results of practitioner hedging are a more egalitarian relationship and conversational space for public "supposing." In addition, polite exchange can result when persons in positions of power make a practice of hedging in conversations (c.f., Vartala, 2001, who studied physician-patient conversations).

**Extending curiosity:** SFBT continues to evolve toward a postmodern position in which meaning is created in conversation (Anderson, 2003). While past SF complimenting practices seemed designed to elicit or declare, the current directions in SF include and encourage co-construction of significance and understandings. Miller and de Shazer (2000, p. 8) promoted this when they wrote, "we also use our understandings of social context to *make sense of* what is going on around us, to react to these activities, and to anticipate what may happen in the future. As Wittgenstein ... states: 'only in the stream of thought and life do words have meaning'" (emphasis added). In keeping with this shift away from "information-gathering towards co-created conversations" (McKergow, 2014, p. 36), the concept of extending curiosity is helpful (Thomas & Nelson, 2007). A stance of curiosity increases possibilities and builds on previous compliments. Past complimenting practices often asked clients, "How did you do that?" and called this self-complimenting; instead, "conversation expanders" (McKergow, 2014, p. 36) might be utilised whenever appropriate to encourage understandings of abilities, resources, and outcomes within the counselling context. Here are examples of extending curiosity while remaining tentative (including hedging):

How do you make sense of the changes you just described?

I wonder if there's something in your ability to "put your mind to it" we should explore ... what do you think?

Suppose you continued to go to bed earlier, like you did last Tuesday, and you were getting more done the next day, at least part of the time. What might that say about your ability to influence this thing you call "procras-

tionation?”

I'm not sure, but ... could it be that you have applied this resource we've been discussing as “bouncing back” in other areas of your preferred future? (If the client agrees and gives details, follow with), What do you think this says about you, that you have used this wonderful resource in different ways?

## Staying Tentative is Central

“... not-knowing is not just a stance/role we take/play, but is the only possible way to be in therapy.” — Plamen Panayotov, August 18, 2015

The SF approach continues to evolve. It has been more than eight years since Insoo Kim Berg died and more than 10 since Steve de Shazer passed away. It is natural that the clinical and conceptual leadership void they left be filled by others, and directions others take are sometimes divergent. While I see significance in the conversation emphasis some have brought to solution building and its de-emphasis on techniques, most in the SF world continue to value particular tools as essential in their SF work. And as long as EBTA, SFBTA, and other international groups insist upon the presence of certain practices in their definitions of SF research, training, and practice, complimenting will be valued.

Although SFBT has a time-honoured tradition of pointing out client strengths and ascribing credit to clients for change, these practices are declarative, an uncomfortable fit with the now-prominent SF notion of “not-knowing”. SF has a decided (and often uncritically accepted) bias toward individual human agency. A person's ability (and right) to choose is implicit to the point that practitioners do not examine their assumptions and expectations on this. In addition, past applications of SF practices such as compliments, tasks, and other techniques were often imposed by the therapist. As SFBT is moving from techniques to partnerships, one change that privileges client experiences is consistently adopting a not-knowing position.

The notion that personal meanings are constructed in SFBT is not new. Decades ago, Michael Durrant (personal communication, October 31, 1991) said, “People are engaged in a constant process of ‘making sense’ of themselves, their relationships, and what happens to them.” The shift toward a “not-knowing” stance encourages SF practitioners to move away from declaration toward co-creation, eliciting client views more than dictating meaning and significance. No one person or organisation is in a position of directing or

policing the evolution of the SF approach. Chang and Nyland (2013) point out attempts to maintain purity of an approach “make(s) no sense” as “ignoring cultural and contextual influences on our approaches to therapy keeps them frozen in time” (p. 82).

In this paper, I have encouraged a confluence of complimenting and not-knowing in an attempt to honour the important role compliments have and continue to play in our practices while remaining true to a not-knowing stance. Since Iveson’s (2005) article prodded me toward serious reconsideration of complimenting and not-knowing, it is fitting he and his colleagues have the closing words on the topic: “a compliment must have no strings attached; it should be unconditional and not be used to try to pressure the client” into a particular way of behaving or understanding (Ratner, et al., 2012, p. 43). This, I believe, is the future of complimenting within SF practices.

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## Confessions of an unashamed Solution-Focused purist: What is (and isn't) Solution-Focused?

**Michael Durrant**

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Solution-Focused Brief Therapy claims to be a (conceptually) simple approach; however, attempts to define the approach are not simple. This paper suggests that, with the rise of “strengths-based” and resilience approaches, it has been easy for the definition of Solution-Focused Brief Therapy to become diluted or broadened almost to the point of meaninglessness. The paper explores some of the issues in constructing a definition of the approach and suggests some necessary characteristics.

People often say to me, in reference to the positive attributes of some particular program or idea, “and ... this is a REALLY Solution-Focused program!” They, then, often appear a little disappointed when I do not seem to share their enthusiasm. Almost without question, the particular program or idea is one that I would happily support and gladly recommend ... HOWEVER, very often, my view is that it is NOT Solution-Focused.

So, what makes something “Solution-Focused”?

### **Solution-Focused is not primarily about solutions**

There is a problem with the word “Solution” in the name of our approach. In most languages, the word “solution” implies the word “problem”. That is, a solution is a solution to a problem. Without a problem, there isn't a solution. That's how it works in mathematics!

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1. I am grateful to Mark McKergow and Evan George for their comments on earlier drafts of this manuscript.

I consulted my doctor about a particular health problem. He told me that, “the main cause is being over 50”. Not much we can do about that! He went on to say, “But, let’s not focus on what might have caused it ... we can’t solve that ... let’s focus on what we need to do, instead”. He then went on to tell me all the things I needed to do in order to “solve” this particular problem (or ... at least ... manage it). This included my taking certain medication that he prescribed.

My accountant is called Sydney Financial Solutions. The firm’s focus is on how to maximise income, or reduce tax, or some other goal that always seems to elude me. To that end, they proffer advice and expertise. If I pose a particular financial problem, they will faithfully take it upon themselves to find a solution. They research the tax laws, they draw on their experience and wisdom, and they tell me in great detail what I need to do.

In both cases, if I do what my expert advisers tell me I should do, my particular dilemma will probably be solved ... and I will probably be happy. In both cases, I have the problem ... and THEY tell me the solution. Both my doctor and my accountant will probably tell me that they focus on solutions, rather than on problems.

Focusing on solutions fits well with modern ideas about “getting on with it”, “moving forward”, “not getting bogged down with the past”, “looking forwards, not backwards” ... these are common injunctions in today’s self-improvement lexicon.

“Solutions” has become a buzz-word.

I have had people say to me, “I’m solution-focused ... I don’t bother with all this childhood stuff, I just tell you what the solution is!”. In terms of language, that is perfectly reasonable. The person is focused on the solution rather than on the problem. However, most Solution-Focused therapists would not class an approach where “I just tell you what the solution is!” as fitting with our understanding of Solution-Focused.

I’ve had other people say to me, in meetings, “Let’s be Solution-Focused ... let’s brainstorm what we are going to DO”. The implication here is that, by focusing on what we are going to do rather than on analysing the problem, somehow we are being “Solution-Focused”. However, that doesn’t fit with my understanding of what constitutes Solution-Focused.

## An early “definition” of Solution-Focused

In 1997, de Shazer and Berg proposed a “definition” of Solution-Focused Brief Therapy and suggested four “characteristic features” of the approach.

- (1) At some point in the first interview, the therapist will ask the ‘Miracle Question’.

(2) At least once during the first interview and at subsequent ones, the client will be asked to rate something on a scale of '0 → 10' or '1 → 10'.

(3) At some point during the interview, the therapist will take a break.

(4) After this intermission, the therapist will give the client some compliments which will sometimes (frequently) be followed by a suggestion or homework task (frequently called an 'experiment').

(de Shazer & Berg, 1997, p. 123)

Further, they suggest:

Once a naive observer is given a description of these four characteristics, their presence or absence can be easily noted. If any or all are missing, then ... we have to conclude that the therapist is not practising SFBT" (p. 123).

Thus, their definition was based solely on the presence or absence of particular techniques. de Shazer and Berg are clear that this is a "research definition" of SFBT and that clinical work may be more flexible and still be regarded as SFBT, nonetheless their message is clear.

However, we immediately have a problem. Anecdotal experience suggests that many therapists who describe themselves as Solution-Focused do not routinely take a break (Huber & Durrant, 2014). Iveson, George and Ratner — the team at BRIEF in London — say that they deliberately do not take a break or give an end-of-session suggestion and that they do not routinely ask the miracle question (Shennan & Iveson, 2012). They would be described by many people in the Solution-Focused world as being thoroughly Solution-Focused; yet, most of their work does not include three of de Shazer and Berg's four characteristics. Does this tell us more about the nature of the work at BRIEF, or more about the usefulness of a definition that is based solely on the presence or absence of particular techniques, particularly if we acknowledge that therapeutic models develop and that Solution-Focused Brief Therapy has itself been described as an "evolving approach" (Trepper, Dolan, McCollum & Nelson, 2006)?

The research definition of SFBT adopted by the European Brief Therapy Association (Beyebach, 2000) specifies that the therapist MAY take a break but still includes the miracle question and end-of-session compliments as among the "minimal requirements" that must be present. Thus, this definition is a little less restrictive; however, it still defines the approach by reference to the presence of particular techniques.

McKergow and Korman (2009) comment,

Much of the existing literature on SFBT has, understandably, focused on descriptions of what Solution-Focused therapists do [and] on the techniques they use ... (p. 35).

de Shazer (1991) famously asserted that the Solution-Focused therapist's task is to "stay on the surface" rather than "dig" for hypothesized deeper meanings. McKergow and Korman (2009), while agreeing with de Shazer's assertion, admit that talking about Solution-Focused Brief Therapy solely in terms of what therapists do has contributed to some other commentators seeing the approach as simplistic or naïve.

Miller and de Shazer (2000) acknowledge going further than just a focus on what therapists do,

The distinctiveness of Solution-Focused therapy involves both the practical strategies that Solution-Focused therapists use in interacting with clients and the intellectual traditions they draw upon in orienting to personal troubles and change in therapy. (p. 5).

and describe their work as emphasising "both the practical and intellectual aspects".

Therefore, I will not reject the claim that something is Solution-Focused solely on the basis of which particular Solution-Focused techniques are (or are not) present!

### **So ... anything goes?**

Nonetheless, I do not believe that this means that anything that claims to be Solution-Focused should be allowed to adopt this label.

Following the deaths of both de Shazer and Berg, there was a sense, in some quarters, of "phew ... now we can relax the tightness of the definition".

McKergow (2016) points out that some people assert that "if it helps the client, it must be Solution-Focused". He suggests that such a broad definition ends up not being helpful. Bannink suggests that SFBT should be seen as a form of Cognitive-Behavioural Therapy (CBT). I do not see the point of this assertion. While there might sometimes be some similarities in what the therapist does, the fundamental assumptions of SFBT and CBT are fundamentally in conflict. (Johnsen, 2014). McKergow calls this description of SFBT as a form of CBT "bizarre" (McKergow, 2016). Further, it raises the question of whether or not it is actually helpful to diminish the distinctions between approaches.

Following McKergow's (2016) observation, I suggest that "if it helps the client, it must be Solution-Focused" is NOT helpful in clarifying what it is we think we do. If I claim to be a Cognitive Behavioural therapist, I presume that it is helpful to be clear about what I do, and about what it is I do that makes it "Cognitive Behavioural" and not something else (even if that something else is actually helpful). Indeed, Gaudiano (2008) specifies as characteristics of CBT its "manualised approach" and the fact that the approach has been "codified".

Part of the rationale behind the launch of the *Journal of Solution-Focused Brief Therapy* was that an academic-standard journal could (and should) begin to decide that certain contributions were — or were not — considered Solution-Focused ... even if they were still intellectually, clinically and practically worthwhile.

So ... it doesn't mean (in my world) that anything you claim to be Solution-Focused should be regarded that way.

## What Solution-Focused is NOT

McKergow and Korman (2009) have bravely sought to suggest what Solution-Focused is NOT. They conclude,

Our view of SFBT is that solution-focused therapists do not use nor draw upon most of psychological theory that is taken for granted by other therapeutic traditions. (p. 35)

They comment that the history of the development of SFBT has been a history of the application of Ockham's Razor and that the Solution-Focused literature has always striven to make the description of what we do as simple as possible.

SFBT can be viewed as a form of practice that helps clients simplify their lives. It does this by simplifying how therapists and clients talk together about life, and by helping clients focus on and attend to what they say is important and helpful to them. (p. 38).

Thus, one of the things they suggest that SFBT does NOT do is appeal to any hypothesized, internal psychological mechanisms or entities. Among the list of "hypothesized, internal mechanisms" they cite, are included not only "personality traits", "attitudes" and "weaknesses" but also "strengths" and (by implication) "resilience".

They make it clear that Solution-Focused therapists might choose to talk to clients about such things as "strengths"; however, they suggest that SFBT

does not think of “strengths” or “resilience” as things that must be changed, developed, nurtured or strengthened. They suggest that thinking our role is to change, nurture, build or develop “strengths” or “resilience”

... leads us immediately into doing something in therapy that is not Solution-Focus. This sets SFBT apart from other models. (p.40)

McKergow and Korman are clear that some of these other ways of thinking may well be helpful, and might be encouraged ... however, in the interests of clarity, they ought not be described as “Solution-Focused”.

## **How does a Solution-Focused approach fit with the Strengths Approach?**

The Strengths Approach (Rapp, 1998), or the Strengths Perspective (Saleebey, 1992), has been an important shift in the way we think about our work in the human services field. Indeed, the term “strengths-based” is almost ubiquitous in the self-description of every non-government child and family welfare agency in Australia and New Zealand! The way that many of the staff from these agencies talk suggests that the Strengths Approach and the Solution-Focused approach are one and the same thing.

Probably the two organisations in Australia most publicly associated with the Strengths Approach have been St Luke’s Family Services in Bendigo, VIC and The Family Action Centre at the University of Newcastle, NSW (who organised the pivotal Australian Family Strengths conferences in the last decade).

Graeme Stuart, from the Family Action Centre, says,

The strengths perspective and strengths-based approaches offer service providers ways of working that focus on strengths, abilities and potential rather than problems, deficits and pathologies. (Stuart, 2012).

Saleebey, one of the founders of the Strengths Approach, (1992, p15) suggests that a Strengths Approach is not a model of practice but rather a “collation of principles, ideas and techniques”. Rather than being a service delivery model, the ‘strengths approach’ is a framework or set of beliefs and values that guide practice. McCashen (2005) defines the Strengths Approach as an alternative “approach to people that is primarily dependent upon positive attitudes about people’s dignity, capacities, rights, uniqueness and commonalities”. (p. v)

Thus, I would argue that the Strengths Approach is a “stance” or “position” we take rather than a model of practice or a consistent “map” that may guide our work with clients.

Silberberg (2001) cautions against a “strengths-based” approach becoming an approach which identifies the qualities of “strong” families and then prescribes them ... or “coaches” families that are seen as deficient in any particular strengths. “Rather than teaching families a set of strength practices, our task is to facilitate families in the process of identifying their own strengths.” (Silberberg, 2001, p. 55).

This is similar to the emphasis in the La Cima Middle School Resilience Project (Oddone, 2002) — a project that saw a 90% reduction in drug and alcohol problems, and violence problems, in a large school, plus a significant increase in academic performance, over five years of applying “resilience thinking”. The emphasis at La Cima was training teachers to ask, “What is the particular way that this student shows resilience?” rather than, “Is this student resilient?” That is, the project began from an assumption that all students are resilient — and staff need to identify the particular ways in which this is shown. This is in marked contrast to an approach that asks, “How resilient is this student?” (or, “IS this student resilient?”) — then the task is to promote or increase resilience.

Iveson (2008) suggests the problem with focusing on strengths (quite apart from them being the reification of very abstract concepts). He suggests that, as soon as we focus on a particular strength — “I had a lot of will-power”, “I was very brave”, etc. — and on harnessing that strength, we potentially diminish the significance of the times when that strength did not seem there, but nonetheless the person was able to be successful.

Thus, he suggests that Solution-Focused Brief Therapy more usefully focuses on “what did you DO to cope/succeed/get through this?”, rather than “what does this tell us about your strength?”. He contrasts a detailed description of successful action with an identification of an hypothesised entity (“strength”).

For example (Evan George, personal communication, 18/8/2016) ,

*Therapist:* What did it take to do that?

*Client:* I guess it took a lot of willpower.

*Therapist:* And what did you see yourself doing, as you tackled that situation, that flowed from that willpower [strength]?

*[Response with lots of detail]*

*Therapist:* Tell me about a time that you managed to act that way even though you weren't feeling that willpower within you.

Further, much of the seminal literature about the Strengths Approach does not nominate a particular therapeutic model. Indeed, I would suggest that

you could adopt a Strengths Perspective and then pursue Solution-Focused Brief Therapy, Narrative Therapy, Appreciative Inquiry, or other approaches.

In the early days of St Luke's exploring a family strengths approach, they had comprehensive training in Solution-Focused Brief Therapy (disclaimer: it was my privilege to conduct this training). Thus, their development of a strengths approach and of Solution-Focused Brief Therapy were intermingled.

McCashen proposes the five-step "Column Approach" to working with clients. He suggests that, "The steps act as a guide for using the Strengths Approach to an issue" (2005, p. 48).

His first two steps are,

1. Outlining the issues (or stories) from the perspectives of all involved, i.e. the child, family, teacher/school and protection agency
2. Creating a picture of the future or visioning what would be a good outcome to the issue

A "purist" Solution-Focused practitioner would argue that Step 1 is NOT essential and, indeed, might not be necessary at all. Step 2 is straight from the Solution-Focused lexicon; however, a number of "strengths" approaches are not primarily driven by a future or outcome focus.

Thus, I would suggest that McCashen has detailed one manifestation of a strengths approach but that he has combined the strengths approach and the Solution-Focused approach in ways that none of the foundational strengths writers have done.

Russel Deal, a key person in the development of Strengths-based work at St Luke's, comments, "when Wayne wrote *The Strengths Approach*, we were unaware of Saleebey's work. It remains a huge oversight" (personal communication, 22/8/2016).

## So ... what IS Solution-Focused?

Evan George, from BRIEF in London, distinguishes between "SF" and "sf". He says,

The work can only be SF when it is based on the client's answer to the 'Best Hopes' question. Most people of course are sf, using lots of the techniques but for whatever reason (and there are good ones), determining the direction of the work themselves. (Personal communication, 18/8/2016).

“Best hopes” is BRIEF’s version of the “how will you know that talking to me has been useful for you?” — a question that immediately orients the therapy/coaching interview to the desired OUTCOME (Korman, 2004).

I have heard some colleagues say, “I am client-focused ... I always begin by asking the client what she/he thinks it would be helpful for us to talk about”. I would suggest that this is NOT being “client focused” ... it is really about being [therapy] session-focused. It is asking “what should we talk about here” rather than asking “how would you like your life to be different when you leave here?”

Thus, George suggests that our conversation is only Solution-Focused if it begins by exploring how the client wants things to be different.

So, I would suggest that our work is “Solution-Focused” if (and only if);

1. It begins with some version of “How will you know that our talking has been useful?” or “How are you hoping that our talking together will make a difference in your life [work, marriage, etc.]?”
2. It is essentially future-focused (Miracle Question or some other question that builds a detailed description of the client’s preferred future).
3. It explores when the client has already been able to achieve aspects of the preferred future.
4. It does not assume that the therapist knows what the client needs to do (to solve their problem, to build resilience, to harness their strengths, etc.).

These steps might not necessarily be in this order.

Other things might well be helpful ... and I might endorse them ... but I do not regard them as “Solution-Focused”.

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## **From school psychology to disaster recovery: A journey of encountering resilience and continually being surprised by peoples' own solutions. An interview with Cynthia K. Hansen\***

**Interviewed by Michael Durrant**

University of Sydney

Dr. Cynthia Hansen, a clinical psychologist, has more than 25 years' experience as a Solution-Focused practitioner in a variety of settings — from seeing children, adolescents and families in a “typical” therapy setting to field work in response to disasters such as Typhoon Pongsona, 9/11 and Hurricane Katrina. She is currently working in the Office of the Assistant Secretary for Health after serving eight years with the Office of the Assistant Secretary for Preparedness and Response in the US Department of Health and Human Services and was previously Special Advisor on Suicide Prevention with the US Substance Abuse and Mental Health Services Administration (SAMHSA). I invited Cynthia to reflect on her Solution-Focused journey.

### **How long have you been working with people therapeutically ... what were the driving forces in your early work with people?**

I've worked with people therapeutically since the early 1980's. For many years, I worked as a paraprofessional — peer counsellor in college, child care worker in a therapeutic group home, and psychiatric aide in an inpatient unit. I began graduate school in 1981, and studied for a doctorate in Clinical Psy-

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chology at the University of Arkansas. During these years, my primary influences ranged from theories of abnormal child development to the systemic approaches of the MRI Group in Palo Alto. I remember being most interested in family systems therapy, Sullivanian approaches to understanding development, and Paul Watzlawick's book about second order change. Most importantly, I was very pragmatic. The individuals and families I saw in Arkansas often did not meet any of the criteria for treatment that I read about in my studies, nor could I expect them to attend weekly sessions, but they were still in my office asking for help. I had great supervisors who taught me to match the theory of change to the people in my office.

Yvonne Dolan once interviewed me about the signs that I might be a Solution-Focused therapist, before I knew about SFBT. I told her about two clinical situations that tapped into my mindset. The first was a multi-generational family who drove to the clinic because they heard that incest could be one of the reasons that an infant had been born with developmental problems. They wanted help to fix this problem in the family. Because there were so many people, and generations, in the room, the therapists decided to divide up the family into small subgroups to make a plan. I remember the most important decision that the grandparents, parents and children agreed upon is how to reconfigure who slept in what bed. I was struck by it being such a practical action, generated by the clients and essential for changing the family dynamics — and ultimately much more practical than the things the professionals devised. For the worried reader, yes, Child Protective Services was involved.

Another individual who came to see me reported hearing voices, but no other symptoms of psychosis. I asked some questions about what he thought would be most helpful with the voices, and he said it would probably help to get a good night's sleep at the hospital. It turned out that he was homeless and knew that he would be admitted to the hospital if he said he was hearing voices. Instead of a psychiatric diagnosis, we worked together on a plan for getting a good night's sleep more often than he could get through admission to a hospital.

**“Getting a good night's sleep” immediately strikes me as a very de Shazer-esque kind of goal formulation, since it immediately makes the question of whether or not the client is actually psychotic completely irrelevant.**

Absolutely ... and, once again, practical. For years, this young man checked in with me as a “walk-in” to discuss how he was managing shelter and money and relationships, and I learned a lot about resilience and independence. I look back on it now, and see how Solution-Focused I was by nature.

### **When were you first exposed to the Solution-Focused approach?**

In 1988, I was working as a school psychologist and saw a brochure for a workshop on substance abuse treatment. The timing was right to meet my continuing education requirements, and I was seeking additional training in substance abuse treatment, so I signed up. Insoo and Steve were teaching. By the mid-morning break of the first day, I was returning calls to colleagues with great excitement about what I was learning. It was as if someone lifted the screen that made my interactions with clients *ad hoc* events, driven by a mix of academic theories of change and practical realities, to show the underlying pattern that could lead to real change. I think back on that day now and can still remember the thrill of finally resonating with a therapeutic approach that suited me. Luckily, I met some people that day that evolved into dear colleagues and, eventually, partners in a Solution-Focused training and consultation business: Phil Trautmann (who began visiting BFTC in the early 1980s), Stuart Levy and JoAnna Henry. With the addition of Carol Nelson and Karen Scott, Incorporated Solutions was born. We travelled together to learn from Insoo, Steve, Yvonne and others, saw clients as a team and sponsored workshops on SFBT in Portland, Oregon. I know that learning SFBT with this team had a profound impact on the creativity, flexibility and philosophy underlying my practice of SFBT.

### **How did it fit with what was already important to you?**

- The approach worked with what the client really had — not what they were supposed to have — and so reconciled my conflict with wanting to help people who weren't supposed to be helped by talking therapy.
- It was practical.
- It realistically understood the power that a therapist has, what he/she pays attention to, even in a few minutes or a single session.
- It gave a language for a team to work together on learning how best to help people.

### **And so, how did that make a difference?**

It gave me a pattern for purposefully practicing therapeutic strategies and believing in the client's resources. It also helped me think through what shifts might make a difference when therapy wasn't working well. For example, scaling helped focus on the goal and small steps. Mastering the miracle question gave discipline and purpose to the theories of systems and interactions. Pre-session change helped build on what was already working. And all of

these strategies interacted with the unique gifts of the therapist. Just as Insoo, Steve, Yvonne, and Peter DeJong used the same strategies but with different “touches”, so did Phil, JoAnna, Carol, Stuart and I.

In addition, I realised that practicing from a Solution-Focused perspective reduced burnout because I could see how to match the client’s resources with their hoped for outcome.

Insoo once told a story that stuck with me a long time. She said that, when I asked clients what they wanted without understanding what they already had, I was acting like a waitress taking an order that the kitchen would fill. Alternatively, if I heard what they wanted with an understanding of what they had in their own kitchen, then we could begin putting ingredients together that worked with what was already available. So, and I think now this was a little funny, I had an odd strategy for practicing being curious about what the client could do to get what they wanted. When I heard the client say what he or she wanted, I internally translated it to a food order in my head (e.g. corned beef on rye) to help me remember to ask the client when a little part of the client’s hopes had been realised or times when things had already been a little better. This kept me focused on doing what was possible in the client’s “kitchen” instead of thinking “how can I make this happen for the client?”.

### **How has SFBT made a difference to how your practice as a therapist has developed?**

The practice of SFBT shifted my stance as a therapist profoundly. I became interested in the client’s expert knowledge, beginning to see him/her as a partner in designing solutions to the problems that brought them to meet with me. Many times I’ve taught this paradigm shift as moving from the three basic questions that I learned in graduate school:

- What is the client’s problem?
- What do I think the client should do about the client’s problem?
- What do I need to do to motivate/educate/persuade the client to do what I think the client should do about the client’s problem?

With SFBT, I learned to ask these three questions with each encounter:

- What does the client want?
- What can the client do about what the client wants (and, indeed, what is the client ALREADY doing)?
- What needs to happen for the client to do what the client can do about what the client wants?

**What have been the particular challenges that your commitment to SFBT have raised in your practice as a therapist?**

Probably the first challenge was curbing the zeal of a “convert” to Solution-Focused. SFBT doesn’t suit everybody — clients or therapists. Steve once said, “Sometimes you want sushi, sometimes spaghetti”, reminding me that there is no “right way” but that we have to understand the client’s preferences.

That being said, SFBT truly suited me and I was profoundly moved by the changes my clients made in their lives. I was lucky to have my own practice so I could dedicate myself to learning Solution-Focused ways to highlight and encourage my clients to clarify their hopes, and act on their inner knowing. In terms of the business of practice, I had many more clients and frequent intakes than my colleagues working in more traditional ways so I had to set up some streamlined procedures so that each session could be the last.

**Some years ago, you produced an audiotape (now CD) with Insoo called *Making a Difference with Adolescents*.**

Oh, yes, that was one of the highlights of my life. For years Insoo had been encouraging me to write a book about my work with children, teenagers and families. I kept telling her I didn’t have time to write and what I was learning and practicing was not enough information for a book. So, Insoo invited me to come to Milwaukee for a weekend, take long walks and talk and work on videos together — but she also wanted to interview me for an audiotape. No pressure; just have a discussion. We could always erase it if we wanted to.

Well, the first morning, after eating breakfast and taking a walk, Insoo and I went to their home office in the basement and set up the audiotape. She just started asking me questions and I answered. We did the tape in one take and she dismissed any idea that we could improve it by doing it again. I’m very glad that my description of how I worked with teenagers has been helpful to clinicians but I really think Insoo’s talent at bringing out the best in anyone is the most noteworthy aspect of the audiotape. And now that Insoo has passed, I treasure this memory and the respect she showed for my eagerness to teach coupled with my reluctance to write. Hey, Michael, I think you may be doing the same thing with this interview! Am I being Insooded?!!

**I never thought of “Insoo” as a verb (and I don’t think I have the energy)! You have been described as being “mentored” by Insoo. What this was like?**

Oh my gosh — I was so lucky! Insoo answered any call or email from me, welcomed me with open arms into formal classrooms and workshops as well as

her home. I could crash on her sleeper sofa at conferences, take drives with Steve to get Insoo her favourite frozen custard and we walked and talked for hours. We'd sit and watch videotapes, discuss ideas my Portland team had for teaching and consulting, review challenges I was experiencing working with my clients, review draft manuscripts and heat up leftovers that Steve (the cook) had frozen for Insoo to eat when he was out of town. She taught me with stories, curiosity, generosity, experience, trust, love and, sometimes, impatience. Insoo recommended me as a SFBT presenter to colleagues in such varied places as Europe, South Korea, Okinawa and Taiwan, so I got to travel the world and learn from so many SFBT practitioners. I have to say that Steve was as kind and generous as Insoo was, albeit in different ways. Steve would sit — or walk — and visit in kind of a meandering way. But at the end of the beer, or the visit, I would have this “ah ha” moment that I couldn't wait to share with my colleagues.

I was truly blessed to have been part of their lives and my practice became more purposeful because of their influence and wisdom. I still remember Insoo reminding me that wisdom is choosing what to ignore! I would add that it's also what never to forget.

### **How did you move from working with children, adolescents and families to working in disaster recovery?**

I never planned to work with people impacted by disasters but my practice included people of all ages trying to cope with the negative consequences of a traumatic event. The event ranged from acute or chronic abuse, witnessing murder, workplace violence or any number of life events where the individual feared for their safety. My work was strongly Solution-Focused and influenced by Insoo, Steve and Yvonne Dolan. I became more skilled, quieted my “inner diagnostician” and focused more on the essence of the individual that survived the event and how it impacted the meaning they made of their lives.

I was on holiday in Nairobi in 1998 when a bomb went off at the US Embassy. Disoriented, I sought out the familiar. I found the office where I had arranged internal travel several weeks earlier and asked if I could get a phone line to my Mom. I will always be grateful to the Kenyans who helped me connect with my family and feel safe on such a terrible day.

While I was listening to the radio in the travel agent's office, I met some medical students who had been getting their visas renewed at the Embassy and were also trying to contact their families in the U.S. We talked and tried to make sense of what was happening that day and what our next steps should be. After a while, the travel agent closed the office and we went our separate

ways, exchanging email to stay in touch.

Looking back, I realise that — while I clearly was not doing therapy — I almost instinctively talked with them about how they were coping and managing to keep going, as well as planning small steps for a future when we all survived this terrible event.

Several weeks later, I received an email from the supervising physician of these medical students. He wanted to tell me that the students who had talked with me were back in the village functioning and learning, but others who had been around the embassy the day of the bombing were staring off into space, unable to sleep or concentrate, and counting the days until they would go home. He asked questions about what we discussed in the office of the travel agent and encouraged me to seek out opportunities to help others in the immediate aftermath of a disaster. I am forever grateful for the time he took to contact me. It is a profound lesson in the power of a compliment.

### **While SFBT is more than a focus on resilience, it seems like your Solution-Focused lens was making you naturally attuned to peoples' resilience.**

Yes, I think so — and it certainly meant that, as I got further and further into disaster response work, my interactions with people always began from a profound respect for what they had been able to do in the midst of terror rather than from some immediate knee-jerk response of diagnosing a disorder or finding ways for someone else to meet their needs. Often I discovered that their natural resources could be readily supported by just a few donations or offers.

### **Where did your journey go after your personal disaster experience in Kenya?**

From there, I began doing *pro bono* work as a Disaster Mental Health responder with the American Red Cross and learned the language of disaster assistance and incident command. The people I met resonated with Solution-Focused questions because they were practical, focused on small steps and reinforced their natural coping strategies and personal hopes. Some of the interventions I developed were to help the organisation of assistance run more smoothly. For example, I jokingly referred to creating interventions with and for the hundreds of people standing in line for hours as treating “line disease”. I also worked with the managers to organise the space and process of disaster assistance centres to improve flow for the people requesting help.

Other times, the interventions were very individualised. For example,

there was one boy who survived a horrible storm would not stop screaming at a disaster assistance centre. After interviewing his caregiver I discovered there was a very good reason for the screaming — he screamed during the storm and the storm finally went away. So, because the assistance centre was so loud and confusing, he screamed to make it stop. I also discovered that, in the past, he had used earphones and music to drown out loud noises but the machine had been destroyed in the storm. A donated audio system made all the difference in this boy's recovery.

**A recurrent theme has been your concern for the disaster responders as much as for the families and communities.**

Absolutely! I remember having dinner with some friends on Long Island one night in September 2001. They told me about a neighbour who had been working at the World Trade Center site non-stop for weeks until a "Red Cross lady from Oregon" talked with him about what he had accomplished, the toll it had taken on him and his family, and when he would know he had done enough. After that conversation, he said he felt he could finally go home. My friends told him they were so glad he was okay and asked what they could do to help, then just happened to ask the name of the lady from the Red Cross. He said my name! So, not only is this an unbelievably small world, it also illustrates the impact of a simple Solution-Focused conversation.

I learned to conceptualise disaster work as using a very small bag of skills (such as a "day pack" for the field) rather than the large array of skills available in an office environment. Modelling on my experience backpacking in Oregon, when we each carried a kit that included 10 essentials such as a fire-starter, water and compass, I identified "ten essentials" for Solution-Focused disaster work. I remember presenting those 10 essential strategies I use in disaster-focused field interactions at the European Brief Therapy Association conference back in 2004.

1. Curiosity about what happened,
2. Coping questions (e.g. what keeps you going, how have you managed, how were you able to)
3. "Wow, how did you do that?"
4. "What did others notice you doing?"
5. "What else?"
6. Practical knowledge about resources (e.g. water, diapers, coffee, charging stations)
7. "There must be a very good reason ..." (see story above about screaming child)

8. Scaling questions (to offer perspective on the challenges, any pre-session change, one small step)
9. Remembering that the client –therapist relationship is like a Mobius strip in a disaster zone — one tremor, one infectious disease, one explosive device, and ‘we are them’.
10. Compliments — reflecting the clients words and values

I continued to work intermittently at disaster sites for the years between 1999 and 2004, in between seeing clients in my practice, teaching and consulting. In 2004, I was offered an opportunity to spend a year in Washington DC as a Fellow with the American Academy for the Advancement of Science working on the organisation and financing of mental health services in the U.S. This tapped into my passion for making a difference, so with Steve and Insoo’s blessing, in January 2015 I took this next step into a different world.

In August, Hurricane Katrina hit the Gulf Coast and I was asked to serve as Deputy Incident Commander of the Emergency Response Center at the Substance Abuse and Mental Health Services Administration. All of my work was informed by Solution-Focused Brief Therapy, some of which is described in this article: <https://www.hsdl.org/?view&did=747354>

**I know you weren’t “doing therapy”. So, can you give us an example of how Solution-Focused ideas made a difference in your work in this context?**

One particular example is the “Returning Home Questionnaire” for federal employees who had been deployed at the front line on the Gulf Coast. There was a need for them to be able to debrief; however, I was clear that I wanted such interviews to be an opportunity to celebrate accomplishment and success as well as to identify the need for additional services. The materials we created can be found at [https://www.osha.gov/SLTC/emergencypreparedness/resilience\\_resources/support\\_documents/supervisorhome/returninghome\\_questionnaire\\_supervisors.html](https://www.osha.gov/SLTC/emergencypreparedness/resilience_resources/support_documents/supervisorhome/returninghome_questionnaire_supervisors.html)

It was exciting to discover how well Solution-Focused approaches could be applied to developing pre-deployment and post-deployment materials, intervening with individuals impacted by the disaster, developing policies and procedures with colleagues, and coping with the day to day challenges in the field and at headquarters. The extent of the catastrophe was mind-boggling and the scope of interventions overwhelming. Small steps that make a big difference over time, exception finding, meaningful goals, scaling, complements, and highlighting coping strategies were the essential skills I applied to each situation.

Looking back on the years since 1998, I see how SFBT gives me a lens to understand the natural trajectory of how disaster impacts people. Yes, some people struggle longer than others with making meaning or coping with the adverse consequences to their health and lives. I've been amazed at the power of the struggle to clarify priorities and create a future unimaginable before the disaster, as well as the network of survivors that reach out to help others that were impacted at a different time. For example, the leaders in communities impacted by shootings in the United States regularly reach out to the leaders involved in a later shooting. It's a network born of tragedy, but also the knowledge and compassion of those who came before.

I've been lucky to work with some incredible leaders to develop policies and procedures that highlight the strengths, meaning and coping that can emerge from response operations. Many of my colleagues resonate deeply with a Solution-Focused orientation and seek out opportunities to develop materials that build on Solution-Focused practices such as exception-finding, scaling, identifying small change and a preferred future.

**What have been the particular challenges that your commitment to SFBT have raised in your disaster work?**

I think it's been important to keep an open mind and always consider both/and rather than being limited to either/or. There are times when a problem focus or "root cause analysis" is very helpful to people. Just like SFBT, though, this is a means to an end that is pre-defined beforehand. In the responder world we say "Begin with the end in mind." So, while this isn't a challenge *per se*, it's an important application of SFBT. I would add the phrase "there must be a very good reason", which I first heard from Insoo, which guides me to be curious when behaviours, reactions, policies or procedures don't make immediate sense. Once I understand the intent, SFBT provides the framework for opening up choices and overlooked experiences that can improve impact.

**I've known you for nearly twenty years and we've shared a conference stage and numerous restaurant tables, but I don't think we've ever talked this much about you. Thank you for this very different conversation. Any final thoughts?**

Solution-Focused Brief Therapy as a model is inextricably intertwined with the curiosity, vibrant intelligence, profound respect and phenomenal integrity of Insoo and Steve. I see the model growing and building on what works, in response to the changes in the world around us, via my colleagues in the

solution focused brief therapy community and how we listen to our clients. I'm grateful to have been in places where I can learn and share SFBT to foster healing, connection and creativity.

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## **Host: Six new ~~rules~~ roles of engagement for teams, organizations, communities and movements**

Mark McKergow and Helen Bailey  
2014. London: Solutions Books.  
Paperback

### **Review by Nick Burnett**

Managing Consultant Queensland for Growth Coaching International

There may well be some discussion and debate as to whether this book sits within the Solution-Focused paradigm and I hope this review positions the book as a pragmatic and practical Solution-Focused leadership tool to help leaders understand, unpack and improve their leadership in a wide range of situations and environments.

McKergow and Bailey define a Host Leader as ‘... someone who engages fellow participants in a purposeful endeavour’. To further position this book within the solution focused approach to leadership they articulate hosting as an activity as opposed to a defining characteristic of a person. This ‘interactional view’ is a key underpinning of the Solution-Focused paradigm, and offers an alternative view to the psychological ‘person as a bag of traits’ paradigm (Jackson and McKergow, 2007).

They also build the case of the importance of metaphors as being very important as they offer a rich and broad set of ideas about leadership in a way which allows interpretation into many different real-life situations. The book builds the case against two current dominant leadership paradigms of hero or servant. Arguing that both of these have significant limitations for the current ‘wicked problems’ (Grint, 2005) organisations and leaders face. They build the case for the key question being for a host leader at every moment is: As a leader, are you going to step forward (hero), or step back (servant)? Therefore, the metaphor both includes former paradigms as well as creating a new more agile and responsive view.

A key point is that leadership in the twenty-first century is about rela-

tionships rather than transactions. A key difference when it comes to helping people make this transition is that it's not about ME anymore; it's much more about US — getting results through engaging others, building cooperation, enhancing relationships and pulling together so that the energies and experience of all are fully engaged. At a high level, McKergow and Bailey argue that hosting could be seen as being about setting context, giving protection and enabling community through an “agile” philosophy.

Host Leadership is positioned as being about roles, not rules — roles that we take on for a while, rather than rules we always follow. Anyone can think like a host — even when the situation looks very unpromising.

There are six roles and four positions for a Host Leader.

## Six roles

1. Initiator
  - Noticing what's needed — a call to action
  - Getting things started
  - Responding to what happens
2. Inviter — about using the soft power of invitation and influence.
3. Space creator
  - The role of space — as a factor in what happens
  - Different types of space — physical, interactional, head space
  - Making the space fit the place — taking care with details
  - Holding the space — stepping back once people have arrived, being aware of how things are going, making adjustments and being prepared to step forward when needed.
4. Gatekeeper — more often concerned with drawing boundaries that will help create and sustain progress. These may be in terms of people involved, in terms of rules and routines, and in terms of psychological safety. We will examine how you can host well using these ideas:
  - Boundaries and thresholds — insiders and outsiders
  - Container size — choosing the boundaries
  - Boundary-spanning leadership
  - Closing the gate
5. Connectors — They build connections between people, link people

and ideas AND know when to leave them to get on with it. We will look at three levels of connector

- Level 1: Connecting with others (understanding people)
- Level 2: Connecting others (connecting people and ideas)
- Level 3: Everything is connected (wise connectedness).

#### 6. Co-participator

### Four key positions for a Host Leader

1. In the spotlight — Being the focus of attention, out front, making things happen
2. With the guests — Still out front, but being “one of the group” – not the centre of attention
3. In the gallery — Standing back, taking an overview of what’s happening
4. In the kitchen — In a more private and intimate space, preparing and reflecting

### Implications

The authors also identify the implications for a leader as host as being:

- Relational — hosting can only happen with others (‘guests’)
- Invitational — hosts tend to use ‘soft power’ and a welcoming hand, rather than coercion
- Creating meaning — providing a context for new interactions and sense-making to occur
- Thinking in phases — looking around the task and including preparation and reflection as integral activities
- Taking care — the host has a traditional primary role in safeguarding their guests
- Taking responsibility — and therefore being accountable for what happens, whether planned or not.

As stated earlier the key question for a host leader is do I step forwards or backwards?

They identify that as a host leader you are dancing between stepping forwards (and acting in an heroic mode) — defining expectations; and stepping backwards (serving and providing, leaving space open for others) — creating space for interaction. To do this the host leader needs three skills:

- Awareness: Of the spectrum of possibilities and how they connect with the organisation and its work
- Flexibility: To actually act and perform effectively in different places along the hero-servant spectrum
- Timing: The contextual intelligence to know when to act, when to move, when to stand back and when to change tack.

Having been a leader, I find the Host metaphor with the six roles and four positions a much more pragmatic and useful metaphor to unpack the complexities of leadership as well as provide a range of possible ways forward for the leader. Whilst there may be some who would argue that Host Leader is a 'model' and therefore not within the Solution-Focused paradigm, its emphasis on the interactional view of leadership positions it within the Solution-Focused paradigm in my view as it allows for the 'every case is different' complex view of leadership as opposed to positioning itself as the 'right answer'.

McKergow and Bailey also identify that as a Host Leader, we will become more skilled at holding two different elements in mind: a future intention, hope or goal; and great flexibility over exactly what steps may be required to make progress. They refer to this as dynamic steering.

Whilst they refer to this in relation to the leadership perspective, from my own practice as an individual, group and team coach, I believe there is a highly useful and practical Solution-Focused coaching tool contained within the book, namely that of 'The User's Guide to the Future'.

Key points to the 'User's Guide to the Future' is that it shows that not every element of the future is seeable or usable in the same way. The horizon, although it may be in the far distance, is vital in terms of setting a direction for progress, as are the first tiny next steps. Next, in terms of importance is what needs to be in place for the horizon, future perfect, to be achieved, and also the first signs that the tiny small steps are heading us in the right direction. The middle distance — "ant country" — is potentially a burden. It's too far away to know effectively and can be a distraction. This four-step coaching and planning tool has proved highly useful with individuals, groups and teams

In summary, this book may well not be for everyone in the Solution-Focused community but I would highly recommend it for those in leadership positions or working with people in leadership positions to enable reflec-

tions at a greater depth due to it bringing the interactional nature of leadership more clearly into focus.

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## The reviewer

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## Encounters with Steve de Shazer and Insoo Kim Berg: Inside stories of Solution-Focused Brief Therapy.

Dr. Manfred Vogt, Dr. Ferdinand Wolf, Peter Sundman and Heinrich N Dreesen (Editors).

2015. London: Solutions Books.

### Review by Dr Alasdair J Macdonald

Retired Consultant Psychiatrist

Steve de Shazer and Insoo Kim Berg met at the Mental Research Institute (MRI) in Palo Alto. Their joint experiences there led them to found the Brief Family Therapy Center (BFTC) in Milwaukee in 1978. There the foundations of Solution-Focused Brief Therapy were laid. This model has had a revolutionary effect on the psychotherapies in general across the world as well as bringing about effects in the fields of management and organisational development. Terms such as solution focus, strengths-based working, the miracle question and future-focused enquiry are passing into everyday language. Every day in the media we hear interviewers asking 'On a scale of one to ten about this issue, where are you today?'

This book was originally published in the German language in 2012. The editors had known Steve de Shazer and Insoo Kim Berg for many years. Following their deaths in 2005 and 2007, they hoped to collect reminiscences and stories that would be of interest to the next generation of Solution-Focused workers. This goal has certainly been achieved. They contacted everyone in their acquaintance who might be able to offer a contribution. Many of these essays were in English and were skilfully translated into German by the editors for the first publication in 2012. This new edition in English was drawn together by Dr Mark McKergow of the UK. Much help was received from the staff of Borgmann Publishers in Dortmund with translation (where necessary) by Ms Gesa Moggenburg and proof-reading by Dr Christina Kotte.

There are 46 essays in the first publication and a closing section by Yvonne Dolan, who was a close friend of the couple. She provides Steve's recipe for Sicilian pasta sauce and her own recipe for chocolate brownies which she often made for the Milwaukee team. Mark McKergow has added an essay to the new translation from his own encounters with them.

The contributions in the text cover most of Steve and Insoo's professional

life. The earliest recollection comes from Janet Bevan Bavelas who met with them on occasions in the 1970s when all of them were involved with the innovative brief therapy project carried out at the Mental Research Institute in Palo Alto. Eve Lipchik had contact with them from 1978 and Professor Wally Gingerich was involved with the Milwaukee Brief Family Therapy Center (BFTC) from 1983. Other memories come from many fellow workers, trainers and trainees down the years. The last essay comes from Sabine Zehner Schlapbach of Bern, who never met either of them but spends her professional life working with others who quote Steve and Insoo all the time. She feels that their presence and creativity still informs her daily practice.

So some of the reminiscences come from fellow workers in contact with the MRI (such as Janet Bavelas), some come from those who shared their activities at BFTC (Dolan, Gingerich, Lipchik, Gale Miller, Scott Miller, Nelson, Weiner-Davis), some from colleagues who attended BFTC for training packages (Ahlers, Panayotov, Wolf) and many others from those who learnt from their many international workshops and training courses (Benniks, Gaiswinkler and Roessler, George, Macdonald, Ratner, Strnad, Wheeler, Visser, Vogt). Some contributions come from those such as Professor Terry Trepper who knew them socially at first, or from Steve's great friend Luc Isebaert, whose close friendship with the couple went far beyond a simple connection through work.

As the approach became more widely known, many authors comment on their own experience of absorbing Solution-Focused ideas into their own previous style of practice. Hans Benniks, Yvonne Dolan and Michele Weiner-Davis linked it with Ericksonian hypnosis, Helene Dellucci with her work using EMDR for trauma and Joachim Hesse with his work with psychological wounds. Marianne and Kaspar Baeschlin enhanced the programme in their residential special school, Heinrich Dreesen found links with his clown and juggling skills and Svea van der Hoorn used it to enhance her over-loaded mental health clinic in South Africa in the 1980s.

The book itself is a patchwork of memories drawn up by people who felt and were close to Steve and Insoo in work and in other ways. I have not space to mention every contribution but I learned something from every essay. Some of the anecdotes are work-related, while others recount personal events or shared experiences. Through the whole book the thinking behind SFBT is constantly present. Anyone interested in the history of ideas will find matter of interest in this book. One can see the process in which some of the BFTC concepts developed into active techniques. There is also evidence of the high regard felt for Steve and Insoo as people. Of course it has been impossible to include essays from every major figure in the current world of

Solution-Focused ideas. Perhaps a second volume will come, before Steve and Insoo's brilliance is diluted in the wider world of therapy advances?

The length, intensity and informality of the contributions makes the text easy to read. The device of listing the entries in alphabetical order by author makes it easy to search for authors and topics of interest. There is also a good index. There are one or two typographical errors in this book but I did not find any which affected the sense of the text.

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## The reviewer

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